2023

KWM INSURANCE POCKETBOOK

Light Trail No.1 by Lin ZIhao

KING&WOOD MALLESONS
金杜律师事务所

LEGAL 500:

BAND 1 INSURANCE

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BAND 1 INSURANCE POLICYHOLDER 2022

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BAND 2 INSURER: NON-CONTENTIOUS 2022

FOREWORD

King & Wood Mallesons is delighted to be bringing you this third edition of the *Insurance Pocketbook*. The inspiration behind the *Insurance Pocketbook* was that we wanted to find a better way of sharing our insight and experience with our clients, and industry stakeholders. We have been overwhelmed by the support and feedback we have received on previous editions and hope to catch up with you soon.

As ever, there has been a team effort on this *Insurance Pocketbook*, and that also reflects the year that we have had. KWM is lucky to have such bench-strength and we have specialists in front-end insurance, back-end insurance, regulatory matters for insurers, W&I and life insurance, and each of those teams have been busy over the last 12 months. As a group we have also helped a number of large Australian institutions with transactions to divest, or acquire general and life insurance entities.

If anything in this publication is relevant to your business – please feel free to contact a member of our team to discuss it further.

Inside this third edition of the *Insurance Pocketbook* you will find:

- informed commentary from Mandy Tsang, Sarah Yu, Jim Boynton, and their teams on trends they are observing in the market, and the impact of current reform;
- exclusive interviews with Nicholas Ferrari (the Head of Transactional Liability Australia and New Zealand at Berkshire Hathaway Specialty Insurance) and Gill Collins with Cyber Incident Management and Cyber Consulting, Pacific at Marsh; and
- succinct case notes on significant decisions from the last year, as well as a spotlight on some classic Australian insurance cases.

SARAH YU
PARTNER

MANDY TSANG
PARTNER

TRAVIS TOEMOE
PARTNER

PETER YELDHAM
PARTNER

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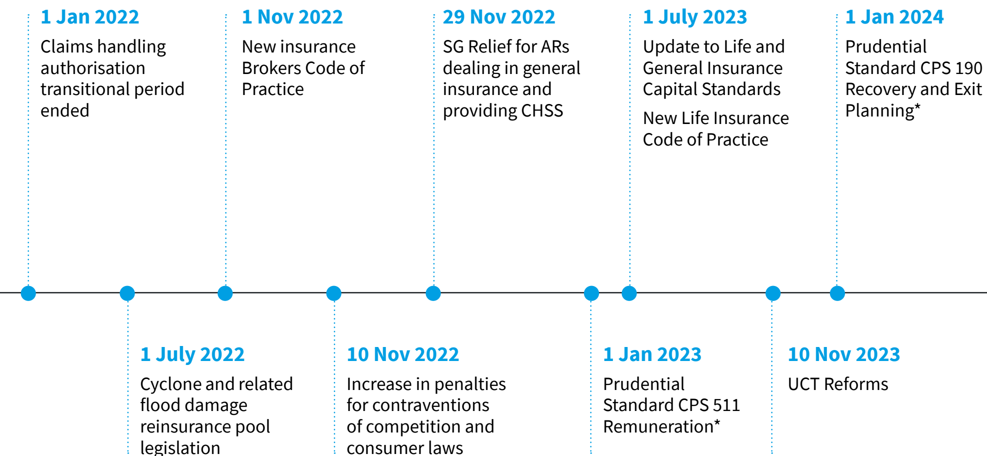
THE INSURANCE INDUSTRY REMAINS IN THE REGULATOR'S SIGHTS FOR ENFORCEMENT AND REFORM

2022 continued to be a busy year for regulatory reform and enforcement, following the many regulatory reforms that were introduced in 2021. These reforms impacted all stages of an insurance product's life, from its design and distribution, to claims handling and complaints handling. The Australian Securities and Investments Commission (**ASIC**) has prioritised the enforcement of such reforms, and have an expectation of readiness for compliance with the new regulatory requirements.

Overview



*The effective date applicable to the insurance industry.

Unfair Contract Terms

The Unfair Contract Term (**UCT**) regime applies to insurance contracts entered into on and after 5 April 2021, following amendments to the *Australian Securities and Investments Commission Act 2001* (Cth) (**ASIC Act**) and the *Insurance Contracts Act 1984* (Cth). The UCT regime has undergone continued reform as the Treasury Laws Amendment (More Competition, Better Prices) Bill 2022 passed on 27 October 2022 and received Royal Assent on 9 November 2022.

Broadly, the amendments:

- significantly increase penalties for contraventions of both competition and consumer laws;
- expand the application of the UCT regime, by widening 'small businesses' to mean businesses with an annual turnover of less than $10 million or less than 100 employees, removing the monetary ceiling for the value of contracts subject to the Australian Consumer Law (**ACL**) regime and raising the threshold for the upfront price payable under contracts subject to the ASIC Act to $5 million;
- prohibit UCTs outright;
- impose financial penalties for breach of the UCT provisions; and
- expand orders available to the court following UCT breaches.

The increased penalties under the ACL took effect on 10 November 2022 and the UCT reforms will commence on 10 November 2023. Given the recent reforms and their impending commencement, insurers should review their 'standard form' contracts with 'small businesses' to ensure compliance with the expanded regime. Terms previously within an insurers' risk appetite may need to be re-evaluated in light of the new reforms.

Product design and distribution obligations

The ASIC Corporate Plan 2022-26 outlines ASIC's enforcement priorities for the next four years, and its particular focus for 2023.[1] This includes four main external priorities which target "the most significant threats and harms in our regulatory environment" and have corresponding actions to be undertaken by the regulator, including enforcement.[2]

One external priority is product design and distribution, and an associated enforcement priority is targeting poor design, pricing and distribution of financial products including in relation to insurance.[3]

We discuss design and distribution obligations in further detail in the article from page 12.

Reportable situations reform

Breach reporting (now called reportable situations) reforms commenced on 1 October 2021, and broadly require licensees to lodge a report with ASIC whenever there are reasonable grounds to believe a "reportable situation" has arisen in relation to a financial services licensee. Further guidance is provided by ASIC Regulatory Guide 78 'Breach reporting by AFS licensees and credit licensees'.

1 ASIC Corporate Plan 2022-26.
2 ASIC Corporate Plan 2022-26.
3 22-302MR ASIC announces Enforcement Priorities for 2023

One of ASIC's 2022-23 priorities involves improving the operation of the reportable situations regime.[4] ASIC's first publication of information lodged under the reportable situations regime noted that:

- a much smaller proportion of licensees reported than anticipated;
- licensees are taking too long to identify and investigate breaches;
- further work is required to identify and report the root cause of breaches; and
- further improvements are needed to licensees' practices toward consumer remediation.[5]

Accordingly, we expect ASIC to give greater regulatory attention to compliance with this regime.[6] General insurance represented 19% of reportable situations, being the second largest category of reportable situations.[7] Motor vehicle insurance, home building insurance and home contents insurance were in the top 10 most reported products across all financial services, credit activities, and product lines.[8]

Hawking provisions

The hawking provisions stipulate that a person must not issue, sell, request or invite the purchase of a financial product if the consumer is a retail client and this is made in the course of, or because of, an unsolicited contact with the consumer.

Pursuant to ASIC's external priority of product design and distribution, ASIC will conduct thematic reviews and targeted surveillance of marketing and distribution practices to address misleading and predatory hawking tactics within the next year.[9]

Claims handling as a financial service

The financial service licensing regime has applied to claims handling from 1 January 2022, removing the claims handling Australian Financial Services Licence (**AFSL**) exemption. We have already seen ASIC enforcing this regime. At the end of 2022, ASIC commenced proceedings alleging an insurer breached its duty of utmost good faith in its claims handling. The case remains ongoing.

The *ASIC Corporations (Financial Services Guides) Instrument 2022/910* (**Instrument**) commenced on 29 November 2022. Under this Instrument, authorised representatives of financial services licensees who deal in general insurance products and provide claims handling and settling services are exempted from the requirement to provide a Financial Services Guide subject to certain conditions.[10]

Financial Accountability Regime

The Financial Accountability Regime (**FAR**) Bill 2022 was released on 8 September 2022 and essentially reflects the previous FAR Bill 2021 with no substantive changes. Broadly, the FAR requires an accountable entity and its "significant related entities" to comply with certain obligations.

4 22-295MR Breach reporting: ASIC publishes insights from the reportable situations regime; ASIC Corporate Plan 2022-26.
5 Report REP 740 Insights from the reportable situations regime: October 2021 to June 2022.
6 22-295MR Breach reporting: ASIC publishes insights from the reportable situations regime.
7 Report REP 740 Insights from the reportable situations regime: October 2021 to June 2022.
8 Report REP 740 Insights from the reportable situations regime: October 2021 to June 2022.
9 ASIC Corporate Plan 2022-26.
10 *ASIC Corporations (Financial Services Guides) Instrument 2022/910.*

Treasury has identified 14 streams of responsibility that are common to all locally incorporated accountable entities, while non-operating holding companies are subject to a separate 5 streams of responsibility. Additionally the FAR imposes two further prescribed responsibilities for insurers:

- first, senior executive responsibility for the actuarial function; and
- secondly, senior executive responsibility for the insurers' claims handling function.

The FAR will apply to the insurance and superannuation industries 18 months after commencement of the FAR Bill 2022. Accordingly, we expect this to be sometime in 2024, although timing is yet to be confirmed.

New codes of conduct

The new General Insurance Code of Practice came into effect on 1 July 2021 and was updated on 5 October 2021 to align with ASIC's Regulatory Guide on internal dispute resolution. Updates included a reduction from 45 to 30 days to resolve a complaint, an updated definition of a complaint, and a new commitment to improving customer awareness by providing information about the availability of financial hardship support on the insurer's website.

The National Insurance Brokers Association launched the 2022 Insurance Brokers Code of Practice on 1 March 2022, which came into effect and replaced the 2014 Insurance Brokers Code of Practice on and from 1 November 2022.

The Financial Services Council launched the New Life Insurance Code of Practice, which will come into effect on 1 July 2023, replacing the 2017 Life Insurance Code of Practice. The Financial Services Council has suggested that the final Life Insurance Code of Practice will be submitted for registration under ASIC's new enforceable code regime.

Crisis preparedness and resolution planning – APRA Prudential Standard CPS 190

On 1 December 2022, the Australian Prudential Regulation Authority (APRA)" released the final Prudential Standard CPS 190 Recovery and Exit Planning (**CPS 190**).[11] CPS 190 aims to ensure all APRA-regulated entities are adequately prepared for scenarios that may impact the financial viability of their business.[12] The key requirement of CPS 190 is that the entity develop and maintain a recovery and exit plan that includes:

- actions to recover its financial resilience during or following stress;
- actions for an orderly and solvent exit from the industry if recovery actions are not effective; and
- the indicators of potential stress to achieve effective and timely recovery or exit actions.[13]

The Board of an APRA-regulated entity is ultimately responsible for the oversight of the entity's recovery and exit planning. CPS 190 will come into effect from 1 January 2024 for banks and insurers, and from 1 January 2025 for RSE licensees.

11 Prudential Standard CPS 190 Recovery and Exit Planning.
12 Prudential Standard CPS 190 Recovery and Exit Planning.
13 Prudential Standard CPS 190 Recovery and Exit Planning.

Life and General Insurance Capital Standards

On 27 September 2022, APRA finalised changes to the capital and reporting frameworks for insurance in response to the introduction of the new accounting standard Australian Accounting Standards Board 17 Insurance Contracts (**AASB 17**). While AASB 17 has a commencement date of 1 January 2023, the revised prudential and reporting standards will come into effect from 1 July 2023.

The introduction of AASB 17 has modified several accounting concepts underpinning APRA's prudential framework and introduces some new concepts. APRA's prudential and reporting standards have been made to ensure compatibility with the new accounting standard, and have also been updated to:

- maintain the resilience of capital and reporting frameworks;
- neither increase nor decrease capital levels; and
- minimise regulatory impact on industries.

Governance and Remuneration – APRA Prudential Standard CPS 511

Prudential Standard CPS 511 Remuneration (**CPS 511**) commenced on 1 January 2023 and sets out the requirements for regulated entities to design and maintain prudent remuneration arrangements that promote effective risk management, sustainable performance, and long-term soundness. It operates alongside the Financial Accountability Regime. The Prudential Practice Guide CPG 511 Remuneration provides principles and examples of better practice to assist entities in meeting their new requirements under CPS 511.

Other

APRA planned to revise the Prudential Standard CPS 220 Risk Management and CPS 510 Governance, with the work to commence in mid-2023.

Reinsurance pool for cyclone and cyclone-related flood insurance policies

On 30 March 2022, the *Treasury Laws Amendment (Cyclone and Flood Damage Reinsurance Pool) Act 2022* (Cth) commenced to establish the reinsurance pool for cyclone and related flood damage, covering residential, strata and small business property insurance policies.

The cyclone reinsurance pool is administered by the Australian Reinsurance Pool Corporation with backing from a $10 billion Government guarantee and commenced on 1 July 2022.

On 20 December 2022, the Australian Competition and Consumer Commission (**ACCC**) released its first report pursuant to the Competition and Consumer (Price Monitoring—General Insurance Policies) Direction 2022, following the commencement of the cyclone reinsurance pool. The first report provides a benchmark for the ACCC's future analysis in subsequent years on factors like reinsurance costs and other premium components, and the collection of data on pricing outcomes for consumers.

Future Reforms

Quality of Advice Review

The Quality of Advice Review commenced on 11 March 2022 on release of its terms of reference which broadly asked how the regulatory framework for financial advice could be changed to make quality advice more accessible and affordable.

The Quality of Advice Review - Final Report (**Final Report**) was released on 8 February 2023 and broadly recommends that:

- personal advice should mean advice that is personal to a client, encompassing more financial product advice (and is the foundation for all other recommendations) but the existing exception from personal advice for general and consumer credit insurance should be maintained;
- providers of personal advice should have a duty to give 'good advice' and the focus should be on internal records for personal advice rather than disclosure to clients;
- the regulation of ongoing fee arrangements be streamlined; and
- a fiduciary best interests duty should apply to financial advisers with no safe harbour steps.
- The Final Report also recommends that the exemption from the ban of conflicted remuneration for life insurance, general insurance and credit insurance be maintained. The Government has indicated that expert analysis and a potential further round of public consultation will be taken before it responds to the Final Report.

ALRC Inquiry into Corporations and Financial Services Law

Following the Australian Law Reform Commission's (**ALRC**) release of the Financial Services Legislation: Interim Report A on 30 November 2021, the ALRC released Financial Services Legislation: Interim Report B (**ALRC Report B**) on 30 September 2022. ALRC Report B considers whether the *Corporations Act 2001* (Cth) (**Corporations Act**) and the *Corporations Regulations 2001* (Cth) (**Corporations Regulations**) could be simplified and rationalised regarding the use of definitions, the coherence of regulations and hierarchy of laws, and how Chapter 7 of the Corporations Act and Corporations Regulations could be restructured. A third interim report on the potential reframing or restructuring of Chapter 7 of the Corporations Act is due by 25 August 2023, and a consolidated final report is due on 30 November 2023.

DDO - "SET AND FORGET" FOR INSURANCE PRODUCTS? YOU MAY REGRET...

One of the Australian Securities and Investments Commission's (**ASIC**) top priorities is to ensure compliance with the product design and distribution obligations (**DDO**) in Pt 7.8A of the *Corporations Act 2001* (Cth). These obligations came into force on 5 October 2021.

As at the end of January 2023, ASIC has issued 23 DDO stop orders, five of which have remained in place and 18 of which have been lifted following actions taken by the entities to address ASIC's concerns. ASIC had also commenced proceedings against a product issuer and against a product distributor.

This article outlines ASIC's actions to date and provides some key takeaways for insurers.

Insurers and distributors subject to DDO

By way of a refresher, the DDO regime imposes certain obligations on the design and distribution of a broad range of financial products and credit products, including the obligation on issuers of such products to make a target market determination (**TMD**) before any retail product distribution conduct, and the requirement that both issuers and distributors take reasonable steps to ensure that the product is distributed consistently with the TMD.

ASIC actions to date – stop orders and enforcement action

ASIC's key areas of DDO focus

ASIC's 2022-26 Corporate Plan states that it intends to pursue risk-based surveillances and take enforcement action, focusing on sectors and products that pose the greatest risks of consumer harm. Indeed, ASIC announced on 3 November 2022 that one of its enforcement priorities for 2023 is enforcement action targeting poor design, pricing and distribution of financial products, including in relation to insurance products.

Why have ASIC stop orders been issued?

It is clear from ASIC's media releases that ASIC is willing to take issue with how a product issuer defines a financial product's target market or determines a product's distribution conditions. Reasons given by ASIC for issuing the stop orders to date fall within the following categories:

1. the target market was too broad or the TMD did not adequately describe the target market with sufficient detail;
2. the TMD did not specify any distribution conditions or the distribution conditions were inadequate;
3. the TMD did not include required content (for example, review periods); and
4. investment companies did not prepare TMDs for offerings of shares.

To issue a stop order, ASIC must be satisfied that there has been a contravention of the DDO provisions. Before making a final order, ASIC must hold a hearing and give a reasonable opportunity to any interested person to make oral or written submissions to ASIC on whether an order should be made. However, if ASIC considers that any delay in making such an order, pending the holding of a hearing, would be prejudicial to the public interest, ASIC may make an interim order which lasts for 21 days unless revoked. Further, at any time during the hearing ASIC can also make an interim stop order which may apply until either ASIC makes a final order or the interim order is revoked.

1. TMDs' target markets too broad

A TMD must be such that it would be reasonable to conclude that, if the product were to be issued to a retail client in the target market, it would likely be consistent with the likely objectives, financial situation and needs of the retail client. A number of stop orders involved a failure by the issuer to identify what ASIC considered was the appropriate target market for their product. The investor attributes in target markets in TMDs that ASIC considered inappropriate included the following:

- risk and return profiles;
- investment objectives; and
- investors' intended product use.

ASIC has expressed concern that issuers are not appropriately considering the features and risks of their products when determining the target market for their products.

For example, due to the high-risk nature of a fund's underlying assets (including secured and unsecured loans) ASIC considered that interests in the fund were inappropriate for investors with a "tolerance for a moderate level of risk" (as described in the fund's TMD).

ASIC also took a similar approach in respect of TMDs for other funds that invested in asset classes that it considered to be high risk. It issued three TMD stop orders for funds that invested in crypto assets (ie funds that invested solely in bitcoin, ether and Filecoin, respectively).

ASIC considered that crypto assets were "very risky and speculative" and disagreed with the description in the TMDs that these single-crypto asset funds were appropriate, even for investors with a medium, high or very-high risk and return profile.

2. Not setting distribution conditions or including inadequate distribution conditions

A TMD must be such that it would be reasonable to conclude that, if the product were to be issued to a retail client in accordance with the distribution conditions, it would be likely that the retail client is in the target market.

Six stop orders were made for TMDs that did not include any distribution conditions and ten other stop orders were made for TMDs that ASIC considered had inappropriate distribution conditions. For example, ASIC considered in numerous instances that it was insufficient for issuers of a TMD to rely solely on self-certification from investors that they fell within the target market without any other processes to identify the investors as being within the target market.

More recently, ASIC also considered that the distribution conditions for a credit product were insufficient to exclude persons that the TMD had identified as being outside the target market for the product. In this instance, ASIC accepted the revised TMD from the issuer, which included distribution conditions that were based on the consumer's experience with the product after acquiring the product (for example, a consumer will no longer have access to the loan product if they miss five repayments in any 12-month period). It is clear that ASIC expects issuers and distributors to consider the entire life cycle of the relevant product, and that they intervene to limit or restrict consumer access to the product if necessary to ensure that the product is not sold to persons outside the target market.

3. Not including required content

Other stop orders were made for TMDs that failed to satisfy the TMD content requirements (for example, the requirement to include mandatory review periods in the TMD).

ASIC is also taking enforcement action

ASIC has commenced enforcement action against both an issuer and distributor for non-compliance with the DDO.

In the first civil penalty action for non-compliance with the DDO regime, ASIC considered that a credit card issuer had not included appropriate distribution conditions, and had also failed to take reasonable steps to cease distribution of the product where it knew, or ought to have known, that a review trigger for the determination had occurred, or an event or circumstance had occurred that would reasonably suggest that the determination was no longer appropriate.

In another civil penalty action, ASIC considered that a distributor had failed to take reasonable steps to ensure that the product was distributed in accordance with the TMD. In this regard, ASIC considered that by employing a distribution strategy of cross-selling interests in a registered managed investment scheme to the same issuer's term deposit holders, there was a likelihood that these deposit holders were outside the target market for the product.

Are insurers and distributors up to date on DDO?

Many insurers engage third-party distributors to distribute their insurance products. More often than not, distributors of general insurance products are not themselves in the financial services industry and are offering distribution services as an ancillary offering. This presents the risk that distributors may not be fully cognisant of the DDO that are directly applicable to their distribution conduct, or may not have the resources or compliance framework in place to meet their DDO.

Importantly for issuers, ASIC expects the issuer to have effective arrangements to manage the risk that distribution is not consistent with the TMD. For example, as part of the reasonable steps obligations, insurers should have effective governance arrangements in place to take appropriate action where a distributor's prior conduct indicates that they may be at higher risk of engaging in conduct that is not consistent with the TMD.

The DDO explanatory memorandum provides examples of such action, including incorporating systems to enable distributors to be alerted of the issuer's updates to the TMD, or for the issuer to require the distributor to cease distributing the product more generally. In this regard, insurers may wish to ensure that the relevant contractual arrangement between the insurer and distributor is dynamic enough and gives the insurer the right to require changes to the distribution conduct if any concerns arise in relation to the distributor's ability to comply with any changes to the TMD, including changes to any distribution conditions applicable to the product.

Key takeaways for insurers and distributors

ASIC's enforcement action reiterates the point that issuers and distributors cannot treat TMDs as a "set and forget" checklist item. In particular, we make the following observations in relation to the insurance sector:

- As part of the reasonable steps obligation, insurers should review existing communication channels and record-keeping practices within the organisation, as well as how information and consumer data are being monitored and reported through its distribution channels. Insurers must have systems in place to amend the design of the product, or revise the TMD and distribution conditions, if they receive data that suggests that the design of the product may not be consistent with the likely objectives, financial situation and needs of consumers in the identified target market, or that the distribution conditions are no longer appropriate.
- This means that insurers should not only monitor data received on their own systems, but also consider information received via the distribution channels (for example, product claim ratios, policy cancellation rates, and the number, nature and magnitude of paid, denied and withdrawn claims). In light of the Australian Prudential Regulation Authority's focus on insurance data collection across the insurance industry, insurers will have a repository of insurance data and will need to be deliberate in their review of the data and how it reflects the performance and distribution of the insurance product.
- Many insurance products are bundled up or cross-sold to existing customers. Where distributors employ cross-selling strategies for a product, what procedures are in place to ensure such distribution is consistent with the TMD? For example, where a retailer has been engaged as a distributor to sell insurance to its customers, how does the retailer satisfy itself that the distribution of the insurance cover is consistent with the TMD? It is important that distributors can demonstrate that even though they have employed a cross-selling strategy, the customers to whom the product was sold were within the target market for the product.

More generally, all issuers and distributors of financial products who engage in retail product distribution conduct should consider the following:

- conducting regular reviews of their product governance arrangements to ensure that they are meeting the DDO (including the reasonable steps obligation) and that there are procedures in place to respond to the monitoring and review of outcomes (for example, whether any changes are required to distribution practices);
- reviewing TMDs in light of ASIC stop orders, priorities, data and customer information;
- ensuring TMDs and advertisements are consistent with the product's product disclosure statement (PDS);
- ensuring that advertisement checklists and sign offs consider the product's target market; and
- the broader implications of not getting DDO right, including:
  - negative publicity from receiving a stop order;
  - having to withdraw a product from market; and
  - the broad orders that a court may make, including returning money paid by the customer and compensating them for any loss.

UNDER THE MICROSCOPE:

DISCLOSURE PREMIUM INCREASES

Introduction

Over the last few years, the insurance industry has faced unprecedented regulatory reform, changing claims experience and broader economic, environmental and social factors which have resulted in substantial increases to premiums. APRA has also written to the life insurance industry raising its concerns about the sustainability of certain types of individual disability income insurance and implementing measures to counteract these.

The combination of these factors has resulted in a surge in customer complaints to insurers, regulators and the Australian Financial Complaints Authority (**AFCA**).[14] Whilst AFCA will not consider complaints relating to the quantum of the premium itself, it can and has considered whether the increases have been correctly applied, and whether there has been a breach of any legal obligations of the insurer, including the adequacy of its disclosures about the insurer's ability to increase premiums. These disclosures include those made at the time of acquisition, such as Product Disclosure Statements (**PDSs**) and any subsequent disclosure, including renewal notices and any "significant events notices" sent by insurers to satisfy their obligations under section 1017B of the *Corporations Act 2001* (Cth) (**Corporations Act**).

14 Since 2018 to the present.

On 8 December 2022, APRA and ASIC jointly wrote to the CEOs of all life companies to express their concern relating to premium increases applied to life insurance policies, particularly relating to level premium policies. They expect all life companies to review:

- past premium increases, including for legacy products, to determine whether increases or repricing decisions were applied in accordance with the relevant policy terms;
- disclosure and marketing material to determine whether policyholders were provided with sufficient clarity about future premiums, including changes to premiums over the life of the policy;
- the appropriateness and clarity of disclosures and marketing material for future premium increases;
- existing product labels, especially relating to the appropriateness where describing a product as having a 'level premium' if there is not a high degree of confidence regarding premium stability; and
- how policyholder expectations are being managed regarding premium increases.

Life companies must have written to ASIC by 31 March 2023 outlining:

- their findings in relation to that review;
- what steps are planned to report, rectify and remedy any issues identified; and
- what actions are being proposed to meet ASIC's and APRA's expectations about future product design.

If a life company will not be able to complete the review by 31 March 2023, it must update ASIC by **28 February 2023**. ASIC will arrange meetings with individual life insurers in **April to May 2023** to discuss their responses.

This issue is a clearly critical one for both regulators and life insurers as it can trigger large-scale remediations and have potentially devastating capital implications on an insurer.

There are a variety of factors which an insurer should consider when assessing their disclosures which are discussed below.

The backdrop – tension between the outcomes for the many versus outcomes for the few

The whole of the insurance industry is grappling with sustainability and rising costs. APRA, charged with the role of promoting financial system stability in Australia,[15] has been active in carrying out its objectives. In recognition of the need to be able to price life insurance policies so that life insurance companies are sustainable APRA recently intervened in relation to individual disability income insurance policies, publishing a letter titled "Final individual disability income insurance sustainability measures," dated 30 September 2020, in which it required a series of measures to be taken by life insurers. In that letter, it states:

> *APRA wants to ensure that there is an appropriate mechanism to keep products in step with changing circumstances, both in respect of changes in the circumstances of individual policyholders and broader societal and economic changes. Such a mechanism should moderate the extent of premium increases that may otherwise be needed.*

15 Section 8(2) of the *Australian Prudential Regulation Authority Act 1998* (Cth).

As the terms of the benefits provided by these long-term policies cannot be altered to the detriment of the policy owner, it is the premiums that need to be altered to reflect "broader societal and economic changes."

AFCA has also acknowledged the link between sustainability and the ability of an insurer to increase premiums:[15a]

> *Firms rely on sufficient premiums being paid to cover potential claims. If the number of claims increases, then the firm may need to adjust its premiums to cover that increase. If a firm does not do this, then its ability to pay future claims may not be sustainable. Whilst customers do not want their premiums to increase, they generally do need their insurer to be in a financial position to pay benefits when they need them.*
>
> *Losses sustained by life insurers have been widely reported. APRA, the prudential regulator for life insurers, has published statistics showing large losses in income protection insurance, and has said it is concerned about the sustainability of this kind of insurance. Other kinds of life insurance have had similar problems.*
>
> *This means many insurers have had to increase their premiums.*

Notwithstanding its acknowledgement, AFCA's mandate is fairness of outcome in all the circumstances for individual complainants, and whilst it takes legal principles into account, it can depart from those in order to make a determination which it believes is fair[16] – something which is clear in its determinations on premium increases.

When information that was disclosed to policyholders is considered, we consider that it is important to bear in mind that the policies under consideration are often long-term policies, some of which may have been taken out under disclosure regimes that pre-date PDSs. For example, under the disclosure regime immediately prior to the Financial Services Reform of 2001, a Key Features Statement was required to state that "any changes in fees and charges will be advised at least three months prior to the change occurring" but at that time there was a distinction made between premiums on the one hand and fees and costs on the other. Context is important especially when considering such long-term policies.

AFCA's determinations are binding on an insurer. Complying with a determination to re-price individual policyholders' cover or an entire book may cause an insurer to fall foul of its other obligations and place stress on the stability of the statutory fund from which the insurance benefits are paid.

The tension is real and insurers can find themselves between a rock and a hard place on the subject of premium increases!

Interpretation of the policy – legal principles and applicable industry codes or guidance

Insurance contracts are interpreted in accordance with the principles that apply to the construction of commercial contracts. The seminal legal principle in the interpretation of an insurance policy was stated by Gleeson CJ in *McCann v Switzerland Insurance Australia Ltd* (2000) 203 CLR 579; at [22]: (see our classic case note from page 78).

> *A policy of insurance, even one required by statute, is a commercial contract and should be given a businesslike interpretation. Interpreting a commercial document requires attention to the language used by the parties, the commercial circumstances which the document addresses, and the objects which it is intended to secure.*

15a See also AFCA, Factsheet - Insurance premium increases <https://www.afca.org.au/about-afca/publications/factsheet-insurance-premium-increases>

16 AFCA Complaint Resolution Scheme Rules, Rule A.14.2, < https://www.afca.org.au/what-to-expect/how-we-make-decisions >.

This requires an assessment of the language of the policy and what would make business common sense as well as consideration of its various components so that as a whole it makes sense.[17] Each of these elements are considered briefly below:

- *The language of the policy itself*: the meaning of a written contract should be determined by reference to what a reasonable person in the position of the parties would understand by the language used.[18] If there are ambiguities, extrinsic evidence of objective facts known to both parties at the time the contract was formed may be admissible to assist in interpretation.[19]
- *Different parts of the policy*: the interpretation of particular terms of a policy cannot be constructed in isolation from other relevant parts of the contract but must be considered in the context of the policy as a whole.[20] The resulting interpretation may be clearer on this basis, or there may be inconsistencies which create ambiguities. Where there are ambiguities of meaning:
    - the *contra proferentem* principle will mean that ambiguity may be construed against the party that drafted the contract, noting that this principle has been described as a rule of construction of last resort. There is some uncertainty surrounding the application of this principle which could influence an outcome for an insurer from AFCA or the Courts;[21] and
    - the duty of utmost good faith can prevent an insurer's ability to rely on a term of an insurance contract if doing so would mean that the insurer is not acting consistently with this duty – see below for more detail on this duty.

17 The Hon Justice A J Meagher, *Getting the Meaning Right: The Correct Approach to Interpreting Insurance Contracts*, a paper presented to the Australian Insurance Law Association, 4 December 2019.
18 *Maggbury Pty Ltd v Hafele Australia Pty Ltd* (2001) 210 CLR 181, [11].
19 *Mount Bruce Mining Pty Ltd v Wright Prospecting Pty Ltd* (2015) 256 CLR 104, [48].
20 *Wilkie v Gordian Runoff Ltd* (2005) 221 CLR 522; [2005] HCA 17, [16] (‘***Wilkie***’).
21 *McCann v Switzerland Insurance Australia Ltd* (2000) 203 CLR 579, [74] (‘***McCann***’). See our classic case note starting at page 78.

- *A businesslike interpretation*: in order to ensure that insurance benefits can be paid by the insurer, the statutory funds from which those benefits are drawn must be sustained. This is particularly crucial for guaranteed renewable policies which cannot be cancelled by the insurer and are intended to be long-term policies.

Accordingly, it is imperative that an insurer can change its premiums to reflect the risk it bears as issuer of the policies. For life insurance, the *Life Insurance Act 1995* (Cth) (**Life Act**) recognises that pricing of policies will change over time for policies through its regulation of changes to the pricing in section 9A(5). This section contains an important consumer protection, by allowing unilateral alteration of premiums in the terms of the policy only if that alteration is made for policies of the same kind on a simultaneous and consistent basis, and also a statutory recognition that the pricing of continuous disability policies will need to be altered on a unilateral basis by a life insurance company to appropriately reflect the risk that an insurer is taking on by issuing the policy and to ensure the sustainability of the statutory fund, so that the insurer is able to pay any benefits that may become payable under the policies.

The duty of utmost good faith

Section 13 of the *Insurance Contracts Act 1984* (Cth) (**ICA**) imposes on an insurer a duty to act with the utmost good faith in relation to any matter arising under or in relation to the contract of insurance. That obligation is owed to policyholders and insureds who are not themselves parties to the insurance contract but for whom the insurance is held (for example, in the case of insurance provided through superannuation products). The duty incorporates notions of fairness, reasonableness and community standards of decency and fair dealing,[22] requires more than honesty and that an insurer pay due regard to the interests of an insured.[23] It is not, however, fiduciary in nature and does not require an insurer to subjugate its interest to that of the insured.[24]

On the basis of this duty, an insurer can be prevented from relying on a term of a policy that is inconsistent with disclosure about that term.[25]

Accordingly, while a combined product disclosure statement and policy document can be drafted so that some sections contain policy terms and others contain disclosure wording, an insurer's duty of utmost good faith may require that it applies a particular policy term in a manner that is consistent with the disclosure of that term.

Ultimately, it is crucial that the key policy terms are properly disclosed to policyholders and insureds and to the extent that this is not the case, an insurer may not be able to apply those terms.

As it stands, the duty of utmost good faith is not capable of exhaustive definition and there is a degree of ambiguity surrounding its application which could influence an outcome for an insurer from AFCA or the Courts.

22 *AMP Financial Planning Pty Ltd v CGU Insurance Ltd* (2005) 146 FCR 447, [89]; *CGU Insurance Limited v AMP Financial Planning* (2007) 235 CLR 1, [15] (‘***CGU Insurance***’).
23 *CGU Insurance*, [15] and [257].
24 *Speno Rail Maintenance Australia Pty Ltd v Metals & Minerals Insurance Pty Ltd* (2009) 253 ALR 364, 163.
25 Sections 13 and 14 of the ICA. See, for example, *Australian Motor Insurers Ltd v Ellis* (1990) 54 SASR 61 in which the Court found that the duty of utmost good faith required the insurer to give the insured adequate warning of the general nature and effect of the policy condition and as the insurer had not done so the insurer could not rely on the policy condition to deny liability.

Other risks

Insurers who are considering the efficacy of their disclosures of premium increases should note the following risks:

- **Misleading or deceptive: conduct:** the concept of conduct that is misleading or deceptive or likely to mislead or deceive is relevant to legislative provisions such as section 12DA(1) of the *Australian Securities and Investments Commission Act 2001* (Cth) (**ASIC Act**) and section 1041H(1) of the Corporations Act.

  The concept of a disclosure document or statement being misleading or deceptive arises in provisions such as section 1021B(1)(a) (in the definition of "defective") and section 1022A(1)(a) (in the definition of "defective" – see next point for further discussion on defective PDSs) of the Corporations Act.

  It is important to note that pursuant to section 1041H(3)(c) should stay with 1041H(3) of the Corporations Act and section 12DA(1A) of the ASIC Act, conduct in relation to a disclosure document or statement within the meaning of section 1022A does not contravene section 1041H(1) or section 12DA(1) respectively. The effect of this being that misleading or deceptive representations in a disclosure document or statement (within the meaning of section 1022A of the Corporations Act) are regulated exclusively by Part 7.9 of the Corporations Act.[26]

  What constitutes a statement that is misleading or deceptive is not defined in the Corporations Act, but the following factors are relevant:

  - failure to draw attention: a document which, when read as a whole, is factually true and accurate may still be capable of being misleading if it contains a potentially misleading primary statement which is corrected elsewhere in the document but without the reader's attention being adequately drawn to the correction;[27] and
  - qualifying statements: failure to qualify a statement may be misleading.[28]

  Insurers considering this risk as part of their reviews should carefully review current and legacy PDSs (and other important associated disclosures) to ensure that their right to increase premiums has been preserved.

- **Defective PDS**: to the extent that there are any misleading or deceptive statements, a PDS will be "defective" as defined in sections 1021B(1)(a) and 1022A(1)(a) of the Corporations Act. Section 1021B(1)(a) is the definition for criminal offences and has the additional element that the statement must be materially adverse from the point of view of a reasonable person considering whether to proceed to acquire the relevant policy.

  The provision of a defective PDS is generally prohibited under the Corporations Act[29] and accordingly is a potential breach of "financial services law."[30] Determining the offence which could apply to the provision of a defective PDS will depend on the relevant circumstances. There is potential civil and criminal liability in relation to a "defective" PDS under sections 1022B (civil liability) and 1021E (criminal liability and civil penalty) of the Corporations Act but both have a potential "due diligence" defence that are on identical terms, which is that the person took reasonable steps[31] to ensure that the disclosure document or statement would not be defective.

  Whether a PDS is defective or not and if there are any available defences and to whom those will be available will depend on the circumstances of each case. As part of their review, Insurers should carefully consider current and legacy PDSs to ensure that their disclosure on increase premiums does not render the document defective and ensure robust compliance processes for the roll-out of future PDSs, continuous disclosures and online updates.

- **"efficiently, honestly, fairly" obligation:** issues with disclosures, especially where they are systemic, may leave an insurer open to a potential breach of its obligation under section 912A(1)(a) of the Corporations Act to do all things necessary to ensure that the financial services covered by its licence are provided "efficiently, honestly and fairly." As this phrase cannot be comprehensively defined, the circumstances of each matter will be key to its application.[32]

  This obligation in particular gives legislative force to social and commercial norms of behaviour, something which was heavily emphasised during the Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry. ASIC may, therefore, also pursue AFS licensees for conduct which it perceives to be a breach of community expectations or commercial norms. This means that as part of its review, an insurer will need to examine not only the terms of the policy itself but its surrounding conduct in light of community expectations and commercial norms.

  A breach of this obligation could result in significant civil pecuniary penalties,[33] including:

  - $11.1 million (current equivalent to the prescribed 50,000 penalty units noting that the amount of a penalty unit will increase from 1 January 2023);
  - three times the benefit derived and detriment avoided; or
  - 10% of the annual turnover of the insurer and their related bodies corporate capped at $555 million dollars (2.5 million penalty units noting that the amount of a penalty unit will increase from 1 January 2023).

  Insurers considering their risk in relation to this obligation can reduce that risk going forward by issuing clearer wording in policy renewal documents to ensure that policyholders are aware of the possibility of changes to the level premiums under the policy.

26 *Bendigo and Adelaide Bank Ltd v Cairncross* [2011] NSWSC 610.
27 *National Exchange Pty Ltd v Australian Securities & Investments Commission* (2004) FCAFC 90.
28 *Redmond Family Holdings v GC Access Pty Ltd* [2016] NSWSC 796.
29 Cf. sections 1021D and 1021E of the *Corporations Act 2001* (Cth) ('**Corporations Act**').
30 Section 761A of the Corporations Act.

31 On "reasonable steps," see *Clarke (as trustee of the Clarke Family Trust) v Great Southern Finance Pty Ltd (Receivers and Managers Appointed) (in liq)* [2014] VSC 516; *Woodcroft-Brown v Timbercorp Securities Ltd* [2013] VSCA 284; *Berry v Questor Financial Services Limited* [2009] NSWSC 1402, 105-6.
32 *ASIC v Westpac Securities Administration Limited* [2019] FCAFC 187 at [173] (Allsop CJ); cf. *ASIC v AGM Markets Pty Ltd (in liquidation) (No 3)* [2020] FCA 208 , 520 (Beach J).
33 Section 1317E and section 1317G of the Corporations Act.

- **Reinsurance:** issues relating to an insurer's ability to increase its premiums may trigger obligations and potential liabilities to its reinsurers. There may be reporting obligations and any retrospective and prospective adjustment of premiums may crystallise rights of the reinsurers under the relevant treaties in respect of warranties, recoveries already paid, indemnification for loss and other matters. Insurers should carefully consider and understand these obligations and regularly monitor so as to comply with them in a timely manner. Although exempt legislatively,[34] it is worth noting that many reinsurance treaties enshrine a duty of utmost good faith as between the insurer and reinsurer.
- *Future product design*: the design of sustainable future products in the life insurance space is clearly a key concern for APRA and ASIC. Life companies should carefully consider the design of products in the future, especially relating to what have been traditionally referred to as 'level premium' options to ensure that the product is sustainable from end to end, including the clarity of the policy and any disclosures at formation and throughout the life of the product.
- **Regulatory action:** insurers with sub-standard disclosure and policy wording should anticipate that regulatory action may be taken against them by ASIC or APRA. This may ultimately result in the acceptance of an enforceable undertaking by ASIC under section 93AA of the ASIC Act or, more increasingly, the commencement of civil and criminal proceedings for contravention of obligations under the Corporations Act. In respect of APRA, it has a range of formal and informal enforcement tools available to it,[35] including the acceptance of enforceable undertakings and the imposition of licence conditions on an insurer.

The issue of disclosure and premium increases is now under the regulatory microscope and cuts to the very heart of the sustainability and stability of the insurance industry itself. The tension between the known protective value of insurances to the community and the cost of obtaining that protection is greater than ever.

As part of the review required by APRA and ASIC, Insurers will need to carefully consider their current and legacy PDSs and other important documents to assess their right to increase premiums, and strengthen due diligence compliance processes around the development and amendment of important disclosures to reduce the risk that any changes made will erode those rights going forward.

The KWM team have deep experience advising on this issue and are happy to assist you in conducting your policy and disclosure reviews.

34 Section 9(1)(a) of the *Insurance Contracts Act 1984* (Cth) (**ICA**).
35 Under the *Australian Prudential Regulation Authority Act 1998* (Cth) and associated legislation applying to a particular insurer.

THE 3 C'S OF W&I INSURANCE IN 2022: CHALLENGES, COMPETITION AND CLAIMS

Warranty and indemnity (W&I) insurance continued to be a feature of private M&A deals throughout 2022, and despite the year coming off the back of the incredibly busy year that was 2021, we still saw a healthy number of W&I insured deals. In fact, 49% of our deals had W&I insurance, and whilst this was a slight drop from 54% in the prior year, it still constituted 72% of deals valued over $100 million, 63% of deals with private equity involvement and 57% of cross-border deals.[36]

In this article, we discuss key W&I insurance trends in 2022, and what we expect to see in the short to medium term.

36 King & Wood Mallesons, 'W&I', *DealTrends* (Web Page, 14 February 2023) <https://dealtrends.au.kwm.com/2022-report/w-i/>.

Bespoke solutions to economic challenges in the market

In 2022, we advised our clients on a growing number of deals with uncommon structures, instigated by tax considerations and the parties' desire to efficiently move capital. Buyers and sellers were equally interested in exploring new solutions including dividing assets across multiple buying and selling entities (including future investors under put and call options), spin-offs, subsequent transfers and alternative holding structures.

Tailoring W&I insurance to these unique deals created opportunities for prospective insureds, their lawyers, brokers and insurers to collaborate on achieving a legally sound and commercially acceptable outcome. We assisted our clients to refine their sale and purchase strategies and with bespoke changes to their sale agreements and W&I insurance policies to preserve optimal policy response.

These ranged from ensuring that the most fundamental aspects of insurance, such as the concept of insured loss, remained intact and traceable (where a deal was spread across multiple transactions) to ensuring that those unique structures would not trigger any limitations or exclusions under the W&I insurance policy. With W&I insurance continuing to be a focus in M&A transactions in this uncertain market, we expect that 2023 will see its fair share of interesting structures for the insureds, insurers and their advocates to resolve.

New market participants and increased competition

With the healthy uptake of W&I insurance in Australia, it was no surprise that several established insurers and brokers from London, Singapore and the US have entered the Australian market, as predicted in the 2022 edition of the Insurance Pocketbook.[37]

The recent competition in the market has given our clients more options than prior years, both in terms of pricing and suitability of the terms on offer. We expect to see this trend continue, leading to better and more stable pricing, as well as broader coverage.

For example, our dealings with brokers and clients operating globally suggest that insurers based in Europe are more open to covering synthetic warranties (i.e., warranties negotiated with and given by the insurer, rather than with and by the seller). UK-headquartered broker Howden has similarly reported on M&A insurers' growing appetite to underwrite distressed or insolvent transactions with synthetic warranties as one option.[38]

Whilst more expensive and requiring a different disclosure and diligence process, this offering to a previously underserved market will drive further competition if it picks up momentum in Australia. The timing is certainly significant, as WTW has predicted increased interest in distressed M&A in 2023, fuelled by more companies selling non-core assets to create value amidst economic uncertainty.[39]

37 King & Wood Mallesons, 'KWM Insurance Pocketbook 2002' (Publication, 14 April 2022) <https://www.kwm.com/au/en/insights/latest-thinking/kwm-insurance-pocketbook-2022.html>.
38 Howden M&A, 'M&A Insurance for Distressed and Insolvent Transactions' (online, December 2022) <https://view.publitas.com/howden-uk-group/m-a-insurance-for-distressed-and-insolvent-transactions-k87aaplzjkgg/page/1>.
39 Willis Towers Watson, 'Q4 2022 – Global M&A set for positive start to year ahead with strong finish in 2022' (Web Page, 16 January 2023) < https://www.wtwco.com/en-AU/insights/2023/01/q4-2022-global-m-and-a-set-for-positive-start-to-year-ahead-with-strong-finish-in-2022>.

In the 2022 edition of this publication, we also predicted that new participants in the W&I insurance market would bring new and different industry focuses with them. This also eventuated. Whereas W&I insurance has traditionally been a product for top-tier and high-value deals, the last day of November 2022 saw Fusion launch an insurtech product offering M&A insurance to small-to-medium enterprises on deals valued between $1m to $100m.[40]

Areas of underwriting focus

Last year, we identified cyber risks, legal compliance, employment and the target's EBITDA and revenue as areas of underwriting focus. These remained of interest to insurers in 2022, although they have evolved due to shifts in the market and significant events. Unique trends also emerged.

AREA OF INTEREST	COMMENT
AML/ABC	Anti-money laundering and anti-bribery and corruption risks in East Asia, South-East Asia and the Middle East continued to be difficult to insure. Australia also saw several high-profile AML proceedings brought by ASIC and AUSTRAC; however, these compliance risks have not become a general focus in domestic transactions, and their exclusion depends on the nature of the deal and the DD conducted.
Cross-jurisdictional risks	If our clients' deals are anything to go by, cross-border activity is on the rise (from 48% in 2021 to 54% in 2022).[41] Insurers will be interested in understanding the operations of the target group in a foreign jurisdiction (including sales and trade activity and legal compliance) and will expect fulsome due diligence to be undertaken. However, even with robust due diligence, it may be difficult to ensure compliance with all regulatory requirements and seller warranties may need to be read down accordingly.
Cyber	Cyber continued to be an area of underwriting focus, particularly given the large-scale cyberattacks against several Australian companies in in 2022. W&I insurers' focus on cyber risks on the one hand, and near-inaccessibility of cyber insurance at a commercial premium on the other hand, means that buyers need to undertake adequate due diligence to obtain (usually limited) W&I cover in this respect. WTW has similarly noted that some insurers in 2022 were unwilling to consider offering cyber insurance unless certain standards were met.[42] New entrants to the market may bring with them increased flexibility in cyber coverage in W&I policies.
Russo-Ukrainian War	Since February 2022, most W&I insurance policies have contained an 'Excluded Area' exclusion, also known as the Russia/Ukraine/Belarus exclusion, to preclude losses arising out of or increased by the war in Ukraine and its geographical surroundings. We have seen this exclusion applied in a range of deals from those involving airports and seaports to transactions for the sale of retirement houses in Australia. Prospective insureds requiring coverage in this area should discuss options with their broker and legal advisors.

40 Daniel Wood, 'POP goes the launch: New digital M&A insurance offering for SMEs', Insurance Business Australia (online, 30 November 2022) <https://www.insurancebusinessmag.com/au/news/breaking-news/pop-goes-the-launch-new-digital-manda-insurance-offering-for-smes-428993.aspx>.
41 King & Wood Mallesons, 'Deal Activity', *DealTrends* (Web Page, 14 February 2023) <https://dealtrends.au.kwm.com/2022-report/deal-activity/>.
42 Willis Towers Watson, 'Cyber Insurance Market Update Q2/H1 2022' (Web Page, 25 July 2022) <https://www.wtwco.com/en-AU/insights/2022/07/cyber-insurance-market-update-q2-h1-2022>.

W&I Insurance Pricing

Aon notes that capacity constraints in H1 2022 led to an increase in pricing pressure for W&I insurance.[43] However, market conditions have since improved, leading to better pricing.[44] KWM has certainly noticed a drop in W&I insurance rates since the incredibly busy period in 2021, where these ranged from 1.7–1.8% for medium sized deals to 2.5–3% for larger deals. In our experience, rates appear to have returned to their pre-pandemic levels of 1–1.5%, and we expect that increased competition over fewer M&A deals in the current market will keep pricing reasonably stable.

Will 2023 be a year of claims?

W&I insurance claims activity has been on the rise in the APAC region in the past few years. In fact, Marsh has noted in its 2022 global transactional risk claims report that its clients have made more than three times as many claims in 2021 than they did in 2017.[45] This is significant because claims activity in this region has historically been lower than the global average, but an uptick in activity seems to now be emerging.

Liberty GTS is already reporting notifications on 8% of the risks placed in 2021, and six notifications in July 2022 alone, breaking the record for the number of notifications it has received in any given month in the region.[46] Aon has similarly noted a change both in the frequency and severity of W&I insurance claims.[47]

A steeper increase in claims activity in 2023 and beyond is likely. It can take a while after the inception of the policy for a breach to be discovered and for a W&I insurance claim to be made. The unprecedented number of placements, combined with a comparatively small percentage of payouts in the APAC region in these past years, a more sophisticated understanding of W&I insurance and higher quality advocacy (reported by Marsh) could easily lay the groundwork for such increased claims activity, making claims an insurance theme of 2023.

If past trends are to be relied upon, we would expect tax and financial warranty breaches to top the charts. In 2022, over half of the notifications made through Marsh related to tax and financial statement breaches, respectively, 30% and 23%, followed by compliance and dispute breaches at 22%.[48]

Liberty GTS has separately identified a few areas which are at an increased risk of claims activity, suggesting that due diligence be directed to these areas. They include undisclosed price increases and customer incentives, inventory issues, accounts receivable, fraud, cyber, third-party claims and ESG issues.[49]

Concluding remarks

W&I insurance has proven itself to be a key risk allocation product in the M&A scene. It did not shy away from challenges proposed by the COVID pandemic, we saw demand for it explode during the most uncertain of times following that economic slowdown, and it continues to dominate larger deals and those involving private equity even as we venture into a shifting market. If our clients' interest, increasing competition and emergence of new players are indications, we expect to continue to see it be used, and look forward to assisting our clients on their deals and (as an unfortunate matter of commercial reality) claims.

43 Aon, M&A and Transaction Solutions Insurance Market Insights 2022 (Report, 2022) 2 ('**Aon**').
44 Aon 4.
45 Marsh, Global Transactional Risk Claims Report 2022 (Report, September 2022) 21 ('**Marsh**').
46 Liberty Global Transaction Solutions, Claims briefing: Exclusive insights guiding global decision making (Report, November 2022) 5 ('**Liberty**').
47 Aon, 16.
48 Marsh, 24.
49 Liberty, 27–28.

"WE'RE CONSCIOUSLY UNBUNDLING" A LIFE INSURANCE BUSINESS?

They may not be in Hollywood or part of a celebrity power couple but many life companies will be currently thinking about the various components of their business and whether they should be 'unbundled' to unlock some of the risk and value caught up in the integrated model.
In this article, we explore some of the important legal and strategic considerations to unbundling a life insurance business 'consciously' and prudently.

Background

Market dynamics and regulatory changes are major driving forces in the insurance industry. The traditional emphasis on owning the whole of the value chain of a life company is being eroded by concerns of unsustainability, the growing competition with private equity platforms, and the challenges in dealing with legacy systems and meeting new technological demands. As such, many life insurers may be in the process of looking to unbundle their value chains and outsource components to specialised third parties without having to build those capabilities in-house.

There are, however, risks and potential pitfalls to consider in unbundling each component in the chain.

Product Design

Life insurance is a long term, 'guaranteed renewable' product for which the terms of cover, once set, are figuratively 'set in stone'. It is also a highly competitive industry and so the best product features for the lowest cost to the consumer has long been the catch cry in the market.

However, over the last few years, profitability and sustainability of life insurance products for insurers have been under both external and internal strain, caused by factors including:

- the cost to develop and maintain systems to administer the different products which an insurer issues over time;
- increased regulatory reform, including design and distribution obligations (**DDO**) and the incorporation of most life insurance into the unfair contracts regime;
- increased regulatory scrutiny relating to product design and sustainability of life insurers;
- increased regulation of the distribution through life insurance, the Life Insurance Framework (**LIF**) reforms and associated changes to the regulation of financial advice;
- the cost of remediations and penalties relating to errors and breaches;
- the costs and risks associated with merger and acquisition activity; and
- the quality of (often historical) contract terms affecting the ability of a life insurer to increase premiums (see the article in this Pocketbook titled 'Under the Microscope: Disclosure Premium Increases' at page 18).

ASIC and APRA have been watching this space with interest and taking action where they deem it necessary to enforce legal requirements or to ensure the long term sustainability of the statutory funds from which the insurance products are issued.

For example, in letters sent to the industry in 2020, APRA expressed concerns over the sustainability of individual disability income insurance products and required insurers to implement a variety of measures (including relating to product design) to address those concerns.[50] APRA has more recently commented that a balance needs to be struck between sustainability and profitability in product design in the individual disability income insurance context.[51]

More recently, on 8 December 2022, ASIC and APRA issued a joint letter addressed to life companies expressing their concern relating to premium increases applied to life insurance policies, particularly relating to level premium policies and required a review of policy terms, past premium increases and disclosures (including marketing material) and to report back findings and proposed actions to remediate to ASIC by 31 March 2023.[52]

Product design is also no doubt being influenced, to an extent, by the relatively new DDO obligations and ASIC's rigorous enforcement of the regime, with a spate of stop orders being issued in late 2022 for products with deficient target market determinations (**TMDs**).[53]

Lastly, most life insurance contracts put in place on and from 5 April 2021 need to comply with the unfair contract terms (**UCT**) regime. This has required insurers to rethink contract drafting for the products that are impacted to ensure the UCT regime's additional obligations are met.

All this adds to the regulatory and sustainability burden that insurers are facing, which may lead some life insurers to consider simplifying and streamlining their offerings or unbundling all or part of the design and issue of life insurance products, relying on white labelling entirely or as a complement to a simplified portfolio of in-house products.

50 < https://www.apra.gov.au/final-individual-disability-income-insurance-sustainability-measures >.
51 < https://www.apra.gov.au/news-and-publications/idii-back-on-track >.
52 < https://www.apra.gov.au/premium-increases-life-insurance-industry >.
53 See 22-323MR; 22-334MR; 22-338MR; 22-352MR; 22-361MR.

Life insurers should carefully consider and stress test their strategic options and their potential benefits in light of the legal, regulatory and compliance obligations and costs which will flow from those options and map those against their existing obligations and costs. Further, a life insurer which outsources any product design must ensure that the products are compliant from a legal and regulatory perspective.

Distribution

Many life insurers currently manage the distribution of new policies directly through relationships with advisers (employed, affiliated or independent) and via incumbent and platform arrangements with superannuation trustees. Distribution carries with it a great measure of legal, regulatory and contractual risk, as demonstrated during the Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry. Since then, the legal, regulatory and compliance obligations, along with the costs, have exponentially increased, including to:

- ensure compliance with the expanded anti-hawking regime;[54]
- ensure compliance with various regimes relating to data and the use and disclosure of personal information, including Prudential Standard CPS 234 *Information Security* (**CPS 234**) and the *Privacy Act 1988* (Cth);
- ensure compliance with the complex and changeable conflicted remuneration obligations;[55]
- ensure compliance with the financial product advice obligations[55] which are currently under review as part of the Quality of Advice Review;
- ensure compliance with the DDO[57] and UCT regimes;[58] and
- prepare for the Financial Accountability Regime (**FAR**),[59] which is imminent.

In addition, remediations, penalties and increased litigation, including class actions and regulator-initiated proceedings, have placed significant pressure on the sustainability of statutory funds.

Technology and Administration

Most life insurers have traditionally maintained in-house administration systems and IT infrastructure at great cost but those costs and the risks associated with this model are increasing, contributing factors which include:

- the demand to make life insurance products digitally accessible in real time;
- the maintenance and upgrade of legacy systems which may be required to administer a number of historical and open products;
- implementation of law and regulatory/prudential reform and regulatory investigations;
- the management of cyber-security to prevent attacks and protect customer privacy;
- the management of incidents, issues, breaches and remediations caused by administrative errors; and
- the implementation of non business-as-usual projects to launch new products or to complete mergers and acquisitions.

54 Sections 992A and 992AA of the *Corporations Act 2001*: (Cth) (**Corporations Act**).
55 Divisions 4 and 5 of Part 7.7A of the Corporations Act.
56 Chapter 7 of the Corporations Act.
57 Part 7.8A of the Corporations Act.
58 Section 15 of the *Insurance Contracts Act 1984* (Cth) (**ICA**).
59 *Financial Accountability Regime Bill 2022.*

All this may prompt life insurers to consider whether the administration of the products they issue should be unbundled and outsourced to a third party. This has the potential to reduce the costs and risk of operating an in-house administration system, however, there are some issues to consider. Whilst outsourcing may transfer some of the risks and costs of in-house administration, the insurer will remain accountable at law for activities outsourced and other risks and costs may emerge, including:

- compliance with CPS 231 *Outsourcing* (which will become CPS 230 *Strengthening Operational Risk Management* on and from 1 January 2024);
- contract risk, particularly relating to conflicted remuneration and oversight of compliance with law for activities outsourced;
- additional compliance costs to ensure sufficient monitoring of service providers; and
- relationship management replacing in-house control.

Thorough due diligence is recommended to assess the potential administrators' abilities, capabilities, strengths and weaknesses, historical performance, regulatory issues and their appetite and agility to improve and change. What will it cost to execute the outsourcing of the administration, including any integration of IT systems? Does the chosen administrator share the same ethos or are they willing to support the life insurer's claims philosophy and approach to customers? To what standard of service will you hold the administrator - first in class, best practice or minimum viable product? How will the administrator implement changes to the underlying systems to respond to regulatory change and at what cost? If the administrator fails, what are the 'Plan B' options and what are the costs, risks and time required to implement?

Cyber security and data protection should be a key concern. In 2019, APRA released its prudential standard on information security, which imposes requirements on registered life insurers' handling of data irrespective of the performance of the administration in-house or externally. In particular, an APRA-regulated entity must assess the information security capability of the outsourced related or third party.

The standard of assessment is to be commensurate to the potential consequences of an incident affecting the information assets being managed.[60] Further, an APRA-regulated entity must have information security controls in place to protect its information assets, whether they are managed in-house or by outsourced parties.[61]

Therefore, if an insurer chooses to outsource, it will face compliance risks in monitoring which will replace the need to maintain the adequacy of their own systems. Through the contract and subsequent arrangements, life companies will still need to ensure that the service provider has robust security systems to discharge their own obligations.

The "conscious" element of "consciously unbundling"

For life insurers looking at unbundling aspects of their value chains, there are a variety of strategic, financial and legal ducks to have in a row before pulling the trigger, including:

- thorough tendering and due diligence of prospective providers;

60 CPS 234.16.
61 CPS 234.21.

- robust contractual terms which provide the insurer with sufficient monitoring, access and reporting rights, termination rights, indemnities and financial penalties as levers for under performance, assurance of compliance with law (including regulatory requirements and the Life Insurance Code of Practice) and protection of intellectual property rights and data security;
- an end to end understanding of the services to be provided, which are comprehensively detailed in a schedule of services (along with any exceptions) attached to the contract documenting the arrangements, which should be updated regularly;
- mapping how any unbundling will affect the life company's FAR obligations and arrangements in place;
- an understanding of the data flows between the life insurer and the provider and any subcontractors or 'fourth party suppliers', including offshoring and handling of personal (especially sensitive information) and ensuring contract terms reflects the role of each party in the process;
- completing an end-to-end review of any change management required for the governance of the life company, including risk management frameworks, outsourcing frameworks, delegations and conflicts management frameworks and policies to ensure that they will correctly reflect the unbundled parts of the value chain;
- the formation of a relationship management function which will own and manage the relationship between the life company and its providers;
- a review of the life company's existing reinsurance arrangements and early and regular communication with reinsurers to manage the unbundling process;
- a legally enforceable commitment from providers in respect of regular technology improvement, in order to meet the expectations of customers and regulators, ensure data security and integrity and remain 'match fit' in the market;
- end to end oversight of the incident management processes, which will no longer be self-contained. A life company will need to ensure that any provider in the value chain has an effective incident management system and a track record of sufficient compliance processes and controls. A level of secure system integration may be required in order to ensure timely reporting and this should be scoped so that a life company can lodge reportable situations in compliance with its legal and regulatory requirements and manage any remediations effectively;
- will any exclusivity or options negotiated with providers fit with mid to long-term strategic planning for the life company and if the strategy pivots, how easily can these be amended?;
- understanding whether any prospective providers are a good cultural fit with the life company;
- analysis of how the projected costs, profits and capital risks of unbundling stack up against remaining in an integrated model; and
- considering how the life insurance company will exit the relationship, and what are the 'Plan B' options (eg the life company stepping in to do the services until the appointment of an alternative provider) and the costs and risks of those options.

Once a life company has an understanding of the above, the key question to ask may be 'to unbundle or remain bundled?'

INTERVIEW WITH GILL COLLINS

Gill Collins is Head of Cyber Incident Management and Cyber Consulting (Pacific) at Marsh (a member of Marsh & McLennan Companies, Inc).

Gill has been working in the insurance industry for her entire career. We caught up with her to discuss her exciting new role at Marsh as Head of Cyber Incident Management and Cyber Consulting (Pacific).

Please tell us about your new role at Marsh

I started with Marsh last year and am heading up two different businesses there.

The first is the cyber advisory business where we provide a suite of consulting services to our clients aimed at supporting their cyber maturity and addressing their cyber risk management challenges. We work with clients to assess and bridge gaps in their cyber resiliency, quantify their maximum potential exposure and uplift their incident response planning and capabilities. We also undertake ransomware and other crisis simulations and work with boards and executives, educating them on how to understand and manage cyber risk.

The second is a new business we are launching at Marsh in Australia and the Pacific after its successful rollout in the US, UK and Continental Europe. This is a cyber incident management service where we offer a complete solution to help clients prepare, respond to and recover from a cyber incident. We provide active support and professional guidance to help align our clients' incident management approach before, during and after an incident.

How did you get into insurance and, more specifically, the cyber insurance industry?

I was first introduced to insurance when I began my professional career at Mallesons (now King & Wood Mallesons (**KWM**)). I worked predominantly in the insurance litigation team on professional lines of insurance matters such as professional indemnity, management liability and directors and officers (**D&O**) liability. After I left KWM, I became the Australian laims manager for Chubb Insurance and then went on to be General Counsel for Chubb Insurance in Europe.

Subsequently, I went on to start and manage two consulting businesses focused on insurance. The first was a general insurance and claims advisory business specialising mainly in professional indemnity claims. The second was a cyber consulting business which focused on cyber resiliency, incident response and cyber awareness training and education.

My move into cyber was organic; it was prompted by the frequency with which we were seeing cyber issues affect other financial lines of insurance as cyber claims came in. I foresaw cyber issues becoming increasingly prevalent and this area hooked my curiosity.

Consequently, I took a course on "Cyber Security in the Information Age" at the Kennedy business school at Harvard and upskilled on cyber risk management and risk transfer, including the benefits of cyber insurance. Moving into a more specialised cyber practice was a natural next step.

What are some of the biggest changes you've observed or experienced in the cyber insurance industry over the past 10 years or so?

Like D&O 20 years ago, the Australian cyber insurance industry has already undergone massive changes. At first, everyone wanted to underwrite cyber risk; it was 'the new best thing'. Lots of underwriters entered the market and provided broad coverage and, with that, significant limits of liability. Inevitably, when the claims arrived, the market hardened, premiums rose significantly and cover was restricted. However, the market is stabilising and looks more settled as we start 2023.

Cyber insurance is a curated insurance with a high level of scrutiny by underwriters who analyse all aspects of a potential insured's cyber posture.

Of course, as cyber attacks have become more prolific and more claims data is available, underwriters have identified a strong correlation between the strength of an organisation's cyber risk management procedures and the corresponding exposure to potential cyber incidents.

In the past, some organisations faced barriers to the availability of cyber insurance – from both a cost and a risk management perspective – but there is now a greater awareness of their 'cyber management obligations', and this is translating into better cyber resiliency and a heightened ability to obtain cyber insurance.

However, it is a work in progress and unfortunately businesses who do not commit to prioritising their own cyber risk management do not always qualify for cyber insurance.

There has recently been a noticeable increase in high-profile cyber incidents (including Optus, Medibank etc). Are you finding that a lot more businesses are procuring cyber insurance policies as a result? What other trends are you seeing?

Recent cyber attacks and their impact have certainly created a change in the cyber insurance and cyber risk management landscape. Conversations are moving away from cyber threat actors threat actors and into the into the areas of vulnerabilities from new technology and the need to improve cyber literacy, cyber communications and cyber information sharing.

Data management is now a major priority along with supply chain risk, and the need to improve and heighten security around the information and operational technology of critical infrastructure.

Current geopolitical tensions have increased concern about cyber threats and a heightened belief that cyber attacks will occur.

All of this has translated into new and more robust discussions about how to manage and transfer cyber risk, including the use of cyber insurance.

How have the past few years with COVID-19 (combined with the recent high-profile cyberattacks) impacted cyber insurance in Australia and around the world?

COVID disrupted lives, economies and businesses across the world. It forced organisations and their employees to embrace new practices of social distancing and remote working. There was a scramble to implement new technology solutions enabling digital customer interfaces customer interfaces, as well as access for employees to business information systems and networks from outside the office. The speed with which these changes were implemented and the massive increase in use of less secure home networks and personal devices meant that most organisations faced a substantially increased 'attack surface'. This translated into more cyber attacks – especially social engineering attacks.

Insurers responded by focusing more on the cyber security posture of a potential insured before offering terms of cover. They looked closely at incident response plans and preparedness, remote work protocols and cyber security risk management practices. In some instances, insurers would even require proof of good cyber hygiene such as multi-factor authentication, privileged access protocols, backup and patching plans and offensive and defensive detection mechanisms.

This higher level of scrutiny meant that some companies could not obtain cyber insurance or found that their insurance premiums increased and coverage limits decreased.

What are you expecting in the 'cyber space' for 2023?

In 2023, I expect the character of cyber attacks will change. There will be less talk about cyber threat actors and more talk about the expanded threat landscape and the evolving and increasingly sophisticated attacks and their impact. Businesses try to solve for a number of risks in building cyber resilience, but reputation or brand risk and business operational risk are becoming the most concerning areas for executives.

There is increased anxiety about mega-scale cyber threats due to geopolitical tensions, in particular more targeted nation state-sponsored cyber attacks. Along with this leaders are acknowledging the increased exposure and vulnerability of critical infrastructure and resources and services.

After last year's high-profile attacks in Australia, data protection and management is under high scrutiny. Organisations of all sizes now need to think about what data they collect and their reasons for collecting it, how they store that data, how it is protected and how it should be cleansed. Their management of access to data is also paramount. Regulatory reforms are also playing into this need as well.

Supply chain risk and systemic risk are also hot topics and organisations need to deeply understand and manage not only their own cyber resilience and posture, but also that of their supply chains. They need to implement increased controls on third parties with access to their IT systems and networks or data.

What does an average working day currently look like for you?

Like everyone, my days are pretty jam-packed. A typical day will include leadership team meetings, strategy calls, client introductions/pitches and reviews of our advisory projects. I also spend time keeping on top of cyber news and updates and regulatory changes. Some weeks I do a number of presentations, so that means writing and refining those and ensuring that they align with what the audience most want to know about cyber security and cyber risk management. At Marsh, we try and provide a bespoke offering for every client that reflects their unique and industry-related business needs and insurance expectations, so every day brings new challenges.

What major challenges do you foresee for the cyber insurance industry?

The pace with which technologies are evolving and the interconnectedness of those technologies is creating new cybersecurity vulnerabilities that need to be protected against. Interoperable edge and quantum computing, IOT devices and autonomous technologies running critical infrastructure are all influencing on cyber exposure and cyber risk management. For example; as technologies become more interlinked and cloud-based, the risk of data encryption, exfiltration and ransomware increases.

Another challenge is how to best provide cover for SME businesses. Many small businesses are equally as vulnerable to a cyber attack as their big business counterparts, but do not have the finance or resources to create sophisticated cyber resilience programs. Collaboration within the industry is needed to uplift cyber resilience across the board. It is critical that we create a culture of of cyber security both in business and in the personal lives of all Australians.

Systemic risk is also a significant industry challenge and there is much discussion around how to insure against it. Likewise, nation-sponsored cyber attacks are increasingly likely and the insurance industry is grappling with measures to limit exposure to huge losses caused by these types of threats.

What one piece of advice would you give about cyber risk?

Prepare, prepare, prepare. The most resilient organisations are those that think holistically about their cyber exposure, implement protocols and procedures aimed at limiting risk and increasing cyber posture and who put in place well-documented and tested incident response plans.

Where can you typically be found when you are not working?

Outdoors. Walking the dog, playing golf, at the beach or just anywhere away from a desk!

INTERVIEW WITH NICK FERRARI

Nick Ferrari is currently the Head of Transactional Liability Australia and New Zealand at Berkshire Hathaway Specialty Insurance.

KWM caught up with Nick over a coffee (and pastries) in February 2023 to learn more about his role, his journey into underwriting from his early days as a KWM lawyer, and how transactional liability is evolving.

Tell us about your role and what it involves.

I have been given the privilege of building BHSI's transactional liability product offering in Australia and New Zealand on our powerful platform with the assistance of some truly exceptional people. The mainstay of our transactional liability offering is warranty and indemnity insurance but it also extends to contingent risk and tax liability. These products are established for BHSI globally, but we have now entered the Australian and New Zealand markets where there continues to be a growing demand. The products offer a great alternative for managing risks compared to more traditional arrangements such as escrows, holdbacks, the buyer taking the credit risk of recovering under warranties, or purchase price reductions.

In standing up the transactional liability business in Australia and New Zealand I have been collaborating closely with my teammates to build our transactional liability products in a way that's consistent with BHSI's philosophy of simplicity over complexity and I am looking forward to growing our forever business into the transactional liability space.

What does a typical working day look like for you?

There is no real typical workday – each day really varies. The only constant is that I start each day at the gym (around 6am by the time I get in there), as I find that's the best time to go (no one puts meetings in my diary that early in the day!). For my actual work day, I could be collaborating with teammates in the transactional liability or legal team on wording, meeting with the claims team to discuss our processes or claims they're dealing with across the business, catching up with brokers, meeting with customers or their advisors to discuss our products, or catching up with teammates from BHSI's other offices virtually. Then there are the more mechanical parts of my job which require me to deal with submissions, prepare terms and pricing of the products, and work with teammates on billing and policy issuance.

Tell us about your journey into the insurance industry. How has your legal experience prepared you for your role?

Everyone seems to say you fall into insurance. I can't say my experience has been too different from that. I used to work as a transactional lawyer at KWM and once I realised that private practice was not where I wanted to be long term, I set out to find an opportunity that would leverage my skill set and I found that in underwriting W&I insurance. I've now been underwriting since 2017.

Transactional liability is a mix of law and insurance that leverages the skill set I had developed as a solicitor around approaching and managing legal risks, how transactions are negotiated, and legal drafting. Now I apply those skills from an insurance angle to price, define, and underwrite risks. It was an interesting transition and required me to engage with risk in a different way, as I moved from being an advisor, where you are advising clients on their risks which they then manage as they see fit, into an insurance role where it is more about understanding the risks, pricing them appropriately, and providing protection against those risks from our balance sheet. My time at KWM also instilled in me a strong sense of legacy and stewardship that the partners live out in their practice and pass on to the junior lawyers. This has given me a great foundation to transition into insurance and particularly at BHSI where we understand that claims is our product and we need to take a long term focus to be sure that when our customers need us we are there and able to respond when they are calling on a policy.

What did 2022 look like for transactional liability insurance?

2022 was a bit of a readjustment in the transactional liability space in Australia and New Zealand (and even globally). 2021 was a boom year for M&A, which meant it was also a big year for W&I (a rising tide floats all boats!). Off the back of the boom, we also saw new entrants into the W&I market, which increased market capacity. However, as deals slowed down in 2022 and early 2023, there has been a corresponding reduction in demand for W&I insurance and the market is in the process of re-adjusting given the increased competitive pressure.

What have been the biggest changes or events in the transactional liability space in the last few years?

While COVID-19 was a big event for parts of the insurance industry, I don't think COVID-19 has had a direct impact on the W&I line to date because the product is retrospective rather than prospective like many other lines.

The biggest changes in the transactional liability space in my view are due to the success of products like W&I insurance which has led to further increased appetite for insurers to look at products that protect intangible assets.

We have also seen growth in lines of products in the transactional liability space that would not have existed 10 years ago. If you looked at insurance, 50 years ago most insurers offered products that protected tangible assets against physical threats (with some exceptions) but as the value of intangible assets has grown for companies (and individuals) there has been increased interest for and in developing products to cover losses in the value of these assets, whether that be taking out intellectual property insurance to protect valuable IP, or a contingent risk policy to de-risk the outcome of litigation, or many other new and evolving products. This has been pronounced in the transactional liability space where there are often balance sheet implications or deal pressures driving customers to look to insurance rather than more traditional risk management tools.

Tell us about the role of insurance and insurers in mitigating risks in large M&A deals.

Insurance plays a number of important roles in M&A deals similar to the support it provides to the stability of any company's operations on an everyday basis.

In this light I think it is important for a buyer to consider and assess the target's existing insurance package when approaching any acquisition.

I am often surprised that some buyers do not always engage in insurance due diligence given the insight it can provide into the risk profile of and management of the target group (for example, the claims history can provide a detailed insight into potential areas of poor management).

Insurance can also play a crucial role in that it is one of the ways that risks around a transaction are managed, mitigated, and allocated. From a W&I insurer perspective we get involved in the transaction to provide protection for a buyer from unknown and undisclosed risks and we look to understand high risk areas in the business being acquired by leveraging our experience and that of our advisors. Where issues are identified in the due diligence, sometimes these become commercial issues to be resolved between the parties but insurance can also play a role by providing solutions in the form of a tax or contingent liability policy where the identified issue relates to a question of law or its interpretation.

What are you expecting to see in respect of transactional liability (and insurance) in 2023?

From a transactional liability perspective, it will depend on what happens to M&A volumes and activity. If it continues to slow down, I expect it will prompt insurers to look beyond W&I insurance and into other products such as contingent risk, tax, and IP to assist their customers manage other risks. I also expect to see increased claims activity following the boom of 2021, given the majority of claims are notified within the first two years of the policy period.

In terms of insurance more broadly, I think the increased frequency of minor CAT events will be front of mind for insurers and reinsurers which will lead to a reset in the reinsurance markets coming off the back of recent events in NSW, QLD, and Auckland for lines which are exposed to those events. For executive and professional lines, I think we will see the market flattening with a moderating of rates and for certain accounts and lines, some rate decreases. The casualty market will likely continue to stabilise.

Inflation (both social and economic) will also be a focus for insurers as its impacts continue to flow through from cost pressure for customers and increased claim costs for insurers.

Is there a piece of advice you give that you wish you had received yourself?

This is a challenging question. One of the things I have learnt recently is that what is good advice for one person, may not be good advice for another. I think the advice I would give is, if you seek and obtain guidance, first consider whether that guidance applies to you (and your own unique circumstances and background) before you apply it carte blanche. If you are giving advice, I would recommend you consider the situation and background of the person you are giving advice to and whether you are best placed to give advice and/or whether the advice that has worked for you is right for the person you are giving it to.

What is a key lesson you have learnt in the insurance industry?

There is no such thing as empty capacity, if you put out a limit you need to be comfortable that it may be called on. Insurance is a promise to pay in the event a policy is called on. As an insurer you need to act with integrity both in dealing with claims but also in pricing your product so that you can look for cover when your customers need you. Claims is our product!

What do you like to do in your spare time?

I am a classic nerd - I enjoy reading and video games. At the moment, I am looking into sharing these interests with my son as he grows. He is a little too young to be reading and gaming at this point, so for now we are filling in our weekends with aquariums, museums, and wildlife parks.

Although I don't have as much time as I would like to game these days, when I do get time, I have been enjoying Call of Duty: Modern Warfare II and The Last of Us (and enjoying the TV series). I'm also looking forward to playing Hogwarts Legacy. Now that we are moving past the pandemic I am also looking forward to travelling again and getting back into diving.

CASE NOTE

AFCA DETERMINATION REGARDING GROUP LIFE INSURER RIGHTS TO AVOID A POLICY FOR MISREPRESENTATION REMAINS ON LIFE-SUPPORT

Sharma v H.E.S.T. Australia Ltd **[2022] FCA 536**

SNAPSHOT

- In cases of fraudulent misrepresentation by an insured to a group life insurer, where there is later a change of insurer, only the original insurer to whom the misrepresentation was made can avoid the contract under section 29(2) of the *Insurance Contracts Act 1984* (Cth) (**ICA**). A later insurer, which is on risk when a claim is made, and which fails to make its own enquires as to any risks, cannot rely on the original representation and section 29(2) ICA to avoid the policy.
- The only remedies available to insurers for non-disclosure and misrepresentation are those statutory remedies available under Division 3 of Part IV ICA. That Division excludes rights at common law and/or in equity to rescind a policy after misrepresentation.
- Despite the above, an insurer may, however, still have a right to avoid a policy for misrepresentation or non-disclosure relying on a breach of the duty of utmost good faith under section 13 ICA.

INSURANCE ISSUES CONSIDERED BY THE COURT

- Can a misrepresentation or non-disclosure by an insured to an earlier insurer under a group life policy be relied upon by a new group insurer, to whom the misrepresentation or non-disclosure was not directly made, to avoid the policy relying on section 29 ICA?
- Can such a life insurer rely upon common law or equitable principles to avoid a contract for misrepresentation or non-disclosure, or does Division 3 of Part IV ICA exclude the application of common law and equitable principles?

Facts

- Dr Deepak Sharma (**Dr Sharma**) held death, total and permanent disablement cover (**TPD**) and income protection cover (**IP**) under a policy with H.E.S.T Australia Superannuation Fund (**Fund**). A default amount of cover was automatically given to superannuation holders without the need for any health information to be provided (**Default Cover**). The cover was held by the Fund through a group life insurance policy. The insurer was ING Life Limited (later called OnePath Life Limited (**OnePath**)).
- On 22 March 2011, Dr Sharma applied for additional TPD and IP cover (**Increase Application**). OnePath required Dr Sharma to complete a health questionnaire. One of the questions asked was whether the applicant had ever been diagnosed, treated or had signs of heart problems. Mr Sharma answered “no”. In fact, he had suffered a heart attack and had undergone a surgical stent placement in 1999. The application form stated Dr Sharma’s duty to respond truthfully, which he acknowledged. OnePath accepted the Increase Application in July 2011 (**Additional Cover**).
- In December 2011, Colonial Mutual Life Assurance Society Limited (**CommInsure** (its insurance business later transferred to AIA)), replaced OnePath as insurer, following a successful tender process. That cover was (so far as relevant) on the same terms as that provided by OnePath. CommInsure did not ask any questions of Fund members.
- In March 2017, Dr Sharma lodged a terminal illness claim with the Fund. He passed away due to heart failure one month later.
- In August 2017, CommInsure notified Dr Sharma’s estate (**Estate**) that:
  - It accepted the terminal illness claim so far as it concerned the Default Cover.
  - Dr Sharma’s Additional Cover was avoided (that is, treated as though it never existed), and that it would refund relevant premium payments relating to that cover.

That decision was made on assessment that there had been a fraudulent misrepresentation by Dr Sharma when he completed the Increase Application.

Dr Sharma's estate lodged a complaint with the Australian Financial Complaints Authority (**AFCA**).

- AFCA had powers to determine what was fair and reasonable. But, in doing so, AFCA was not permitted to make a determination that would be contrary to law.
- AFCA found CommInsure's decision was fair and reasonable. The reasoning is complicated. But, in short, it found:
  - Dr Sharma had given fraudulent answers in the Increase Application.
  - CommInsure could not rely on section 29 ICA to avoid the policy, because section 29:
    - Only provides a mechanism to do so to the particular insurer to whom the misrepresentation was directly made by the insured prior to the contract of insurance being entered into.[62]
    - Does not provide the same mechanism to a later insurer which took on the role of insurer in a group policy context and to which the misrepresentation was not directly made (e.g. CommInsure). Section 29 was not available to such an insurer.
  - However, a later insurer in a superannuation group life policy context could still rely on general rights at common law and/or in equity to avoid a policy on the grounds of misrepresentation. AFCA reached that view on the basis that the ICA did not contemplate the circumstances of a change in the group insurer, such that (in such circumstances) the ICA did not exclude the operation of common law or equity.
  - The decision not to pay the Additional Cover was fair and reasonable because common law or equity may accept that a fraudulent misrepresentation has a continuing effect and would allow the insurer to avoid the contract due to fraudulent misrepresentation.

Analysis by the Court

- The Estate referred a number of questions of law to the Federal Court of Australia. The Federal Court's task was not one of judicial review but to decide whether AFCA had applied the correct legal principles in determining what was fair and reasonable.[63]
- McElwaine J undertook an extensive statutory interpretation task of the whole of Division 3 of Part IV ICA (and other provisions of the ICA).[64]
- McElwaine J found that AFCA had materially misdirected itself as to the meaning and effect of the law and ICA.[65] McElwaine J:
  - Examined the interplay of various sections in the ICA, and found that the focus of the insured's duty of disclosure and the effect of making a misrepresentation "*is on an identifiable insurer at an identifiable point in time* [before the contract is entered into], *and not a subsequent insurer which assumes the risk at a later point in time*".[66]
  - Agreed with AFCA that CommInsure could not rely on section 29 ICA because section 29 only provides a mechanism to avoid policies in the case of the particular insurer to whom a misrepresentation was directly made.
  - Accepted that the ICA does not adequately deal with the (common) circumstances of a change of insurer in a group insurance context. But his Honour noted that such a "lacuna" was a matter to be addressed by parliament.[67]
  - Found that the statutory language was clear that the provisions of Division 3 excluded any other rights of an insurer in respect of misrepresentation or incorrect statement.[68] That is, it prevented access to common law or equitable principles.[69]
  - Found that CommInsure could not have any rights in cases of misrepresentation or non-disclosure in equity or at common law.
  - Found that it was not open to AFCA to determine that CommInsure's decision to avoid the policy was fair and reasonable according to common law and/or equitable principles, because they are not relevant considerations.[70] AFCA could only make its decision by reference to principles in the ICA.[71]
  - Recognised that there may be other arguments, avenues and remedies available to insurers in these circumstances to avoid a policy for misrepresentation or incorrect statement, for example relying on the duty of utmost good faith found in section 13 ICA. But while his Honour's commentary indicated support for such a position, it was unnecessary for McElwaine J to state a final view on this point (noting that that was an issue for consideration by AFCA once the matter was remitted to it).[72]

Result

- The Federal Court set aside AFCA's determination on the basis that AFCA had materially misdirected itself as to the meaning and effect of the law and ICA. The complaint was remitted to AFCA for redetermination.

Appeal Update

- CommInsure appealed the decision to the Full Court of the Federal Court. By order of the Full Court, the orders made by McElwaine J were stayed pending determination of the appeal.
- The matter was heard on 2 and 3 March 2023, with a decision pending at the time of publication.

62 Consistent with what was said in *Sharma v LGSS* [2018] FCA 167.
63 Under section 1057(1) of the *Corporations Act 2001* (Cth), a party to a superannuation complaint may appeal to the Federal Court of Australia on a question of law from AFCA's determination of the complaint.
64 McElwaine J considered Division 3 of Part IV of the ICA as it operated prior to the amendments made by the *Insurance Contracts Amendment Act* 2013 (Cth) on 28 June 2014 (that is, the law at the time the misrepresentation was made). The state of the law will be a relevant consideration in any matters cases that deal with similar issues.
65 *Sharma, v H.E.S.T. Australia Ltd* [2022] FCA 536, [75] (McElwaine J) ('***Sharma***').
66 *Sharma*, [76]-[77].
67 *Sharma*, [78]-[80].
68 *Sharma*, [88], and referring to *Macquarie Underwriting Pty Ltd v Permanent Custodians Ltd* (2007) 240 ALR 519; [27].
69 *Sharma*, [91].
70 *Sharma*, [98] [94].
71 *Sharma*, [106].
72 *Sharma*, [98]-[105].

CASE NOTE

INSURANCE ON THE DANCE FLOOR

***Legge v Universal Hospitality Group Ltd & Ors (No 3)* [2022] NSWSC 709**

SNAPSHOT

- Questions in insurance renewal forms must be capable of being clearly understood by prospective insureds and make clear that the information sought is relevant to the insurer's decision to accept the risk and if so, on what terms.
- If insurers want to demonstrate that cover would have been denied if certain information had been fully disclosed in a proposal form, then they should have clear internal policies and procedures, and the evidence presented needs to be consistent with them.

INSURANCE ISSUES CONSIDERED BY THE COURT

- Whether the insured breached its duty of disclosure (under section 21 of the *Insurance Contracts Act 1984* (Cth) (**ICA**)) and/or made misrepresentations (within the meaning of section 28 of the ICA) in relation to information it provided on a public liability insurance renewal form.
- Whether the insurer is entitled, under section 28 of the ICA, to:
  - Avoid the policy; or
  - Reduce its liability under the policy, and if so, to what extent.

- On 16 February 2011, Stephen Legge fell down the stairs at the Civic Hotel and sustained spinal injuries causing paraplegia.
- Neon Underwriting Limited (for and on behalf of a Lloyds syndicate) (**Neon**) provided cover to the Civic Hotel for Hotel Resort/Restaurant Public and Products Liability Insurance from 17 February 2010 to 31 January 2011 (**Policy**).
- The Policy was effected through Neon's Australian cover holder, ASR Underwriting Agencies Pty Ltd (**ASR**).[73] The Civic Hotel comprised of a basement with seating, a dance floor and console for a DJ, ground floor public bar and gaming area, and a top floor restaurant bar.[74]
- Mr Legge commenced proceedings in the New South Wales Supreme Court in July 2014 against the occupiers and licensees of the Civic Hotel – Universal 1919 and James Kospetas (together, the **Insured**). The Insured then cross-claimed against its insurer, Neon, after it denied the Policy responded on the basis that there were non-disclosures/misrepresentations in the completed renewal form by the Insured.
- The renewal form consisted of questions with yes/no response boxes and boxes for provision of further information.[75] Relevantly, the Insured:
  - ticked 'yes' to having a dance floor (though the box as to size of the dance floor was left incomplete);
  - ticked 'occasionally' to having dancing;
  - ticked 'occasionally' to having live entertainment (noting "DJ and cabaret" in the box requesting a description);
  - ticked 'no' to having discos;
  - ticked 'no' to having a cover charge; and
  - ticked 'no' to having a "Nightclub".[76]

73 *Legge v Universal Hospitality Group Ltd (No 3)* [2022] NSWSC 709, [52] ('***Legge (No 3)***').
74 *Legge (No 3)*, [1].
75 *Legge (No 3)*, [16].
76 *Legge (No 3)*, [25].

The Policy renewal terms were provided to the Insured – this included an exclusion for 'Nightclubs' and 'Nightclub Activities'.[77] Given the Civic Hotel had numerous spaces over three levels available for hire (which were often hired out by promoters for events involving DJs and which were also used by Universal from time to time), there was debate as to whether there was in fact a 'nightclub' within the premises.

Neon contended that had there been proper disclosure, Neon would have declined insurance altogether.[78] As a result, Neon sought relief under section 28 of the *Insurance Contracts Act 1984* (Cth) (**ICA**) to avoid the Policy.

Analysis by the Court

Lonergan J had three insurance related questions to answer in this case – and her Honour answered them as follows:

- Whether Universal breached its duty of disclosure under section 21 of the ICA – **No**.
- Whether Universal made a misrepresentation within the meaning of section 28 of the ICA – **No**.
- Whether Neon is entitled, pursuant to section 28 of the ICA, to avoid the policy, or reduce its liability under the policy – **No**.

Lonergan J considered various aspects of the renewal form, including the manner in which questions were formulated, the amount of information sought from a customer and the definition of key terms as used in the Policy.

No non-disclosure or misrepresentation by Insured

Neon argued that ticking the box 'no' for the word 'Nightclub' on the questionnaire was deliberately misleading in light of the physical characteristics of the basement room and the fact that it had often been referred to as a 'nightclub' by promoters and in Council applications.

Lonergan J found the definition of 'Nightclub' in the Policy was "bizarre and blurs concepts in a way that introduces confusion".[79] Moreover, her Honour took issue with the general vagueness of the terms and questions asked in the renewal form.[80] Her Honour suggested it would be illogical for a reasonable person to have to leap to the conclusion that if there was a 'nightclub area/attitude/activity', Neon would refuse to insure the *whole* three-level premises,[81] particularly given the Policy stipulated that the underwriters might agree not to exclude certain activities "provided full details are submitted to them and an additional premium (if any) is paid to cover these activities".[82]

Lonergan J was not satisfied that there had been a misrepresentation by the Insured.

Lonergan J reasoned that even if her Honour was wrong about this conclusion, section 26 of the ICA would protect Mr Kospetas because:

> *His belief that there was no "nightclub" was genuinely held by him, with valid reasons, and I accept that a reasonable person in his circumstances would have held the same view, given the mixed use premises, the varying use of the basement depending on the night of the week and what, if anything, was booked to occur there, and the clumsy and confusing "definition" and status of "Nightclub" in the Policy documents.*[56]

77 *Legge (No 3)*, [38].
78 *Legge (No 3)*, [6].
79 *Legge (No 3)*, [85].
80 *Legge (No 3)*, [85].
81 *Legge (No 3)*, [86].
82 *Legge (No 3)*, [60].
83 *Legge (No 3)*, [88].

Lonergan J held that there had not been any relevant misrepresentation regarding "disco" or "frequent dancing" for similar reasons.[84]

Lonergan J was also critical of the approach Neon had taken to challenging the claim. Her Honour did not think that "close lawyerly hindsight analysis" was the proper basis on which to assess what Mr Kospetas,[85] or what a reasonable person in his position, knew or should have known about the operation of the term 'nightclub' and what information was relevant to whether Neon should offer insurance and on what basis.[86]

Further, Lonergan J found that any duty of disclosure relating to the size of the dance floor (Mr Kospetas did not answer this question on the renewal form), had been waived under section 21(3) of the ICA given neither Neon nor ASR at any point made an inquiry regarding the dance floor prior to renewing the Policy.[87]

In relation to section 27 of the ICA, her Honour noted that "clearly the insurer has some role in ensuring the answers are complete and cannot passively guess or blame the insured if the insurer fails to seek clarification".[88]

Not persuaded that Neon would have refused cover

Her Honour concluded that even if Neon was entitled to relief under section 28 of the ICA (which it was not), it had not persuaded her that it would have refused to insure the premises if there had been full disclosure as the "evidence on that issue was contradictory and in respect of the evidence of the underwriters, incomplete and unsatisfactory".[89]

Neon had called two of their underwriters in cross-examination who had attempted to state that they had an 'invariable' practice of refusing to underwrite anything that 'looked or smelled like a nightclub'.[90] However, her Honour stated that she had "significant doubts about the reliability of [their] evidence" and that those accounts were "simply not consistent with the policy documentation, or the binder, both of which allow for discretionary cover and/or referral to London in certain circumstances".[91]

Result

The Court held that Neon was not entitled to avoid the Policy or reduce its liability under section 28 of the ICA as there had been no relevant misrepresentation by the Insured and any duty to disclose had been effectively waived.

Even if there was an entitlement to such relief, Neon failed to persuade the Court that it would have refused to insure the Civic Hotel altogether had the renewal form been completed differently.

84 *Legge (No 3)*, [87].
85 *Legge (No 3)*, [84].
86 *Legge (No 3)*, [83].
87 *Legge (No 3)*, [87].
88 *Legge (No 3)*, [49].
89 *Legge (No 3)*, [90].
90 *Legge (No 3)*, [36].
91 *Legge (No 3)*, [37].

CASE NOTE

"FLOATS LIKE A BUTTERFLY – STINGS LIKE A BEE": LIMITATION PERIODS

Ali v Insurance Australia Ltd [2022] NSWCA 174

SNAPSHOT

- The date at which an insurer becomes liable to compensate an insured turns on the construction of the policy.
- Courts will consider the 'commercial reality' of an insurance policy for both the insured and insurer when assessing how the terms of a policy operate.
- Where there remains ambiguity in the construction of the policy with respect to the limitation period, the court will construe the limitation period in favour of an insured.

INSURANCE ISSUES CONSIDERED BY THE COURT

- Whether an insurer's obligation to compensate the insured for loss arises upon the occurrence of the damage or upon the insurer's determination of the insured's claim.

Facts

- On 9 October 2013, an unknown person forced entry into Mr Ali's home, stole goods, and caused damage. On 10 October 2013, Mr Ali made a claim under his home and contents insurance policy which he had taken out with the respondent, Insurance Australia Ltd (**IAL**) in June 2013. On 20 May 2014, IAL denied Mr Ali's claim.[92]
- On 16 October 2019, Mr Ali commenced proceedings against IAL in the District Court of NSW, seeking damages for failure to comply with the policy.[93] The primary question for determination by the District Court was whether IAL became liable under the policy on the occurrence of the break in (9 October 2013) or only once it denied cover (20 May 2014). If it were the earlier, then the six-year limitation period pursuant to section 14 of the *Limitations Act 1969* (NSW) expired prior to the commencement of proceedings by Mr Ali (and his claim was out of time). If it were the later, the proceedings were brought within time.
- For alleged breaches of contract, proceedings must be commenced within 6 years of the alleged breach.[94] The District Court held in favour of IAL, finding that Mr Ali's cause of action first accrued when the break-in occurred.
- The Primary Judge held that "*the word 'cover' in this policy is no more than a different word for 'indemnify'*" and subsequently determined IAL's obligation to indemnify "*arises immediately on the occurrence of a 'listed event'*".[95] As such, the proceedings commenced by Mr Ali were dismissed.
- Mr Ali appealed the District Court's decision. The matter was heard by the Court of Appeal in May 2022.

Analysis by the Court

- The NSW Court of Appeal rejected the District Court's construction of the policy, and held that Mr Ali's claim arose on 20 May 2014 upon IAL's determination of the claim.[96]
- The key questions answered by the Court of Appeal in reaching their conclusion were (1) could the relevant policy be distinguished from that in *Globe Church Incorporation v Allianz Australian Insurance Ltd* (***Globe Church***);[97] and (2) what the proper construction of the relevant policy was.

92 *Ali v Insurance Australia Ltd* [2022] NSWCA 174, [4] (**Ali Appeal**).
93 *Ali v Insurance Australia Ltd* [2021] NSWDC 369, [2] (**Ali District Court**).
94 *Limitations Act 1969* (NSW) section 14(1)(a).
95 Ali District Court, [20], [24].
96 Ali Appeal, [80]-[81].
97 *Globe Church Incorporated v Allianz Australia Insurance Ltd* (2019) 99 NSWLR 470.

Distinguishing Globe Church

- In reaching their conclusion, the Court of Appeal distinguished the relevant policy from that in *Globe Church*. At first instance, the District Court's construction relied on the following passage from *Globe Church*:[98]

  > *Absent a provision in an indemnity insurance policy that makes lodgement of a claim a condition precedent to liability, the concept of a promise to indemnity (to make good the loss or hold harmless against loss) in the context of a property damage insurance policy is such that the promise is enlivened when the property damage is suffered.*

- The Court of Appeal refused leave for Mr Ali to argue that *Globe Church* was wrongly decided. Rather, it was deemed irrelevant insofar as the decision was not determinative of the construction of Mr Ali's policy because it was drafted in "distinctly different terms".[99]

- Notably, the policy in *Globe Church* was an Industrial Special Risks policy, whereas Mr Ali's policy was intended for retail clients and written in plain English.[100]

The Construction of the Policy

- The Court of Appeal was required to determine whether the relevant policy contained a clear contractual promise to the effect that the respondent was liable to indemnify an insured upon the occurrence of a listed event. In examining the Policy (as with any written contract), the Court will assess the intention of the parties as expressed in the agreement.

- The Court of Appeal confirmed that this is to be done objectively, "*by reference to what a reasonable person would have understood the language of the contract to convey*".[101] Further, it was "*necessary to construe the language according to its natural and ordinary meaning having regard to the circumstances which the document addresses, and the object which it is intended to secure*".[102]

Application

- The Court's analysis focused on Section 3 and Section 6 of the policy. Section 3 read:

  > *We **cover** your home or contents **when** certain things happen…*
  >
  > *You **can** make a claim if a listed event you are covered for takes place and causes loss or damage to your home or contents during the policy period.*

- The Court of Appeal rejected the argument that "when" was used in the temporal sense to signify that the respondent's obligation arose at the occurrence of a listed event. Instead, a reasonable retail client in the position of the offeree would understand "when" to be conditional (i.e., the policy had no application unless and until a listed event had occurred).[103]

- Similarly, the Court of Appeal rejected the argument that "can" was permissive because the insurer's liability had arisen prior to any claim. The Court of Appeal considered that "can" was understood to be conditional (i.e., a pre-condition to the insurer incurring liability under the policy).[104]

98 Ali District Court, [6]-[8]; further consideration of *Globe Church* in Ali Appeal, [30]-[35].
99 Ali Appeal, [8]-[9].
100 Ali Appeal, [10].
101 Ali Appeal, [28]-[29] citing *Toll (FCGT) Pty Ltd v Alphapharm Pty Ltd* (2004) 219 CLR 165, [40]; *Electricity Generation Corporation v Woodside Energy Ltd* (2014) 251 CLR, [35]; *HDI Global Specialty SE v Wonkanka No 3 Pty Ltd* (2020) 104 NSWLR 634, [18]-[31] (Meagher JA and Ball J), [114]-[118] (Hammerschlag J); *Australian Casualty Co Ltd v Federico* (1986) 160 CLR 513, 525.
102 Ali Appeal, [29] citing *HDI Global Specialty SE v Wonkanka No 3 Pty Ltd* (2020) 104 NSWLR 634, [22]-[23] (Meagher JA and Ball J).
103 Ali Appeal, [49]-[51].
104 Ali Appeal, [52].

- Further, the Court of Appeal observed that subsection 3.1 titled 'Listed Events' catalogued events as either "*covered*" or "*not covered*" and, therefore, held that the word "cover" is descriptive as it operates to delineate particular events to which the policy applied. "Cover", understood in this sense, cannot constitute a clear contractual obligation for the Insurer to indemnify an Insured upon the occurrence of a listed event.[105]

The Primary Judge Erred in Conflating 'Cover' and 'Indemnity'

- The Court of Appeal held that the primary judge erred in concluding that a reasonable non-expert in insurance law would understand that the word 'cover' was, at all times throughout the policy, used interchangeably with the word 'indemnity'.[106] A critical problem was that the word 'cover' was consistently used to explain the scope of the insurance policy, but it was at times, used interchangeably with "insurance".[107]

The Contra Proferentem Rule

- In reaching their decision, the Court of Appeal held that Mr Ali's and the respondent's contended constructions resulted in "*equally uncommercial*" outcomes. However, the uncommercial outcome of Mr Ali's construction, whereby the running of the limitation period would be in the hands of the insured, was relevant but not decisive.[108] Conversely, the respondent's construction would enable a policyholder to bypass the dispute resolution procedures contemplated in the policy and seek relief in court proceedings, even in circumstances where there may be no dispute as between the insured and insurer.[109] Therefore, insofar as "*there remains 'real doubt' as to the correct construction*" the contra proferentem rule had a role to play.[110]

Result

The Court of Appeal held that, in this case, as the insurer's obligations arose upon their rejection of Mr Ali's claim (20 May 2014), section 14 of the *Limitation Act 1969* (NSW) did not bar Mr Ali's cause of action.[111] The proceedings were remitted to the District Court for determination.

105 Ali Appeal, [58]-[62].
106 Ali Appeal, [77].
107 Ali Appeal, [77].
108 Ali Appeal, [78].
109 Ali Appeal, [76].
110 Ali Appeal, [41]-[43] citing *LCA Marrickville Pty Ltd v Swiss Re International SE* (2022) 401 ALR 204, [102] ('***LCA Marrickville***').
111 Ali Appeal, [81].

CASE NOTE

THE HIGH COURT CLARIFIES THE ROLE OF PROPORTIONALITY IN THE IMPOSITION OF CIVIL PENALTIES

***Australian Building and Construction Commissioner v Pattinson* [2022] HCA 13**

SNAPSHOT

- The amount of a civil penalty is not constrained by proportionality to the contravention. That is, penalties are not to be determined by grading relevant contraventions on a scale of seriousness.
- Imposition of the relevant maximum civil penalty is not reserved for the most serious examples of offending comprehended by the relevant section of legislation under consideration. The amount of a civil penalty should be whatever is reasonably necessary (up to the relevant maximum legislative amount), in the particular circumstances, to deter future contraventions of a like kind.

INSURANCE ISSUES CONSIDERED BY THE COURT

- No insurance issues were directly considered.
- However, given the existence of (similarly worded) civil penalty provisions concerning insurers and their representatives (such as: section 1317G *Corporations Act 2001* (Cth); section 76 *Competition and Consumer Act 2010* (Cth); and section 12GBB *ASIC Act 2001*) (Cth), this decision is an important one. That is particularly so, given an increasing focus on consumers, and on insurers satisfying their legislative and regulatory obligations; and also, given an increasing propensity for ASIC to take action where breaches occur and to seek the award of penalties.
- Insurers should be aware that civil penalties sought from and awarded by the court will very likely be greater in the future than previously, and that they are at risk of penalties at the higher end of the scale given the generally high revenue of insurers.

Facts

- The first respondent, Mr Pattinson, was employed by Multiplex Constructions Pty Ltd. He was also an officer of the Construction, Forestry, Maritime, Mining and Energy Union (**CFMMEU**), and a CFMMEU delegate.
- Two employees of a subcontractor on a worksite were prevented from working by Mr Pattinson, relying on the CFMMEU's policy of requiring all workers on sites where the CFMMEU had a presence to hold union membership (the "no ticket, no start" policy). Mr Pattinson misrepresented to the workers that they could not work on site without being union members. The two workers were not members of the CFMMEU, and were therefore prevented from working.
- Mr Pattinson's behaviour amounted to two contraventions of section 349(1) of the *Fair Work Act 2009* (Cth) (**Act**). It has been a breach of the law since 1996 to implement a "no ticket, no start" policy. It was recognised in the findings of all courts in this matter that, despite this, the approach was a longstanding (but unlawful) practice which the CFMMEU adopted and continued to adopt (despite the imposition of penalties for doing so).
- As the delegate of the CFMMEU, Mr Pattinson's actions were also attributable to the CFMMEU. As such, the CFMMEU also contravened section 349(1) of the Act. The CFMMEU was the second respondent in the proceeding.

- Section 349 of the Act is a civil remedy provision. Section 546(1) of the Act provided that:

  > *The Federal Court, the Federal Circuit and Family Court of Australia (Division 2) or an eligible State or Territory court may, on application, order a person to pay a pecuniary penalty that the court considers is appropriate if the court is satisfied that the person has contravened a civil remedy provision.*

- The maximum penalty available for a contravention was $12,600 for Mr Pattinson and $63,000 for the CFMMEU.

Analysis by the Court

- At first instance, Snaden J took the view that the maximum penalty should be imposed on the CFMMEU for each contravention because of its long history of contravening the Act. However, ultimately, Snaden J reduced the civil penalty for the CFMMEU for each contravention by half because the contraventions had occurred in the course of a single episode. Snaden J imposed civil pecuniary penalties of $6,000 on Mr Pattinson ($3,000 for each contravention), and $63,000 for both contraventions on the CFMMEU ($31,500 for each contravention).
- The penalties were reduced, on appeal, by the Full Court of the Federal Court. It was held that:
  - The history of prior contraventions by the CFMMEU and the deterrent purpose of the Act did not warrant the imposition of a penalty (viewed as) disproportionate to the nature, gravity and seriousness of the circumstances of the contraventions in issue.
  - The maximum penalty (which it was submitted the above was in respect of the CFMMEU) should only be imposed in the most severe of contraventions.
- The Full Court took the view that the penalty must be proportionate to the seriousness of the conduct that constituted the contravention.
- The High Court disagreed with the Full Court.
- The High Court noted that a court's task in coming to the amount of a civil penalty is to exercise its discretion (fairly and reasonably) to determine what is an "appropriate" penalty in the circumstances of a particular case, having regard to the subject matter, scope and purpose of the legislation.[112] The High Court confirmed that the purpose of a civil penalty is to protect the public interest by deterring future contraventions.
- In that regard, the High Court noted:
  - The proportionality of the penalty to the contravention/s in question is not relevant in determining the amount of a civil penalty to be awarded. Penalties are not to be awarded by grading contraventions on a scale of seriousness.[113]
  - The maximum penalty is not reserved for the most serious cases of offending comprehended by the relevant section. The imposition of a maximum penalty will be justified where it is apparent that no lesser penalty will be an effective deterrent.[114]

112 *Australian Building and Construction Commissioner v Pattinson* [2022] HCA 13, [12] (**'*Pattinson*'**).
113 *Pattinson*, [49].
114 *Pattinson*, [50].

  - A civil penalty regime is concerned primarily with deterrence. The purpose is primarily (if not solely) the promotion of the public interest in compliance with the provision of the relevant Act by the deterrence of further contraventions of the Act.[115]
- Penalties imposed will be appropriate if they:
  - are "*reasonably necessary to deter further contraventions*" by the respondents or others;[116] and
  - represent a reasonable assessment of what is necessary to make continuation of non-compliance with the law too expensive to maintain.
- Therefore, what is required is the imposition of a penalty in an amount:
  - reasonably necessary to deter future contraventions of a like kind (up to the maximum legislative amount); and
  - of such a magnitude (up to the maximum legislative amount) that undertaking the relevant contravention and the associated penalty would not be considered by an offender simply as an acceptable cost of doing business.[117]
- Proportionality is relevant when that term is used in the context of balancing the deterrent nature of a penalty with its potential oppressive severity (in order to consider what is required as a deterrent).[118]
- Bearing in mind the aim of imposing a penalty that will provide deterrence and protect the public through deterrence (and incentivise offenders to remain mindful of their remorse), what will be the appropriate penalty requires consideration of matters, including:
  - The revenue and assets of an offender, and means to pay any penalty that might be imposed (including the oppressive nature of any penalty vis-a-vis the particular offender). The Court recognised that a greater financial incentive will be necessary to persuade a well-resourced contravener not to continue to contravene the law.
  - Any history of contraventions, including contravention of the relevant provision.
  - Whether the offender had treated previous penalties imposed as a cost of doing business. The court recognised that a greater financial incentive will be necessary to persuade a more determined contravener not to continue to contravene the law.
  - Whether the conduct was deliberate or inadvertent.
  - Other considerations as set out in *Trade Practices Commission v CSR Ltd* [1990] FCA 521.[119]

115 *Pattinson* [9].
116 *Pattinson* [45].
117 *Pattinson* [26], [43], citing: *Agreed Penalties Case* (2015) 258 CLR 482, [110]; *Australian Competition and Consumer Commission v TPG Internet Pty Ltd* (2013) 250 CLR 640, [66]; and *Singtel Optus Pty Ltd v Australian Competition and Consumer Commission* (2012) 287 ALR 249, [62]-[63].
118 *Pattinson* [41].
119 *Trade Practices Commission v CSR Ltd [1990]* FCA 521, [42].

CASE NOTE

BE NOT A FRAUD: THE PRICE OF A PUMPED UP DISCLOSURE

***Citiline Concrete Pumping Pty Ltd v Chubb Insurance Australia Ltd (No 2)* [2022] NSWSC 1152**

SNAPSHOT

- Brokers and insureds have a duty to disclose, prior to policy inception, matters that a reasonable person in the position of the insured would expect to be relevant to an insurer's decision to accept risk.
- In order to for an insurer to rely on a 'fraudulent' representation by a policyholder, the fraudulent representation is not required to: (1) be about the incident the subject of an insured's claim; or (2) prejudice or deceive the insurer in order for an insurer to be relieved of a liability to indemnify. However, if only a minimal part of the claim is made fraudulently and non-payment of the remainder of the claim would be harsh and unfair, a court may order the insurer to pay a portion of the claim that is just and equitable.

INSURANCE ISSUES CONSIDERED BY THE COURT

- **Misrepresentation:** What is required for a statement to constitute a misrepresentation under sections 26 and 28 of the *Insurance Contracts Act 1984* (Cth) (**ICA**)?
- **Non-disclosure:** What constitutes non-disclosure about prior claims and accidents under sections 21 and 28 of the ICA?
- **Fraud:** What is required for an insurer to establish fraud and deny liability under section 56 of the ICA and, in what circumstances will the court exercise its discretionary power to require payment of a portion of the claim in any event on the basis that it is just and equitable to do so?

Facts and background

- Citiline Concrete Pumping Pty Ltd (**Citiline**) owned and operated a concrete pumping business.
- On 24 January 2019, Citline engaged an insurance broker (**Broker**) to take out a Mobile Plant & Equipment Package Insurance Policy (the **Policy**) with respect to a concrete pump fitted on a truck (the **Unit**). Importantly, the Unit had been damaged in separate incidents on 23 August 2017 and 11 September 2018, following which Citiline successfully made claims against the responsible third parties. Citiline was uninsured at the time of these prior incidents.
- In procuring the Policy, neither Citiline nor the Broker completed a proposal form. Rather, the Broker emailed Chubb Insurance Australia Ltd (**Chubb**) with information about the insurance being sought by Citiline. The email relevantly stated "no accidents/claims/convictions" (**Broker Statements**). Chubb responded to this email providing a quote and the Policy wording and stating that they were "issued on the basis of nil losses or claims last 5 years".
- On 21 February 2019, the Unit sustained damage while it was being cleaned and Citiline sought indemnity under the Policy in respect of that damage. There was no dispute between the parties that the Policy responded to Citiline's claim for indemnity.
- Chubb contended that:
    - it was entitled, pursuant to section 28(3) of the ICA, to reduce its liability to nil by reason of Citiline's misrepresentation and non-disclosure relating to the Unit's history (the **Misrepresentation/Non-Disclosure Defence**); and
    - Citiline's insurance claim was made fraudulently and therefore, pursuant to section 56 of the ICA, Chubb was entitled to refuse payment (the **Fraud Defence**).

These issues were determined separately.

- Voiding a policy, or refusing a claim on the basis of a fraudulent misrepresentation, is a serious decision for insurers to take. In its own guidance on what constitutes fraudulent misrepresentation, AFCA says: "A misrepresentation or non-disclosure is fraudulent when the person did so knowingly, without belief in its truth or recklessly (not caring whether it is true or false). If it was made negligently or carelessly, this is not fraud".[120]

Analysis by the Court

The Misrepresentation/Non-Disclosure Defence

- The evidence was that the insurer would not have provided cover if it had known the history, which was not contested by Citiline.[121]
- Citiline sought to persuade the Court of a novel construction of the Broker Statements. Counsel for Citiline submitted that the Broker represented that there had been no "accidents" in which Citiline was at fault and, no "claims" made by Citiline that were not "made whole" by a third party (rather than that there had been no accidents or claims whatsoever). The submission continued that Chubb would have understood as the email exchange involved "experts speaking to each other in shorthand".[122] The Court did not accept this submission as it considered the Broker Statements to be unqualified representations that there had been no "accidents" or "claims" at all.[123]
- The Court concluded that a reasonable person in the position of Citiline should have known that prior damage to the Unit would have been materially relevant to Chubb's decision to accept risk (especially in circumstances where no proposal form was completed) and provide property damage insurance in relation to the Unit.[124] The obvious reason for this is that prior damage can compromise a machine's integrity and resistance to further damage, and Citiline received significant amounts to settle the prior claims.[125]
- Accordingly, the Court found that:
  - the Broker Statements were misrepresentations for the purposes of section 26 of the ICA;[126] and
  - Citiline/the Broker breached its duty to disclose under section 21 of the ICA.[127]
- As a result, Chubb was permitted to reduce its liability to nil pursuant to section 28(3) of the ICA as this would be the position that it would have been in had the misrepresentation not been made and the true position of the Unit been disclosed.

The Fraud Defence

- Chubb denied cover for the damage to the Unit due to "pre-existing, poorly repaired damages" to the Unit and indications "that the unit was suffering a fatigue related failure prior to the incident" and, during a follow up interview with Citiline's sole director and shareholder (**Director**) on 20 June 2019, the following exchange took place:[128]

  [Chubb] *In the time that you've owned the pump, has it sustained any damage?*

  [Director] *No*.

  [Chubb] *Okay. In the time, or the Volvo truck?*

  [Director] *No.*

  [Chubb] *Okay, no worries. Has the boom pump ever been out of operation in the time that you've owned it?*

  [Director] *When I went overseas yes, that was the only time. If I travel.*

  [Chubb] *But that's not due to damage?*

  [Director] *No, no.*

- During cross-examination, the Director admitted that, to avoid jeopardising Citiline's claim under the Policy, she knowingly made statements that were untrue, including that the Unit had not previously sustained damage and had only been out of operation when the Director was overseas.
- Chubb is enabled to refuse payment of a claim under section 56 of the ICA if the claim is made fraudulently. The Court determined that the Director's statements were false and knowingly made in connection with a claim for the purpose of inducing Chubb to meet the claim.
- A false statement is not required to be analysed to determine whether or not the falsity attaches to the basis upon which the insured is claimed to be liable.[129] That is, it is not necessary for the false statement to be about the incident the subject of the claim.[130]
- Under section 56(1) of the ICA:
  - it is not necessary for the false statement to have deceived or prejudiced the insurer for it to constitute fraud for the purpose of section 56 of the ICA;[131] and
  - "fraudulently" encompasses both a lie which could not prejudice the insurer even if it were believed in addition to a lie that does not prejudice the insurer because the insurer was not deceived.[132]
- It was therefore immaterial whether the Director's lie was "silly" and "easily discoverable" (as was submitted by counsel for Citiline).[133]
- Under section 56(2) of the ICA, the Court is able to order an insurer to pay such amount as is just and equitable if "only a minimal or significant part of the claim is made fraudulently" and it would be "harsh and unfair" to deny the insured "the remainder of the claim".[134]
- However, the Court concluded that the false statements made by the Director were not minimal or insignificant. Rather, the Director's statements were made explicitly in relation to Citiline's claim for indemnity in respect of damage to the Unit. Therefore the Fraud Defence was successfully established.

Result

- The Court found that Chubb had established both the Misrepresentation/Non-Disclosure Defence and the Fraud Defence and was therefore entitled to refuse Citiline's claim.

120 AFCA, 'The AFCA Approach to nondisclosure and misrepresentation', July 2020, p 5.
121 *Citiline Concrete Pumping Pty Ltd v Chubb Insurance Australia Ltd (No 2)* [2022] NSWSC 1152, [44] (**Citiline**).
122 *Citiline*, [31]-[35].
123 *Citiline*, [34].
124 *Citiline*, [40].
125 *Citiline*, [40].
126 *Citiline*, [41].
127 *Citiline*, [42].
128 *Citiline*, [49].

129 *Tiep Thi To v Australian Associated Motor Insurers Ltd* (2001) 3 VR 279; [2001] VSCA 48, [19] (**To**).
130 *Tiep Thi To*, [25].
131 *Tiep Thi To*, [21].
132 *Tiep Thi To*, [21].
133 *Citiline*, [63].
134 *Citiline*, [64].

CASE NOTE

ONE STONE, NEVER TWO BIRDS

FKP Commercial Developments Pty Ltd v Zurich Australian Insurer Ltd [2022] FCA 862

SNAPSHOT

- The cover a policyholder has turns on the precise wording of the policy (and the actual product purchased).
- For a civil liability claim to be "based on" an insured's provision of professional services, the provision of professional services by or on behalf of the insured must form a factual or legal foundation (causally, temporally, or otherwise) of the potential liability of the insured.

INSURANCE ISSUES CONSIDERED BY THE COURT

- The proper construction of the phrasing "based on the insured's provision of the professional services".
- Whether the phrasing of a provision as a 'claims condition' is sufficient to exclude the operation of an insuring clause.

Facts and background

- The applicants, FKP Commercial Developments Pty Limited (**FKP Commercial**) and FKP Constructions Pty Limited (**FKP Constructions**) (together, the **FKP Parties**) were insured under a Design and Construction Professional Indemnity policy issued by the respondent, Zurich Australian Insurance Limited (**Zurich**).[135]
- In coinciding proceedings in the Supreme Court of New South Wales,[136] the owners of Strata Plan No 84298 and the registered proprietor of the common property in two residential and commercial buildings at Rosebery (**Plaintiff**),[137] alleged that defects existed in common property.[138] Further, the Plaintiff alleged that the FKP Parties were liable for the resulting loss suffered by reason of breach of the statutory warranties in the *Home Building Act 1989* (NSW) and/or a common law or statutory duty of care owed to the Plaintiff.[139]
- Before Jagot J in the Federal Court (as her Honour was then), the FKP Parties sought indemnity from Zurich under the policy in respect of any liability it might have to the Plaintiff in the Supreme Court proceedings.[140]

The Policy

Insuring Clause

We agree to indemnify the insured against loss incurred as a result of any claim for civil liability first made against the insured and notified to us during the period of insurance, based on the insured's provision of the professional services.

Advancement Provision

We will advance claim expenses incurred by an insured in the defence of a claim, as they are incurred and prior to the final adjudication of the claim, where:

(a) indemnity under this policy is confirmed in writing by us; or

(b) at our absolute discretion, without admitting indemnity, we agree to advance such claim expenses.

135 *FKP Commercial Developments Pty Ltd v Zurich Australian Insurance Ltd* [2022] FCA 862 (**FKP Commercial Developments**), [3].
136 Supreme Court of New South Wales proceeding 2017/00233806.
137 FKP Commercial Developments, [4].
138 FKP Commercial Developments, [5].
139 FKP Commercial Developments, [5].
140 FKP Commercial Developments, [10].

All such payments shall be repaid to us by the insured (or where more than one insured has received such payments, by such insureds severally and according to their respective interests) in the event and to the extent that the insured is not entitled to payment of such claim expenses under the terms and conditions of the policy.[141]

Issues

- The Court was required to determine:

  1. whether the policy provides that the insured's sole right to payment of claims expenses prior to final adjudication was under the Advancement Provision; and

  2. whether the claim against the FKP Parties was *"based on the insured's provision of the professional services"*.[142]

Jagot J answered both questions in the negative.[143]

1. Does the Policy, on its proper construction, provide that the insured's sole right to payment of claims expenses prior to final adjudication of the claim is under the Advancement Provision?

- Zurich contended that the FKP Parties' sole right to payment of claims expenses prior to final adjudication of the claim existed pursuant to the Advancement Provision.

Determination of Loss prior to Final Adjudication

- Zurich argued that covered and uncovered loss could not be ascertained and judicially determined prior to the final adjudication of the Supreme Court proceedings because the Allocation Provision "*speaks of a single task of allocation*" which is *"something that can only be done at the time that all elements of loss are known"*, including the final adjudication.[144]

- Jagot J rejected this argument as:

  - no provision of the policy expressly prevented an insured from seeking and obtaining a judicial determination that all loss incurred (and will be incurred) is loss within the insuring clause;[145] and

  - the Allocation Provision recognised that claim expenses were within the definition of "loss" and recognised that there may be a judicial determination between Zurich and the insured.[146]

- The Court found that covered and uncovered loss could be ascertained and judicially determined prior to the final adjudication of the Supreme Court proceedings and subsequently, there could be multiple allocations throughout the life of a claim.[147]

Exclusion of the Insuring Clause

- Zurich argued that any payment of claim expenses could only be made under the Advancement Provision which operated to the exclusion of the Insuring Clause.[148]

- Jagot J rejected this argument in the absence of an express statement that excluded the operation of the Insuring Clause in all cases. Instead, her Honour construed the Allocation Provision alongside the Advancement Provision as being intended to operate in circumstances where there was uncertainty about the allocation of claim expenses insofar as such allocation depends on the extent to which loss is covered under the insuring clause.[149]

- Her Honour interpreted the operation of the policy as:

  > *… the allocation provision and the policy as a whole leave it to Zurich (if it agrees with the insured) or, failing agreement, the court to decide if a judicial determination between Zurich and the insured can and should be made as to whether the whole or part (and if so what part) of the claim expenses are within the definition of loss and accordingly the insuring clause prior to a final adjudication of a claim.*[150]

2. Is the whole of the claim made against the applicants in the Supreme Court proceedings a *"claims for civil liability… based on the insured's provision of professional services"* within the meaning of the Insuring Clause?

The Insuring Clause applies to Agents

- Zurich contended that the Insuring Clause was only engaged where the professional services had been "personally" performed by the insured.[151] Jagot J rejected this argument insofar as it contravened the common law doctrine of agency which permits the Insuring Clause to apply where the FKP Parties had contractual responsibility for the performance of a professional service by another party (i.e., under a principal-agent relationship).[152]

Interpreting "based on the insured's provision of professional services"

- To determine whether the whole claim made against the Applicants in the Supreme Court proceedings was a *"claim for civil liability"*, Jagot J considered whether the claim was for a cause of action "based on" the insured's provision of professional services. Her Honour first concluded that "civil liability" and "cause of action" were equivalent terms,[153] and then framed this inquiry as whether the cause(s) of action depended on the *"insured's provision of, or failure to provide, the professional services"*.[154]

- Jagot J concluded that there was no identifiable relationship between the provision of professional services and the cause(s) of action.[155] Rather, the source of the alleged duties which formed the factual and/or legal foundation of the FKP Parties' potential liabilities was their position as owner/developer and as head contractor respectively. It did not depend on either one of them having provided any professional services.[156]

141 FKP Commercial Developments, [20].
142 FKP Commercial Developments, [1].
143 FKP Commercial Developments, [156].
144 FKP Commercial Developments, [41].
145 FKP Commercial Developments, [48].
146 FKP Commercial Developments, [78].
147 FKP Commercial Developments, [55].
148 FKP Commercial Developments, [44].
149 FKP Commercial Developments, [46].
150 FKP Commercial Developments, [78].
151 FKP Commercial Developments, [83].
152 FKP Commercial Developments, [104].
153 FKP Commercial Developments, [134].
154 FKP Commercial Developments, [134].
155 FKP Commercial Developments, [139].
156 FKP Commercial Developments, [150].

- In other words, FKP Commercial would have been liable for any breach of the statutory warranties under the *Home Building Act 2014* (NSW), under section 37 of the *Design and Building Practitioners Act 2020* (NSW), and at common law in negligence, regardless of whether professional services were provided.[157] Ultimately, the provision of professional services by or on behalf of the FKP Parties was not a factual or legal foundation (causally, temporally, or otherwise) of the potential liability of the FKP Parties.[158]

- In the separate Supreme Court proceedings, the liability of the FKP Parties "*may wholly be based on or arise from 'construction, manufacture, assembly, installation, erection, maintenance or physical alteration of buildings, goods, products or property' and/or defects in or lack of suitability of products and goods used in the construction of the common property of the residential building. It follows that the FKP parties have no present entitlement to indemnity under the insuring clause.*" [159]

- Jagot J continued "*No doubt, the FKP parties could have obtained developers and design and construction style insurance policies not confined to a form of professional indemnity insurance… The point is that, in the insurance context, a party gets the policy they pay for, not some other policy they could have paid for but (apparently) did not.*"[160]

157 FKP Commercial Developments, [139].
158 FKP Commercial Developments, [150].
159 FKP Commercial Developments, [153].
160 FKP Commercial Developments, [153].

CLASSIC CASE
"I'M NOT SHARP, THE BAND'S FLAT"

***Wilkie v Gordian Runoff Ltd* (2005) 221 CLR 522**

SNAPSHOT

In this 2005 judgment, the High Court determined that, as in other situations of contractual construction, policies of insurance should be interpreted in a way and in a manner that:

- Considers and examines all the language used in the policy and the interplay of the various clauses and parts of the policy, and adopts an interpretation of the policy that supplies a '*congruent operation to the various components of the whole*';
- Considers and examines (in an objective way, having regard to the terms of the policy) the '*commercial circumstances which the document addresses, and the objects which it is intended to secure*'; and
- Provides a 'businesslike interpretation'.

INSURANCE ISSUES CONSIDERED BY THE COURT

- Whether, having regard to the particular terms of the policy under consideration, the insurer could deny indemnity and decline to pay the insured's advance defence costs under a distinct extension clause headed "advance payment of defence costs', relying on an exclusion clause which arose where particular types of conduct (or misconduct) had 'in fact occurred' but where there had been no admission or adjudication of the issue by a court.

Facts

- Daniel Wilkie was a director of FAI Insurance Ltd (**FAI**). FAI held a Directors & Officers/Company Reimbursement insurance policy (**Policy**) with Gordian Runoff Ltd and RE Brown Syndicate at Lloyds of London (together, **GIO**).[161]
- Mr Wilkie was charged by ASIC with offences under the *Corporations Act 2001* (Cth). They included: making omissions that rendered information provided to a company auditor misleading; knowingly failing to act honestly; and acting with an intention to deceive.[162]
- Mr Wilkie sought indemnity from GIO for his costs of defending the allegations. He did so as and when the costs were incurred. Mr Wilkie did not admit the charges made against him. The charges had not been heard or decided.[163]
- Mr Wilkie sought his costs under Extension 9 of the Policy (an extension to the primary insuring obligation) headed 'ADVANCE PAYMENT OF DEFENCE COSTS'. Extension 9 provided as follows:

  *If **GIO** elects not to take over and conduct the defence or settlement of any **Claim**, **GIO** will pay all reasonable **Defence Costs** associated with that **Claim** as and when they are incurred PROVIDED THAT:*

  *(i) **GIO has not denied indemnity for the Claim; and***

  *(ii) **the written consent of GIO is obtained prior to t**he **Insured** incurring such **Defence Costs** (such consent not to be unreasonably withheld).*

  ***GIO** reserves the right to recover any **Defence Costs** paid under this extension from the **Insured** …, in the event and to the extent that it is subsequently established by judgement or other final adjudication, that [the Insured was] not entitled to indemnity under this policy.*[164]

- GIO denied indemnity under Exclusion 7 of the Policy – a dishonesty exclusion. GIO relied upon its own assessment of the brief of evidence provided by the Commonwealth Director of Public Prosecutions in support of its case. Consequently, GIO refused to pay Mr Wilkie's defence costs.[165]

161 *Wilkie v Gordian Runoff Ltd* (2005) 221 CLR 522, [1]-[2] (**Wilkie**).
162 *Wilkie*, [5]-[6].
163 *Wilkie*, [4] and [7]-[8].
164 *Wilkie*, [29] (emphasis in original).
165 *Wilkie*, [4] and [8].

- Exclusion 7 stated (relevantly):

  *This policy does not insure **Loss** arising out of any **Claim**… based upon, attributable to, or in consequence of:*

  (i) any dishonest, fraudulent, criminal or malicious act or omission; or

  (ii) any deliberate breach of any statute, regulation or contract;

  where such act, omission or breach has in fact occurred…

  …the words 'in fact' shall mean that the conduct referred to in those Exclusions is admitted by the Insured or is subsequently established to have occurred following the adjudication of any court, tribunal or arbitrator.[166]

- Mr Wilkie brought a claim against GIO in the Supreme Court of New South Wales challenging the decision to refuse to pay defence costs, and seeking a mandatory order that GIO pay all of his reasonable defence costs as and when they were incurred, on the condition that GIO has a right to recover those payments from him in the event and to the extent that it was later established by judgment or other final adjudication that Mr Wilkie was not entitled to indemnity.[167]

- At first instance, Nicholas J held that GIO was entitled to decline to indemnify Mr Wilkie and to decline to pay Mr Wilkie's defence costs.[168]

- Mr Wilkie was given leave to appeal directly to the High Court.[169]

Analysis by the Court

- This decision is one of contractual construction, the contract being the policy of insurance. The approach taken continues to be the approach adopted by courts today, almost 20 years after delivery of this judgment.

- The High Court (all five justices of the Court concurring) confirmed long standing comments made in *McCann v Switzerland Insurance Australia Ltd* [170] that, for a commercial contract, a 'businesslike interpretation' should be given to a policy of insurance,[171] and that:

  > *Interpreting a commercial document requires attention to the language used by the parties, the commercial circumstances which the document addresses, and the objects which it is intended to secure.*[172]

  This approach continues to be adopted in cases today.[173]

- Further, the High Court held that in construing any contract, '*preference is given to a construction supplying a congruent operation to the various components of the whole*'.[174] This principle also continues to be applied today.[175]

- The High Court's decision turned on the wording and operation of Extension 9 and Exclusion 7, and their interaction with one another, and the broader Policy and its components.

- By a close examination of such matters, it was found that by operation of the wording and terms of the policy, GIO was not entitled to decline to pay Mr Wilkie's defence costs.

166 *Wilkie*, [27] (emphasis added).
167 *Wilkie*, [11].
168 *Daniel Wilkie v Gordian Runoff Limited and Anor* [2003] NSWSC 1059; *Wilkie*, [13].
169 The appeal was to be heard with appeals to the High Court in the matters of *Silbermann v CGU Insurance Ltd; Rich v CGU Insurance Ltd; Greaves v CGU Insurance Ltd*. Ultimately, however, because of its distinct facts, Mr Wilkie's appeal was determined separately.
170 (2000) 203 CLR 579 at [22].
171 *Wilkie*, [15].
172 *Wilkie*, [15].
173 For example, in: *Catlin Australia Pty Ltd v Diamond World Jewellers Pty Ltd* [2022] NSWCA 282 and *Arch Underwriting at Lloyd's Ltd on behalf of Syndicate 2012 v EP Financial Services Pty Ltd* [2022] QCA 229.
174 *Wilkie*, [16].
175 For example, in: *Keegan v Ballast Point Pty Ltd* [2022] NSWCA 179 [26]–[27]; *LCA Marrickville Pty Ltd v Swiss Re International SE* (2022) 401 ALR 204, [57].

- The High Court's reasoning was as follows:
  - Extension 9 provided distinct (and separate) cover to primary insuring clause A;[176]
  - the operation of Extension 9 and Exclusion 7 was incongruent;[177]
  - Exclusion 7 was 'inaptly' drafted to exclude liability under Extension 9;[178]
  - Exclusion 7 required there to be misconduct that 'has in fact occurred'; that is, misconduct that was admitted or had been established by the outcome of proceedings. It was not enough for it to be the insurer's opinion that there had been misconduct;[179] and
  - Extension 9 provided an obligation to:
    - pay all reasonable Defence Costs associated with a Claim as and when they were incurred; and
    - pay such costs, in advance, at times when any liability to indemnify under the policy might be uncertain because the claim was unadjudicated (and not admitted).[180]

- The High Court found further support for the above position in GIO's express right, under Extension 9, to recover from Mr Wilkie any Defence Costs paid to him under the Extension *"in the event and to the extent that it is subsequently established by judgement or other final adjudication, that [the Insured was] not entitled to indemnity under this policy"*.[181]

- The High Court also found support for its position in its consideration of the commercial purpose of the Policy, which was to '*afford assistance with defence costs when an insured is faced by allegations of wrongdoing, including criminal wrongdoing*.'[182]

- In essence, it was held that because of the wording and operation of the policy terms, GIO could not refuse to pay Mr Wilkie's advance defence costs under Extension 9 (and could also generally not deny indemnity for misconduct) relying on its own views as to misconduct. Rather, the relevant allegations of misconduct either had to be admitted by Mr Wilkie or adjudicated upon and determined in order for Exclusion 7 to be enlivened.

- The High Court's decision confirmed (and continues to confirm) that:
  - Courts will adopt an objective, commercial and business-like approach to interpreting any policy, examining the policy and its terms as a whole; and
  - Close attention by an insurer when drafting any policy is important, including close attention to the interaction and interplay of different clauses and parts of the policy, and the specific wording of such including vis-à-vis an insurer's intended purpose.

Result

The appeal was allowed, with costs. The wording of Exclusion 9 was such that there was only an entitlement to deny indemnity and an entitlement to refuse advance payment of defence costs, where there was an admission by the insured or a determinative and binding finding by a court of misconduct of the type specified (neither of which had occurred in Mr Wilkie's case).

176 *Wilkie*, [32] (note, the wording of primary insuring clause A can be found at *Wilkie*, [19]).
177 *Wilkie*, [33]-[34].
178 *Wilkie*, [33].
179 *Wilkie*, [37]-[42].
180 *Wilkie*, [33]-[34], [38]-[39] and [43].
181 *Wilkie*, [39]-[43].
182 *Wilkie*, [46].

CLASSIC CASE

AH M[C]CANN, YOU'RE REFERENCED AGAIN

***McCann v Switzerland Insurance Australia Limited* (2000) 203 CLR 579**

SNAPSHOT

- Consistent with general principles of contractual construction, when interpreting policies of insurance, the Courts will: pay attention to
  - the particular words and language used by the parties,
  - the commercial circumstances which the policy addresses, and the objects which the insurance policy is intended to secure; and
  - seek to provide a businesslike interpretation.

INSURANCE ISSUES CONSIDERED BY THE COURT

- The proper approach to the construction of insurance policies. (This is a seminal decision).
- The meaning of "brought about by" in the context of the particular exclusion clause in this policy of insurance.

Facts

- A professional services firm (**Firm**) acted for Nauru Phosphate Royalties Trust (**Trust**).
- The particular transaction under consideration concerned a proposition that the Trust transfer monies (**Monies**) into The Firm's trust account for the purchase of a 'Prime Bank Instrument' (**Transaction**). The partner of the Firm dealing with the transaction:
  - directed the Trust to pay the monies into an the Firm's Trust account which did not in fact exist;
  - intended to, and did, misappropriate US $150,000 of the monies; and
  - attempted to buy a 'Prime Bank Instrument' with the remaining US $8.55 million, but the money was stolen by third parties during the course of that transaction without the Trust receiving a Prime Bank Instrument or any other security.[183]
- The Trust filed proceedings against the Firm to recover the monies (**Recovery Proceedings**), alleging breach of mandate, breach of fiduciary duties and negligence.[184] No allegations were made of fraud or dishonesty.[185] The Recovery Proceedings were settled.
- The Firm sought indemnity for the US $8.55 million under three policies of excess layer professional indemnity insurance (**Policies**) held with a number of insurers (**Insurers**).[186] It was accepted that there was no right of indemnity for the misappropriated US $150,000.
- The Insurers had an obligation to indemnify the Firm against:

  > *all loss arising from claims in respect of any description of civil liability whatsoever incurred in connection with their legal practice.*[187]

- The Insurers denied indemnity on the basis of the dishonesty and fraud exclusion, which provided an exclusion:

  > *in respect of any liability brought about by the dishonest or fraudulent act or omission of [the Firm], including by any Partner or former Partner.*[188]

183 The facts are set out in detail in the judgment of Hayne J in *McCann v Switzerland Insurance Australia Limited* (2000) 203 CLR 579, [96]-[142] ('*McCann*').
184 *McCann*, [117].
185 *McCann*, [70] and [122].
186 *McCann*, [2].
187 *McCann*, [94].
188 *McCann*, [91] (emphasis added).

- At first instance, it was held that the Firm was entitled to indemnity on the basis that the partner's dishonest conduct did not bring about the Firm liability to the Trust.[189] The trial judge found that the partner had:
    - a true belief that a market existed for Prime Bank Instruments (although, none did);
    - personally been involved in numerous failed transactions to buy Prime Bank Instruments on behalf of clients and had lost substantial money doing so; and
    - entered into an arrangement with a third party whereby he would receive commissions in transactions for Prime Bank Instruments.
- On appeal, the New South Wales Court of Appeal held that the dishonesty and fraud exclusion applied.[190]
- The matter was appealed to the High Court by the Firm.

Analysis by the Court

- The High Court undertook a close examination and analysis of the Policies and the particular words used to determine whether the conduct and circumstances (payment of US $8.55 million from the Firm's purported trust account) fell within the exclusion clause.
- The seminal statement made by Gleeson CJ is still relied upon after more than 20 years:[191]

> *A policy of insurance…is a commercial contract and should be given a businesslike interpretation. …[This] requires attention to the language used by the parties, the commercial circumstances which the document addresses, and the objects which it is intended to secure.*[192]

- The High Court found that what needed to be established for the exclusion clause to apply was:
    - the basis of the liability of the Firm to the Trust (as opposed to for the losses suffered);
    - that such liability was '*brought about by*' an act or omission of the partner; and
    - that such act or omission was dishonest and fraudulent.
- The majority were unanimous in their approach that in identifying the bases for the liability, the Court:
    - was not limited to those grounds raised by the Trust in proceedings against the Firm; and
    - could (and should) analyse and examine all possible bases on which the Firm might have liability to the Trust for the claimed amount.
- The meaning of the phrase '*brought about by*' was a significant point of contention and consideration. The Court held that '*brought about by*' did not require direct causation between the dishonest act and the loss, nor that the loss be intended.
- In considering these issues, Kirby J confirmed that the same basic legal principles which govern construction of ambiguous phrases in other commercial contracts apply to policies of insurance, noting them as:[193]
    - Policies must be given meaning according to their terms.
    - Interpretations of a policy should give the words used in the policy their ordinary and fair meaning.
    - The meaning given must take into account the commercial and social purposes for which the policy was drafted.
    - Where the policy uses language which has a settled meaning, the courts will ordinarily endeavour to adhere to that meaning.
    - A court cannot make a new contract for the parties, through interpretation, that is at odds with the terms they have agreed upon.
- Other legal principles applied in the interpretation process were:
    - Words should not be read into a policy, or into a clause, which are not there, or which would result in a construction contrary to business sense.[194]
    - Each clause and sub-clause must be read as a whole and in its own particular context.[195]
- The majority[196] found that the Firm was not entitled to indemnity. The majority reasoned that:
    - the Firm's liability to the Trust arose because the Firm owed fiduciary duties to safeguard the monies supplied by the Trust and to only use those monies for the purpose for which they were supplied and, to warn against foreseeable risk.
    - Those duties were breached by the partner as he:
        - paid the monies out with undue haste and insufficient care (without receiving any security in return), in the course of which a third party stole the monies; and
        - disregarded his own conflicting interests in favour of obtaining an (undisclosed) commission from the transaction.
    - This conduct was motivated by a desire by the partner to conceal the truth and obtain an advantage for himself to which he knew he was not entitled.
    - This resulted in the necessary causal connection between the dishonest and fraudulent breach of the fiduciary duties of the partner, and the liability of the Firm to the Trust. While the Firm partner did not intend the US $8.55 million to be lost, it was his preceding dishonest behaviour which caused the loss.
- Gaudron J also commented that it was contrary to common sense to treat the result as being other than '*brought about by*' the partner, and that:

> *…it would be absurd for the law to impose a duty to protect or warn against risk from a third party or an external force and, at the same time, allow that in the event of a breach, no liability attaches because the event was brought about by an external force or by the third party…*[129]

- The decision is a reminder as to the importance of closely (and objectively) considering each word and phrase used when both drafting an insurance policy and interpreting the same; and also, of the need to pay close attention to the interplay between various parts, clauses and terms of the policy.

Result

The majority, through separate judgments, upheld the Court of Appeal's decision that the exclusion clause applied and that the Firm was not entitled to indemnity under the Policies.

189 *McCann*, [41]-[42].
190 *McCann*, [91].
191 Gleeson CJ's statement has been cited in over 250 judgments.
192 *McCann*, [22].
193 *McCann*, [74], [81].
194 *McCann*, [23] (Gleeson CJ).
195 *McCann*, [49] (Gaudron J).
196 Through separate judgments, and with Callinan J dissenting.
197 *McCann*, [52].

CLASSIC CASE

I'LL LOOK THIS WAY (AT MY PERIL)

***CGU Insurance Limited v Porthouse* (2008) 235 CLR 103**

SNAPSHOT

- This classic decision (which examined a known circumstance exclusion clause) is a reminder of the need to engage, when drafting and interpreting a policy of insurance (and, indeed, any commercial contract), in a close analysis of the words and phrases used and what might be required by them.

INSURANCE ISSUES CONSIDERED BY THE COURT

- Considerations when seeking to rely on a 'Known Circumstances' exclusion.
- 'Known Circumstances' exclusions are, generally, subject to a subjective and an objective test, to protect insurers where an insured holds a genuine but unreasonable or unrealistic belief in relation to whether an allegation or claim might be made.

Facts

- Mr Porthouse was a barrister in New South Wales. He was required to take out professional indemnity cover on an annual basis.
- On 20 May 2004, Mr Porthouse completed a professional indemnity proposal form (**Proposal Form**), which asked:

  > *Are you aware of any circumstances, which could result in any Claim or Disciplinary Proceedings being made against you?*[198]

- The Proposal Form stated that cover was not provided in relation to:

  > *facts or circumstances [of] which you first became aware prior to the period of cover, and which [you] knew or ought reasonably to have known had the potential to give rise to a claim under this policy.*[199]

- Mr Porthouse answered 'No', and CGU Insurance Limited (**Insurer**) issued insurance.
- This occurred in the following circumstances:[200]
  - Around June 2001, Mr Porthouse was instructed to provide advice on whether a claimant had a claim under the *Workers Compensation Act 1987* (NSW) (**the Act**), or otherwise.
  - The advice Mr Porthouse gave was wrong, in that it stated that no claim was available under the Act. His advice caused delay in commencing proceedings.
  - On 26 November 2001, solicitors instructed Mr Porthouse to draft proceedings on behalf of the claimant, which were filed on 11 December 2001.
  - Between June or July 2001 and 26 November 2001, legislative reform was proposed which would restrict the ability to claim under the Act to individuals whose personal impairment was at least 15%. The changes were introduced and applied to proceedings commencing after 27 November 2001.
  - Had proceedings been commenced prior to 27 November 2001, the claimant would have been successful, but his injuries did not satisfy the necessary criteria after this time.
  - The fact that the legislative changes acted as a bar to the claim was only raised:
    - on 30 October 2002, with the claimant's solicitors. Nevertheless, at arbitration, the claimant was awarded damages;

198 *CGU Insurance Limited v Porthouse* (2008) 235 CLR 103, [1] and [21] ('***Porthouse***').
199 *Porthouse*, [21].
200 *Porthouse*, [10]-[20].

- on appeal, on 15 May 2003, in the District Court. Mr Porthouse researched the point and found that (if it were correct) the claimant would not succeed. The District Court awarded the claimant damages; and
- when, around 2 April 2004, on further appeal, Mr Porthouse was informed by senior counsel that there were reasonable prospects that the claim was barred.

- On 29 August 2004, the claim for personal injuries was dismissed on appeal.
- The claimant then commenced proceedings against Mr Porthouse alleging negligence on the basis that proceedings ought to have been filed before the changes to the Act.
- Mr Porthouse sought indemnity under his professional indemnity insurance. The Insurer denied indemnity, relying on the 'Known Circumstances' exclusion in the Policy.
- The exclusion provided:

  We do not cover any of the following Claims (or losses):

  6.1 Known Claims and Known Circumstances

  …

  (b) Claims (or losses) arising from a Known Circumstance; or

  (c) Claims (or losses) directly or indirectly based upon, attributable to, or in consequence of any such Known Circumstance or known Claims (or losses)…[201]

  "Known Circumstance" was defined as:

  11.12 Known Circumstance

  Any fact, situation or circumstance which:

  (a) an Insured knew before this Policy began; or

  (b) a reasonable person in the Insured's professional position would have thought, before this Policy began.

  Might result in someone making an allegation against an Insured in respect of a liability, that might be covered by this Policy.[202]

- At the first instance, it was held that Mr Porthouse was entitled to indemnity. The Court found that Mr Porthouse did not believe, when the Proposal Form was completed, that he had done anything wrong, nor that a claim would be made against him.
- The Insurer appealed. The Court of Appeal examined clause 11.12(b) and considered: whether it was appropriate to consider Mr Porthouse's subjective state of mind; and, what was otherwise required by the words used in the exclusion clause. The Court of Appeal upheld the first instance decision.
- The Insurer appealed to the High Court.

Analysis by the Court

- The High Court engaged in a close analysis of what was required by the words and phrases used in the exclusion clause.
- The decision is a reminder of the necessity in any drafting and interpretation exercise:
  - to closely and thoroughly examine and consider the precise words and phrases used; and
  - of the need to go back to 'first principles'. Reference was made to the seminal statement of Chief Justice Gleeson that:[203]

    A policy of insurance, even one required by statute, is a commercial contract and should be given a businesslike interpretation. Interpreting a commercial document requires attention to the language used by the parties, the commercial circumstances which the document addresses, and the objects which it is intended to secure. (footnotes omitted)

- As to the commercial circumstances of the policy, the High Court confirmed that:

  An insurance contract is a contract requiring the utmost good faith… a person seeking insurance [has] a duty to make full disclosure of all material circumstances.[204]

- In that context, the High Court noted that:

  A test of disclosure, which operates by reference to both the insured's actual knowledge and the knowledge of a reasonable person in the same circumstances, is calculated to balance the insured's duty to disclose and the insurer's right to information. The insurer is protected against claims where the insured's disclosure is inadequate because the insured is unreasonable, idiosyncratic or obtuse and the insured is protected from exclusion from cover, provided he or she does not fall below the standard of a reasonable person in the same position.[205]

- Based on that (objective) understanding of why the exclusion clause had been framed in the way it had been, the High Court came to the conclusion that:[206]
  - clause 11.12(a) provided a subjective test; and
  - that clause was then 'moderated' by the objective standard contained in clause 11.12(b).
- As such, the approach adopted by the High Court was to examine:[207]
  - first, the state of mind of the Insured (Clause 11.12(a)); and
  - independently, the state of mind of a reasonable person in the same position as the Insured at the time the Proposal Form was completed (and without hindsight) (Clause 11.12(b)).
- In analysing what was required by the phrase "*a reasonable person in the Insured's professional position*" within clause 11.12(b), the High Court found:
  - that such clause meant *"a hypothetical reasonable person with the experience and knowledge of the insured [but not the insured's personal idiosyncrasies or actual state of mind] coupled with the capacity of such a reasonable person to draw a conclusion… as to the possibility of someone making an allegation against the insured"*;[208] and

201 *Porthouse*, [5].
202 *Porthouse*, [6].
203 *Porthouse*, [43], citing *McCann v Switzerland Insurance Australia Ltd* at [22] (see our case note starting at page 78).
204 *Porthouse*, [49].
205 *Porthouse*, [53].
206 *Porthouse*, [46]-[59].
207 *Porthouse*, [55].
208 *Porthouse*, [56]-[57].

- that the conclusion may need to command a consensus among those in the same professional position as the insured that it is reasonable (not a plain and obvious conclusion).[209]

- In analysing what was required by the phrases: "*would have thought*" there was any fact, situation or circumstance which "*might result in*" someone making an "*allegation*" against an Insured within clause 11.12(b), the High Court found:[210]

  - this was to be assessed objectively, not by reference to an insured's state of mind;

  - it was necessary, only, for there to be the potential for "*allegations*", rather than for "claims" to be made.;[211] and

  - the phrase "*would have thought*" requires an assessment by a hypothetical "*reasonable person in the Insured's professional position*" with "*knowledge* of *any fact, situation or circumstance*".

Result

The High Court:

- Overturned the decision of the Court of Appeal. It held in favour of the Insurer, that there were 'Known Circumstances' and that the exclusion clause applied; and

- Found that there was no real doubt that a reasonable barrister in the circumstances would have thought that there was a real possibility that an allegation might be made in respect of a liability which might be covered by the policy.

209 *Porthouse*, [58].
210 *Porthouse*, [60]-[74].
211 *Porthouse*, [61].

CLASSIC CASE

ONE'S COMPANY, TWO'S A CROWD, AND A THIRD PARTY'S CLOSER THAN YOU THINK

***Malamit Pty Ltd v WFI Insurance Ltd* [2017] NSWCA 162**

SNAPSHOT

- Related party exclusion clauses are not uncommon in insurance contracts. It is also not uncommon for professional indemnity policies to have more than one insured.
- An insurance policy should be construed with a view to resolving inconsistencies and giving effect to all of its terms. When there are competing constructions of terms, preference should be given to a contractual construction that gives a consistent operation to the policy as a whole.

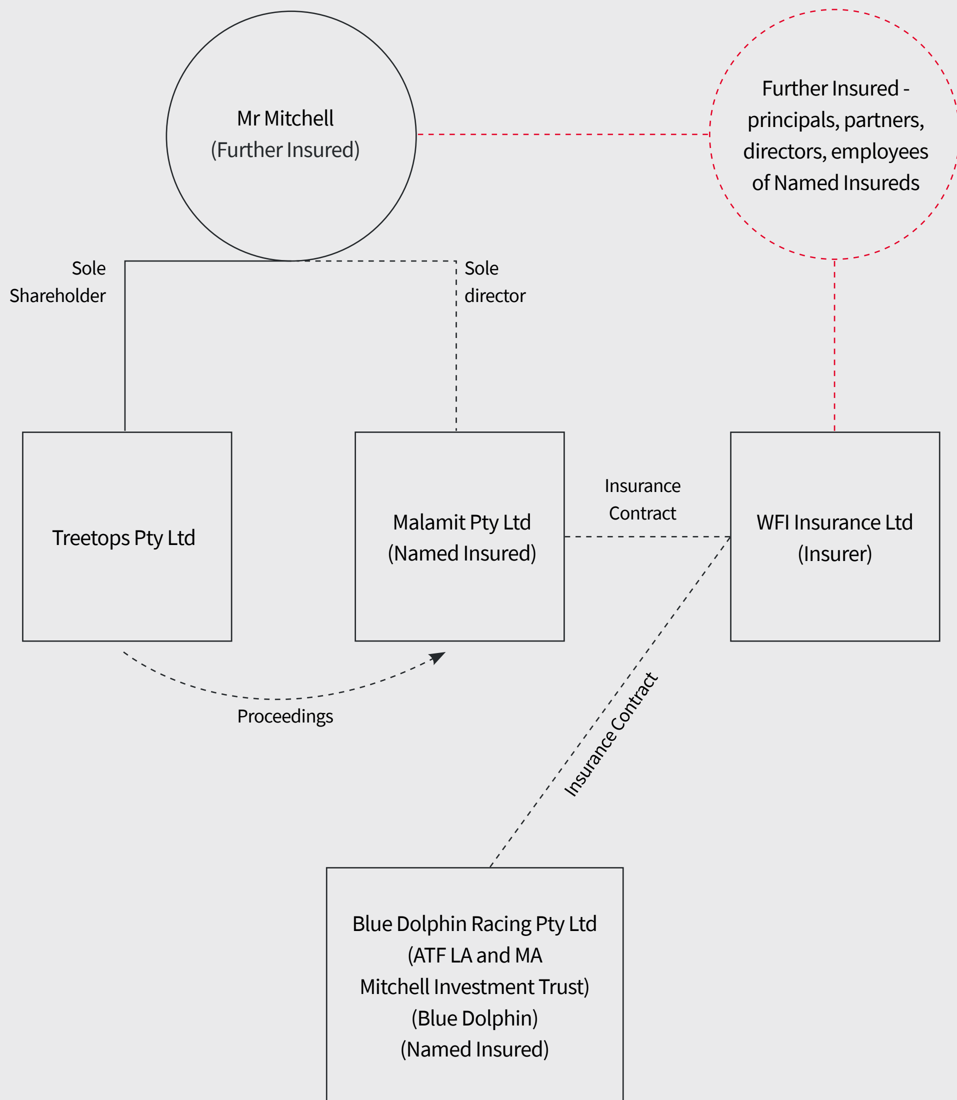
INSURANCE ISSUES CONSIDERED BY THE COURT

- This case concerned a related parties exclusion, and whether a claim against an insured (that was brought by a separate insured) comprised a claim brought by a "third party" for the purposes of the policy.

Facts

- In 2009, WFI Insurance Ltd (**WFI**) issued a professional indemnity policy to Malamit Pty Ltd (**Malamit**) and Blue Dolphin Racing Pty Ltd as trustee for the MA and LA Mitchell Investment Trust (**Blue Dolphin**). Malamit was a provider of project and development management services.
- A claim was brought by Treetops Lismore Pty Ltd (**Treetops**) against the insured, Malamit, for alleged negligence in the provision of project management services. The sole director of the insured, Mr Mitchell, was also a director and the sole shareholder of Treetops. Mr Mitchell and his wife were also the only shareholders of a company which wholly owned Malamit.
- Malamit made a claim under the professional indemnity policy it held with WFI. The insuring clause provided that WFI would indemnify the "Insured" for any "Claim" against the Insured, brought by a "third party", for breach of professional duty in the course of its a professional business during the "Insurance Period".[212] "Insured" and "Claim" were defined terms under the policy. The term "third party" was not defined.
- Broadly, the policy defined "Insured" and "Subsidiary" as:
  - **Insured**:
    - Malamit and Blue Dolphin, the parties listed as Insured in the Schedule (**Named Insureds**); and
    - any person who is a present or former principal, partner, director, employee of the Insured in the Schedule, where they were acting in the course of the Professional Business of a Named Insured (**Further Insureds**).
  - **Subsidiary** meant any entity that by applicable law is deemed a Subsidiary of the Insured or any entity for which the Insured owns or controls, directly or indirectly, 50% of shares.[213]

212 *Malamit Pty Ltd v WFI Insurance Ltd* [2017] NSWCA 162, [5] ('***Malamit***').
213 *Malamit*, [6] and [9].



- An exclusion in the policy excluded any Claim:
  - by;
  - on behalf of; or
  - for the benefit of,

  any Insured or Subsidiary irrespective of the capacity in which the Claim is brought.[214]
- On 9 July 2015, WFI denied indemnity, for a two reasons.
  - First, because the policy only responded to litigation against an Insured brought "by a third party", and Treetops was not a third party.
  - Second, the claim under the Policy was excluded as the litigation was brought by Treetops, which was:
    - a Subsidiary of an Insured under the Policy as a company owned by Mr Mitchell); and/or
    - brought "on behalf of" or "for the benefit of" Mr Mitchell or his Family Members.[215]
- Following WFI's refusal of indemnity, Malamit commenced a claim in the Supreme Court of New South Wales seeking a declaration that it was entitled to indemnity from WFI, or alternatively damages from its insurance brokers (who were joined as a party to the litigation).[216] The primary judge, Sackar J, held that Treetops was a Subsidiary (and not a third party) for the purpose of the policy, meaning that the claim by Malamit under the policy was:
  - excluded by an exclusion; and also
  - not covered by the insuring clause.
- Malamit appealed the decision of the Supreme Court of New South Wales.

Analysis by the Court of Appeal

- On appeal, the NSW Court of Appeal considered whether, for the purpose of the Claim, Treetop's litigation against Malamit was:
  - brought by a third party and therefore covered by the insuring clause of the policy;
  - brought by a Subsidiary and therefore excluded by the Subsidiary Exclusion; and
  - brought "on behalf of" or "for the benefit of" Mr Mitchell, who was a Further Insured, or his Family Members.

Whether proceedings had been brought by a third party

- The first issue for the Court of Appeal was whether Treetops, which was owned by the Insured, Mr Mitchell, was a third party for the purpose of the policy.
- In construing a contract of insurance, "preference is given to a construction supplying a congruent operation to the various components of the whole."[217]
- The Court of Appeal relied on orthodox jurisprudence regarding policy interpretation, namely that the contract should be construed with a view to resolving inconsistencies and giving effect to all of its terms,[218] and that exclusions are to be construed to "cut out something already included by the general recitals and provisions".[219]

214 *Malamit*, [8].
215 *Malamit*, [12].
216 *Malamit Pty Ltd v WFI Insurance Ltd* [2016] NSWSC 1306.
217 *Wilkie*, [16] (Gleeson CJ, McHugh, Gummow and Kirby JJ).
218 *Malamit*, [20].
219 *Malamit*, [22].

- The Court of Appeal interpreted the meaning of third party (in the policy) in light of an exclusion which excluded from cover a claim by, on behalf of, or for the benefit of any Insured.[220] For the Court of Appeal, the term "third party" meant anyone other than the particular Insured subject to the proceedings.[221] The litigation brought by Treetops against Malamit was, therefore, a claim brought by a third party for the purpose of the policy.

- The Court of Appeal notably distinguished *Chubb Insurance Company of Australia Ltd v Robinson*[222] where the term "third party" was interpreted in a differently worded policy.[223]

  - In that case, the relevant policy insured claims for acts or omissions occurring while the insureds acted as directors and officers of companies in a defined group. An exclusion excluded claims for "any actual or alleged act or omission" by the insureds in the rendering of "any professional services to a third party".

  - The Full Federal Court interpreted "third party" to mean a person or entity outside the defined group of insured companies. Accordingly, the exclusion applied to services rendered by an insured to a person or entity outside the defined group.

- Although the Court's interpretations in *Malamit* and *Chubb* differ, both cases are consistent with the principle of construction of favouring an interpretation that gives a consistent operation to the whole of the contract.

Whether the claim was brought by an Insured's subsidiary or for the benefit of an Insured

- Mr Mitchell was the sole director of Malamit and owned all shares of Treetops.[224]
  Mr Mitchell, as a director of Malamit, was an Insured. Subsidiary was defined to include any corporate entity in which the Insured owns or controls 50% of the voting shares.[225]

- The second (and separate) issue for the Court of Appeal concerned whether Treetops was a "Subsidiary" as a company wholly owned by Mr Mitchell, or whether the litigation brought by Treetops (as trustee of Lismore Business Park Unit Trust) against Malamit was brought for the benefit of an Insured, and therefore excluded from cover.

- WFI denied the insurance claim by Malamit and argued that Treetops was a Subsidiary, as a corporate entity in which Mr Mitchell as an Insured owned all issued voting shares, regardless of the fact that the relevant Insured was a natural person, who was a Further Insured, and was not the Insured being sued in this claim.[226] Malamit argued that the definite phrase "the Insured" (singular) in the definition of Subsidiary referred to subsidiaries of the Named Insureds.[227]

- The Court of Appeal considered the purpose of excluding litigated claims made against the Insured by another Insured, or any Subsidiary or Family Member of an Insured (as defined) was to avoid the risk of collusion or assistance between the Insureds in making an insurance claim under the WFI policy.[228] Accordingly, the exclusion of proceedings brought by "any Insured" or "any Subsidiary", excluded any Insured and any company or legal body in the definition of "Subsidiary".[229]

220 *Malamit*, [23].
221 *Malamit*, [19].
222 *Chubb Insurance Co of Australia Ltd v Robinson* (2016) 239 FCR 300 (***Chubb***).
223 *Malamit*, [24].
224 *Malamit*, [26].
225 *Malamit*, [26].
226 *Malamit*, [26]-[27].
227 *Malamit*, [28]-[29].
228 *Malamit*, [32].
229 *Malamit*, [32].

- The Court of Appeal concluded that Treetops was a Subsidiary of Malamit for the purpose of the Policy, and was therefore excluded from cover by virtue of exclusion 7.15 under the policy.[230]

Result

- The policyholder, Malamit, was unsuccessful in its appeal.

- The Court of Appeal construed the insuring clause to respond to claims brought by any party besides the Insured being sued. On this basis, the policy responded to the claim submitted by Malamit in respect of the Treetops litigation. However, an exclusion applied to exclude the insurance claim from cover as Treetops (the Plaintiff in the litigation) was the Subsidiary of another Insured under the policy.

230 *Malamit*, [33].

KEY CONTACTS

TRAVIS TOEMOE

PARTNER
SYDNEY

TEL +61 2 9296 2430
MOB +61 458 485 105
EMAIL travis.toemoe@au.kwm.com

SARAH YU

PARTNER
SYDNEY

TEL +61 2 9296 2321
MOB +61 414 253 457
EMAIL sarah.yu@au.kwm.com

MANDY TSANG

PARTNER
SYDNEY

TEL +61 2 9296 2751
MOB +61 409 679 806
EMAIL mandy.tsang@au.kwm.com

PETER YELDHAM

PARTNER
SYDNEY

TEL +61 2 9296 2890
MOB +61 418 159 319
EMAIL peter.yeldham@au.kwm.com

MAX CASH

SPECIAL COUNSEL
SYDNEY

TEL +61 2 9296 2384
MOB +61 415 250 246
EMAIL max.cash@au.kwm.com

REBECCA SCOTT

SPECIAL COUNSEL
BRISBANE

TEL +61 7 3244 8123
MOB +61 458 346 605
EMAIL rebecca.l.scott@au.kwm.com

DIANA NICHOLSON

PARTNER, FINANCIAL SERVICES SECTOR LEADER

TEL +61 3 9643 4229
MOB +61 418 481 632
EMAIL diana.nicholson@au.kwm.com

JIM BOYNTON

PARTNER
SYDNEY, MELBOURNE

TEL +61 2 9296 2086
MOB +61 419 264 796
EMAIL james.boynton@au.kwm.com

CONTRIBUTORS

Amelia Blefari
Alex Wu
Ben Micallef
Blake Sherry
Brian Whelan
Bryony Evans
Charlie Carpenter
Dan Canta
Ed Goodman
Emma White
Gauri Prabhakar
Georgia Cowley
Georgie Parletta
Henry Higgins
Imogen Purcell
Jessie Zhang
Jim Boynton
Kevin Zhou
Laurice Elten
Leonie Bayntun
Lucinda Everson
Maeve Moore
Magan Goh
Mandy Tsang
Marie Veinberg
Max Cash
Michael D’Anella
Dr Michelle Borg
Peter Yeldham
Rebecca Scott
Rouzbeh Ansari
Ruthvik Rao
Sam Bagnall
Sarah Yu
Stephanie Coelho
Sophie Crowe
Travis Toemoe

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