

**THE LAW COMMISSION
AND
SCOTTISH LAW COMMISSION**

**REFORMING INSURANCE CONTRACT LAW: INITIAL
DRAFT CLAUSES**

January 2014

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PART 1: INTRODUCTION

- 1.1 The Law Commission and Scottish Law Commission are reviewing the law of insurance contracts. Our first report focused on consumers' disclosure obligations, resulting in the Consumer Insurance (Disclosure and Representations) Act 2012 (CIDRA), which came into force in April 2013.
- 1.2 Our intention is to publish a second Bill covering:
 - (1) disclosure and misrepresentation in business insurance contracts (fair presentation);
 - (2) the law of warranties;
 - (3) damages for late payment of claims; and
 - (4) insurers' remedies for fraudulent claims.
- 1.3 The hope is that the Bill will be suitable for the special Parliamentary procedure for uncontroversial Law Commission Bills.¹
- 1.4 Damages for late payment and fraudulent claims were discussed in our December 2011 consultation paper (CP2).² Fair presentation and warranties were discussed in CP3, published in June 2012.³ Readers are referred to these documents for an account of the current law and a full explanation of the reasons for the reforms.

THE DRAFT CLAUSES

- 1.5 These notes accompany initial draft clauses covering:
 - (1) fair presentation in business insurance contracts;
 - (2) damages for late payment of claims; and
 - (3) insurers' remedies for fraudulent claims.
- 1.6 There is also a short clause dealing with good faith.

¹ The procedure is intended to reduce the time that Law Commission Bills spend on the floor of the House by providing for certain stages to be carried out in Committee. Further information about the procedure is available at: <http://www.publications.parliament.uk/pa/ld200708/ldselect/ldprohse/63/63.pdf>.

² Law Commission and Scottish Law Commission, LCCP 201/SLCDP 152: *Insurance Contract Law: Post Contract Duties and other Issues*, covering damages for late payment, insurers' remedies for fraudulent claims, insurable interest and policies and premiums in marine insurance (2011). Available at: http://lawcommission.justice.gov.uk/docs/cp201_ICL_post_contract_duties.pdf and http://www.scotlawcom.gov.uk/index.php/download_file/view/947/107.

³ Law Commission and Scottish Law Commission, LCCP 204/SLCDP 155: *Insurance Contract Law: The Business Insured's Duty of Disclosure and the Law of Warranties* (2012). Available at: http://lawcommission.justice.gov.uk/docs/cp204_ICL_business-disclosure.pdf and http://www.scotlawcom.gov.uk/index.php/download_file/view/1020/107/.

- 1.7 This is a partial draft of the Bill. In particular, we are still working on clauses dealing with:
- (1) warranties; and
 - (2) contracting out. We propose mandatory regimes for consumer insurance, but only default provisions for business insurance. We think that commercial parties should be free to contract out of the reforms and substitute their own agreed regimes.
- 1.8 The proposals in our consultation papers received strong support.⁴ The draft clauses are intended to reflect those proposals in broad terms, updated in some respects to reflect consultation responses.
- 1.9 These notes are not intended as a further consultation on the policy behind our proposals. However, we are interested in views on whether the draft clauses implement the policy effectively.
- 1.10 We welcome comments to commercialandcommon@lawcommission.gsi.gov.uk by 21 February 2014.

⁴ Summaries of responses to each consultation paper, with a break-down of the numbers of consultees agreeing and disagreeing with our proposals, are available on our websites: <http://lawcommission.justice.gov.uk/areas/insurance-contract-law.htm> and <http://www.scotlawcom.gov.uk/law-reform-projects/joint-projects/insurance-law>.

PART 2: THE DUTY OF FAIR PRESENTATION

- 2.1 A policyholder often knows more about the insured risk than the insurer. It is therefore important to encourage the full and frank exchange of information before the insurance contract is made.
- 2.2 Under the current law, the onus is on a prospective business insured (the “proposer”) to disclose information to the insurer. They must “present the risk”. We propose to retain that duty. It enables the UK insurance market to provide insurance for a wide variety of large and specialist risks, efficiently and cost-effectively.
- 2.3 We think, however, that the current law does not work as well as it should. It is unclear, and the consequences of breaching the duty are harsh. We propose reforms which build on case law and current best practice.

SECTION 18 OF THE MARINE INSURANCE ACT 1906

- 2.4 The law in this area was codified in the Marine Insurance Act 1906 (the 1906 Act), sections 17 to 20.
- 2.5 Section 18 is the key section. Section 18(1) states that the insured must disclose “every material circumstance” which it knows or ought to know “in the ordinary course of business”. Under section 18(2), a material circumstance is defined as “every circumstance which would influence the judgment of a prudent insurer in fixing the premium, or determining whether he will take the risk”. Although some exceptions to the duty are set out in section 18(3), these are poorly understood.
- 2.6 The consequences of failure are harsh. If the insured fails to disclose a material circumstance, the insurer may “avoid the contract”. In other words, the insurer may treat the insurance contract as if it had never existed and refuse all claims under it.

OTHER PROVISIONS

- 2.7 The duty of disclosure in section 18 is supported by three other sections of the 1906 Act:
 - (1) Section 17 sets out the general principle. It states that an insurance contract is “based upon the utmost good faith” and provides avoidance as a remedy for breach.⁵
 - (2) Section 19 requires information known to the broker to be disclosed.
 - (3) Section 20 places a duty on the insured not to misrepresent material facts. A representation as to a matter of fact must be true or “substantially correct”. A representation as to a matter of expectation or belief must be made in good faith.

⁵ Clause 13 of the draft Bill removes the remedy of avoidance.

- 2.8 If any of these duties is breached, the insurer may avoid the contract with the insured.

Problems with the current law

- 2.9 In CP3, we identified five problems with the way the duty of disclosure operates.⁶
- (1) The duty is poorly understood. Proposers struggle to understand what facts might be material to a prudent insurer and consequently what they should disclose. It is difficult for an entity whose main business is not insurance to deduce what facts an insurer is likely to be interested in.
 - (2) By requiring disclosure of every material fact, the 1906 Act encourages data dumping - that is, the presentation of huge volumes of material without distinction between the material and trivial.
 - (3) Medium and large companies struggle to collate all material facts. It is difficult both to understand what is relevant to the insurer and to corral the necessary information in one place within the organisation.
 - (4) The 1906 Act encourages “underwriting at claims stage”. Insurers can take a passive approach to the presentation of a risk, asking no questions when underwriting it, and only applying their minds to the real risks where a claim is made.
 - (5) The single remedy of avoidance in all cases is too inflexible.
- 2.10 The majority of consultees thought that the law required updating. However, most agreed that the core principles of the law had stood the test of time and should be retained for non-consumer insurance. We have therefore adopted an evolutionary approach, building on the current case law. We have provided a scheme for remedies which is neutral and seeks to place the parties in the position they would have been in if a full and accurate presentation of the risk had been provided.

OVERVIEW OF PROPOSALS

- 2.11 Our proposals are aimed at all non-consumer insurance, whether that insurance is taken out by a micro-business or large multi-national business. They also cover marine insurance and reinsurance.
- 2.12 The key elements are:
- (1) To retain the proposer’s pre-contractual duty of disclosure and non-misrepresentation as part of a “duty of fair presentation”.
 - (2) To underpin and encourage professionalism in the market by:
 - (a) encouraging active engagement by the insurer rather than passive underwriting; and

⁶ Law Commission and Scottish Law Commission, LCCP 204/SLCDP 155: *Insurance Contract Law: The Business Insured’s Duty of Disclosure and the Law of Warranties* (2012), Chapter 4.

- (b) giving guidance as to what measures the proposer should take in order to satisfy the fair presentation requirement, including a requirement to make reasonable searches of the information available to it.
- (3) To clarify whose knowledge in the proposer's organisation is relevant to the duty of disclosure.
- (4) To clarify the exceptions to the duty of disclosure (currently set out in section 18(3)).
- (5) To replace the single remedy of avoidance for breach of the duty with a regime of proportionate remedies based on what the insurer would have done had it received a fair presentation.

“NON-CONSUMER INSURANCE”

- 2.13 Our draft Bill applies to all insurance contracts which are not entered into by a “consumer”, as defined in CIDRA. This will primarily mean insurance transacted with legal persons, but could also include natural persons where they are buying insurance mainly for purposes related to their trade, business or profession. Thus sole traders and entities such as partnerships⁷ and joint ventures come within scope, where these are entered in to for a trade, business or profession. We considered using the term “business insurance”, but we wished to stress that it covers everyone who is not a consumer, including charities and not-for-profit organisations.
- 2.14 The pre-contractual obligations we propose here differ from those on consumers. Under CIDRA, there is no duty on consumers to volunteer information - only to answer the insurer's questions.⁸ Further, under CIDRA, an insurer must show that the breach of the consumer's duty was either careless or deliberate/reckless.⁹ For non-consumer insurance, the onus will remain on the proposer to present the risk fairly. An insurer will also have a remedy for an innocent breach of the duty, even if it is neither careless nor deliberate/reckless.

THE DUTY OF FAIR PRESENTATION

- 2.15 Clause 3(1) of the draft Bill places a duty on the proposer to make to the insurer a fair presentation of the risk before a contract of insurance is entered into. Further details of this duty are given in clauses 4 to 8. These replace the existing law in sections 18, 19 and 20 of the 1906 Act.
- 2.16 Our proposals are incremental rather than radical. In particular, the duty of fair presentation is based on existing case law.¹⁰ Clause 4 takes principles from a series of current cases and incorporates them into the statute.

⁷ In Scots law, partnerships have separate legal personality.

⁸ Consumer Insurance (Disclosure and Representations) Act 2012, section 2.

⁹ Consumer Insurance (Disclosure and Representations) Act 2012, sections 2, 4 and 5.

¹⁰ *CTI v Oceanus* [1984] 1 LI LR 476 and *North Star Shipping v Sphere Drake (no 2)* [2006] EWCA Civ 378.

The proposer

- 2.17 “Proposer” and “insurer” are defined in clause 1. The proposer is the party who ultimately enters into the insurance contract and becomes the “insured”. However, because the duty of fair presentation is a pre-contractual duty, at the point at which the duty applies they are not yet the “insured”.
- 2.18 We welcome views on whether it is helpful to distinguish the “proposer” from the “insured” in this way. An alternative option would be to refer to the insured throughout the Bill, and then define “insured” as both the insured party under the contract and the party who becomes the insured when the contract is entered into.

The substance of the duty of fair presentation

- 2.19 Clause 4(1) defines the duty of fair presentation, which comprises three elements. Very broadly, these are:
- (1) what must be disclosed;
 - (2) how that information is presented; and
 - (3) a requirement of truth for all material representations.

4(1)(a) The duty of disclosure

- 2.20 Clause 4(1)(a) defines a new duty of disclosure, which reflects the existing duty in section 18(1) of the 1906 Act, with some important changes. Under the draft, the proposer must *either*:
- (1) disclose every material circumstance which the proposer knows or ought to know; *or*
 - (2) taking the information provided by the proposer in the round, give the insurer sufficient information, in relation to those material circumstances, as would put a prudent insurer on notice that it needs to make further inquiries [as to circumstances which may prove material].

MATERIAL CIRCUMSTANCE AND THE PRUDENT INSURER

- 2.21 A material circumstance is defined in clause 4(1)(5), using similar words to section 18(2) of the 1906 Act. A circumstance is material if it would influence the judgment of a prudent insurer in determining whether to take the risk and, if so, on what terms.

WHAT THE PROPOSER KNOWS AND OUGHT TO KNOW

- 2.22 Section 18(1) states that the assured must disclose to the insurer every material circumstance “which is known to the assured”, and “the assured is deemed to know every circumstance which, in the ordinary course of business ought to be known by him”. In other words, under the 1906 Act, the duty of disclosure applies to information which the insured knows or ought to know.

- 2.23 The draft clauses take the same approach, by referring to “every material circumstance which the proposer knows or ought to know”. What the proposer “knows” and what the proposer “ought to know” are defined in clause 5, discussed below.

SUFFICIENT INFORMATION AS WOULD PUT A PRUDENT INSURER ON NOTICE

- 2.24 The text in the second part of clause 4(1)(a), as set out above, is still under consideration. The policy position, however, is settled. Even where a material circumstance is not itself disclosed, the proposer may have done enough to satisfy the duty of fair presentation if it has given the insurer sufficient “signposts” which would lead a prudent insurer to make further inquiries which, when answered, would reveal material circumstances. This reflects the approach already taken by the courts in some cases.¹¹
- 2.25 This proposal is intended to ensure that insurers are engaged in the disclosure and fair presentation process. Insurers should not “underwrite at claims stage”, allowing questions to go unasked until a claim is received. If a prudent insurer, reviewing the disclosed information, would be prompted to ask further questions or to seek further information, a failure on the part of the actual insurer to do so should not prejudice the insured party at a later stage.

Example: putting a prudent insurer on notice

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

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

The failure by X Co to state that its valves were used for storing petrol is likely to be a non-disclosure under the existing law, given that this is more likely to lead to serious damage than in non-combustible industries. We think it also breaches the fair presentation standard as making “specialist” valves does not give the underwriter enough information to decide whether to ask questions about the industries in which these valves are used.

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

EXCEPTIONS

- 2.26 Exceptions to the duty of disclosure (similar to those in the 1906 Act) are contained in clause 6 of the draft Bill, discussed below.

¹¹ For example, *CTI v Oceanus* [1984] 1 Lloyd’s LR 476; *Garnat Trading and Shipping v Baominh Insurance Corporation* [2011] EWCA Civ 773.

4(1)(b) The manner of presentation

- 2.27 Clause 4(1)(b) relates to the *form* of presentation, rather than the substance. It states that the disclosure of information must be made in a manner which would be reasonably clear and accessible to a prudent insurer. It is designed to target the practice of convoluted presentations and data dumping, where a proposer overwhelms an insurer with a large amount of undigested information.
- 2.28 On a strict view of the 1906 Act, data dumping is permitted, but we propose to change this. We think that a lack of structuring, indexing and signposting may mean that a presentation is not “fair”.
- 2.29 The way that this is applied will depend on the facts. A large volume of data, appropriately broked in person to the underwriter or otherwise organised to highlight the material issues would not be objectionable. Equally, a large volume of data accompanied by an overview highlighting material points would be acceptable.

4(1)(c) The duty not to make misrepresentations

- 2.30 Clause 4(1)(c) provides that every material representation made by the proposer must be:
- (1) substantially correct, if as to something the proposer “knows” or “ought to know” (as defined in clause 5); or
 - (2) made in good faith, if as to something else (such as a matter of expectation or belief).
- 2.31 This is based on section 20 of the 1906 Act. We have brought it within the duty alongside the duty of disclosure because there is often little practical difference between a non-disclosure and a misrepresentation.¹² We intend to treat non-disclosures and misrepresentations in the same way as far as possible.

¹² See Lord Mustill in *Pan Atlantic v Pine Top* [1995] 1 AC 501 at 549 who noted that in practice the difference between the two is “often imperceptible”. In Scots law, although silence does not usually constitute a misrepresentation, where the law recognises a duty to disclose, a failure to do so will amount to a misrepresentation. See MacQueen and Thomson, *Contract Law in Scotland* (3rd ed, 2012), p181.

2.32 Section 20 of the 1906 Act recognises a difference between matters of fact and matters of expectation or belief. Facts must be substantially correct, whereas expectations or beliefs must be represented in good faith under section 20(5). The distinction between a representation of fact and one of belief is a matter of construction. The courts have been alive to attempts to present facts as beliefs in order to benefit from the lower standard, and have rejected them.¹³ In practice, the courts are heavily influenced by whether the matter is one which the insured knew about or should have known about. If so, the court is likely to hold that the statement must be true or “substantially correct”. If it is outside the matters which the insured could be expected to know about, it is probably a matter of expectation or belief.

2.33 We gave the following example in CP3:

A company is asked whether a particular employee has a non-spent criminal conviction. The company answers in the negative but this is factually incorrect. Arguably, if the answer is not true, the company has breached its duty under section 20 of the 1906 Act and the contract can be avoided.

It may be, however, that the company followed reasonable procedures and still failed to find out about the conviction: the employee lied and, as the conviction occurred abroad, it did not appear on the criminal record check the company carried out. In these circumstances, the court may well find that the statement that the employee did not have a criminal record was no more than a statement of belief. In this case it is sufficient for the company to have acted in good faith.

2.34 The distinction between fact and belief in the 1906 Act only applies in relation to misrepresentations, not to non-disclosures. As we have said, we propose to reduce the differences in treatment between those breaches. We therefore propose that a proposer has a duty to make a fair presentation of information which is known or which ought to be known to them. We have already seen that this information has to be disclosed under clause 4(1)(a).

4(6) Examples of things which may be material circumstances

2.35 In CP3 we discussed the possibility of including some guidance as to what constitutes material circumstances based on our review of the case law. We have drafted this in clause 4(6) which lists the following as things which may be material circumstances:

- (1) special or unusual facts relating to the risk;
- (2) any particular concerns which led the proposer to seek insurance cover for the risk;

¹³ For example, a representation about fire hydrants in *Sirius International Insurance v Oriental Assurance Corp* [1999] 1 All ER (Comm) 699 was not transformed into a matter of belief by being expressed in the form of an opinion as the matter was one of fact.

- (3) anything which those concerned with the class of insurance and field of activity in question would generally understand as being something that should be dealt with in a fair presentation of risks of the type in question.
- 2.36 We welcome views on whether it is helpful to include this non-exhaustive list on the face of the Bill.
- 2.37 Of these three categories, the final one causes the greatest concern. We hope it would encourage insurers and insureds to work together to develop guidance and protocols over what a standard presentation of the risk should include in certain circumstances. Where an insurer could show that it had not been told information which the guidance specifically stated should be included, the insurer would find it easy to show that the risk had not been fairly presented.
- 2.38 Clauses 4(2), (3), (4), (5), (7) and (8) provide additional information and definitions, most of which reflect the provisions of the 1906 Act.

KNOWLEDGE

- 2.39 The issue of knowledge within a corporate entity is important for non-consumer proposers, brokers and insurers alike. The 1906 Act frames the duty of disclosure by reference to information known by the assured and its agent, and excludes from the duty information already known to the insurer. There are considerable difficulties in applying this law to modern corporate organisations, in which knowledge may be spread through hundreds, if not thousands, of employees or located in IT systems.
- 2.40 We identified two issues which would benefit from clarification. The first is actual knowledge: whose knowledge is relevant when the business or insurer is a corporate entity? The second issue is what businesses and insurers “ought to know” about their operations (their constructive knowledge).
- 2.41 We propose that the common law rules of attribution should be ousted for these purposes in order to provide clarity. Instead, the legislation should state whose knowledge is relevant. We also clarify, in clause 2, that “knowledge” includes blind-eye knowledge.

Clause 5 The proposer’s knowledge

- 2.42 In clause 5 we set out what is meant by “know” and “ought to know” in terms of disclosures and representations in clause 4.

What the proposer “knows”

- 2.43 Where a proposer is an individual (such as in the case of a sole trader or practitioner), as well as that individual’s own knowledge they will also be taken to “know” anything which is known by the person or people who are responsible for the proposer’s insurance. This is in 5(2).
- 2.44 Under 5(3), where the proposer is not an individual, it will be taken to “know” what is known by individuals who are:
 - (1) part of the proposer’s senior management; or

(2) responsible for the proposer's insurance.

2.45 "Senior management" is defined in clause 5(5)(a) as those individuals who play significant roles in the making of decisions about how the proposer's activities are to be managed or organised, or in the actual management or organisation of those activities. We expect this would include (and be more or less limited to), board members or their equivalent in a non-corporate organisation.¹⁴ In a large partnership, for example, there may well be a board which makes decisions about how the proposer is to be organised and managed. If not, and this is done by all of the partners, then all the partners would be caught by this test.

2.46 A person "responsible for the proposer's insurance" is defined in clause 5(5)(b) as an individual who participates on behalf of the proposer in the procurement of the proposer's insurance whether as an employee, agent or in another capacity. We expect this to include, for example, a company's risk manager/risk management department if they have one, or any other employee who assists in the collection of data or negotiates the terms of the insurance. Exactly who is caught will depend on the particular circumstances of an individual case. It would also include an individual acting as the proposer's broker.

What the proposer ought to know

2.47 Clause 5(4) defines what a proposer "ought to know" as that which would have been revealed by a reasonable search of information available to the proposer (whether within its own organisation or held by others, for example its agent). This provision therefore clarifies what has been suggested by some recent cases: that is, proposers have a positive duty to seek out information about their business.¹⁵

2.48 We expect that what is "reasonable" will depend on the size, nature and complexity of the business.

The proposer's agent

2.49 Under the 1906 Act, the duty to disclose is not confined to circumstances which the insured knows or ought to know. Under section 19, where the insured uses a broker or other agent to effect insurance, the agent is also required to disclose information to the insurer. As set out in CP3, we propose to repeal section 19 and make alternative provision for agents' knowledge.

¹⁴ In Scots law, partnerships have separate legal personality.

¹⁵ See, for example, *London General Insurance Co Ltd v General Marine Underwriters' Association Ltd* [1920] 3 KB 23.

- 2.50 Section 19 is a difficult provision to understand. It appears to place a duty on the broker to the insurer, but it does not in fact give the insurer a cause of action against the broker.¹⁶ The only remedy for breach by the broker is that the insurer may avoid its contract with the insured. The effect of the section, therefore, is to extend the insured's duty to the insurer, not only to disclose information which the insured knows or ought to know, but also to disclose additional circumstances which are known only to the broker. If taken literally the section appears to be wide: it could extend to information which the broker acquired from another client, and which the insured has no reason to know. This has the potential to lead to conflicts of interest.
- 2.51 Brokers may have acted for clients for many years, and acquired considerable knowledge of the proposer's business. It is therefore right that the duty of disclosure should include not only information known by the proposer, but also any information received or held by the agent in the course of acting for the proposer. This should apply to all brokers in the chain.
- 2.52 Under our proposals, an agent's knowledge is attributed to the proposer in the following ways:
- (1) An agent will fall within those individuals who are "responsible for arranging the proposer's insurance" so that what is known to the individual broker, managing agent or other agent must be disclosed; and
 - (2) The proposer's duty to make a reasonable search will catch information held by the broker or other agent (but only insofar as it is reasonably "available to the proposer" so that it excludes, for example, confidential information held by the agent about another client).
- 2.53 The duty of fair presentation rests on the proposer, who is ultimately responsible for ensuring that the agent's knowledge and information is disclosed accurately. However, the agent will owe a professional duty of care to the proposer to ensure that it does not cause the proposer to be in breach of its duty.

Clause 6 Exceptions to the duty of fair presentation, and the insurer's knowledge

- 2.54 As in section 18(3) of the 1906 Act, the draft Bill contains exceptions to the proposer's duty of disclosure.
- 2.55 Under clause 6(1), the proposer is not required to disclose anything which:
- (a) diminishes the risk,
 - (b) is known by the insurer,
 - (c) ought reasonably to be known by the insurer,
 - (d) is presumed to be known by the insurer,

¹⁶ *HIH Casualty and General Insurance Co Ltd v Chase Manhattan Bank* [2003] Lloyd's Rep IR 230.

- (e) is something as to which the insurer waives information, or
- (f) is covered by an express or implied warranty (and it is therefore superfluous to disclose).

2.56 Exceptions (a), (e) and (f) replicate the relevant provisions in the 1906 Act.

2.57 The rest of clause 6 defines things which the insurer “knows”, “ought reasonably to know” and is “to be presumed to know”. “Things” includes information of any kind, including facts, rumours, expectations and beliefs.

What the insurer “knows”

2.58 Clause 6(2) states that the insurer knows something only if it is known to one or more of the individuals who participate on behalf of the insurer in the decision whether to take the risk and, if so, on what terms. Those individuals may be, for example, employees or agents of the insurer. This provision is intended to capture the person or people who are involved in making the particular underwriting decision.

What the insurer “ought reasonably to know”

2.59 Under clause 6(3), an insurer ought reasonably to know something only if:

- (1) an employee or agent of the insurer knows it and ought reasonably to have passed it on to the underwriter(s) (this will catch, for example, reports produced by surveyors or medical experts); or
- (2) the relevant information is readily available to the particular underwriter(s) (this would require the underwriter(s) to make a search of such information as is available to them within the insurer’s organisation).

What the insurer is “presumed to know”

2.60 Under clause 6(4), the insurer is presumed to know:

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

2.61 This clause is a restatement and modernisation of section 18(3)(b) of the 1906 Act. Given problems with naïve capacity, the type of insurance sought is a relevant factor in what an insurer ought to know which may not have been adequately addressed in current case law. An insurer ought to have some insight into the industry for which it is providing insurance, but this insight may reasonably be limited to matters relevant to the type of insurance provided. Many underwriters work not by industry sector but by class of business. Thus an employers’ liability underwriter will know something about the range of industries they insure such as the usual rates of injury in construction or off-shore marine business. It is unrealistic to suppose that they will have a detailed knowledge of all the industries they provide cover for.

REMEDIES FOR BREACH OF THE DUTY OF FAIR PRESENTATION

Breach of the duty of fair presentation

- 2.62 The proposer's duty under the draft Bill is to make a fair presentation. The remedies are therefore expressed in terms of a breach of this duty. The duty is breached if the presentation fails to satisfy one or more of the three elements in clause 4(1).

Inducement

- 2.63 Before an insurer has a remedy under the 1906 Act it must show that it was induced to enter into the policy on the relevant terms by the proposer's breach.¹⁷ This 'inducement test' requires the specific underwriter to show that they would have acted differently had there not been a failure. Without inducement there can be no remedy under the present law. We do not intend to change this position, which has become a fundamental element of the law.
- 2.64 In line with our approach in CIDRA, we have included the inducement test in clause 7(1) of the draft Bill. An insurer therefore has a remedy for a proposer's breach of the duty of fair presentation only if, had the proposer made a fair presentation, the insurer:

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

- 2.65 A breach for which the insurer has a remedy is referred to as a "qualifying breach".

Deliberate or reckless breaches

- 2.66 As in CIDRA, an insurer will have different remedies depending on whether or not the proposer's breach of the duty of fair presentation was deliberate or reckless. Under clause 7(5), a breach is deliberate or reckless if the proposer:

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

- 2.67 This echoes the definition in CIDRA. However, in CIDRA a "qualifying breach" must be either deliberate/reckless or careless, since the consumer's duty is to take reasonable care not to make a misrepresentation to the insurer. In non-consumer insurance, breaches do not have to be careless or deliberate/reckless in order to be actionable. "Innocent" breaches of the duty will also give an insurer a remedy if the insurer can show inducement. This reflects the current law.

Remedies for breach of the duty of fair presentation

- 2.68 The remedies are set out in the Schedule to the draft Bill. As far as possible, the Schedule follows the structure and language of the Schedule to CIDRA, but some differences are necessary due to the difference in the primary duty.

¹⁷ *Pan Atlantic v Pine Top* [1995] 1 AC 501.

- 2.69 At present, the law makes almost no distinction in non-consumer insurance between honest and dishonest mistakes. The remedy in all cases is avoidance of the policy (though under section 84 of the 1906 Act, premiums are only returnable for disclosure failings which are not dishonest). We propose a fundamental change to this regime. The insurer's remedy for deliberate or reckless breaches of the duty of fair presentation will still be avoidance. In all other cases, a proportionate remedy will be imposed based on what the insurer would have done had the proposer made a fair presentation of the risk.
- 2.70 The courts are best placed to decide what evidence is admissible and sufficient to show how the insurer would have acted. We have not seen evidence to suggest that further guidance is needed.

Deliberate or reckless breaches

- 2.71 Paragraph 2 of Part 1 of the Schedule confirms that, in the event of a deliberate or reckless breach, the insurer may avoid the contract and refuse all claims. Further, it need not return any of the premiums paid.
- 2.72 This is similar to the insurer's remedy under CIDRA for deliberate or reckless misrepresentations.

Other breaches

- 2.73 A scheme of proportionate remedies for breaches which are neither deliberate nor reckless is set out in paragraphs 4 to 8 of Part 1 of the Schedule. Paragraph 4 confirms that the insurer's remedies are based on what it would have done if a fair presentation had been made.

IF THE INSURER WOULD NOT HAVE ENTERED INTO THE CONTRACT

- 2.74 If the insurer can show that, had it received a fair presentation of the risk, it would not have accepted that risk or entered into the contract on any terms, its remedy is avoidance and it may refuse all claims. This is set out in paragraph 5. Since in this situation the breach of the duty is neither deliberate nor reckless, the insurer must return the premiums paid. Both parties are effectively restored to the situation they would have been in had the contract never been entered into.

IF THE INSURER WOULD HAVE ENTERED INTO THE CONTRACT, BUT ON DIFFERENT TERMS

- 2.75 If the insurer would have entered into the contract but only on different terms (other than as to the premium charged) then the insurer may require that the contract be treated as if it had been entered into on those different terms from the outset. This is set out in paragraph 6, and means that additional warranties or exclusions, for example, may be imported into the contract which may affect the recoverability of claims.

IF THE INSURER WOULD HAVE ENTERED INTO THE CONTRACT, BUT WOULD HAVE CHARGED A HIGHER PREMIUM

- 2.76 If the insurer would have entered into the contract but only at a higher premium, paragraph 7 provides that the insurer may “reduce proportionately” the amount to be paid on a claim. “Reduce proportionately” is defined in paragraph 8 as meaning that the insured need only pay X% of claims under the relevant policy, where $X = (\text{premium actually charged} / \text{higher premium}) \times 100$.
- 2.77 The remedies in paragraphs 6 and 7 may be applied together if the insurer would have entered into the contract on different terms and at a higher premium.

VARIATIONS

- 2.78 Where an insurance contract is varied, the fair presentation obligation arises in relation to the variation only. Clause 2(3) of the draft Bill confirms that the fair presentation provisions apply to variations as they do to contracts of insurance, but amended as necessary. Proportionate remedies will also apply to variations, with necessary modifications to the Schedule. These will be addressed in Part 2 of the Schedule, but have not yet been drafted.

PART 3 : INSURERS’ REMEDIES FOR FRAUDULENT CLAIMS

BACKGROUND AND POLICY

- 3.1 Where there is no express term in the insurance contract dealing with fraud, the courts must look to the general law to determine the consequences of a fraudulent claim by an insured. Under the common law, the fraudster forfeits the fraudulent claim.¹⁸ However, section 17 of the 1906 Act gives the insurer a statutory remedy of avoidance in the event of a breach of good faith. Theoretically at least, this allows the insurer not only to avoid the fraudulent claim but to treat the contract as having been void from the outset, but in practice the courts have been reluctant to apply this.
- 3.2 The uneasy juxtaposition of section 17 and the common law leaves two issues which would benefit from clarification:
- (1) The effect of a fraudulent claim on the insurer’s liability in respect of a genuine loss suffered before the fraud is committed; and
 - (2) The effect of a fraudulent claim on a genuine claim in respect of loss suffered after the fraud but before the insurer has taken action to terminate the contract.

¹⁸ See the discussion in *Manifest Shipping Co Ltd v Uni-Polaris Insurance Co Ltd and Others (The Star Sea)* [2001] UKHL 1, [2003] 1 AC 469 at para 62 – 67. Forfeiture was confirmed in the recent case of *Versloot Dredging BV v HDI-Gerling Industrie Versicherungs AG (The “DC Merwestone”)* [2013] EWHC 1666.

Summary of recommendations

- 3.3 We set out the full legal background in this area, and consulted on our proposals, in Consultation Paper 2¹⁹ (CP2) and Issues Paper 7.²⁰ We recommend a default statutory regime to the effect that, when an insured commits fraud in relation to a claim, the insurer should:
- (1) have no liability to pay the fraudulent claim; and
 - (2) have the option to terminate their liability to pay out in respect of losses after the fraud; but
 - (3) remain liable for legitimate losses *before* the fraud.
- 3.4 We also recommend special provisions to address fraud committed by a member of a group policy, so that the insurer has remedies against the fraudster rather than the policyholder (usually an employer) or the other group members. We do not yet have drafting on our group insurance recommendations.
- 3.5 Our aim is not to produce a complete statutory re-statement of the law on fraudulent claims generally. For example, we do not seek to define fraud. We recommend the introduction of targeted provisions to confirm the remedies available to an insurer who discovers a fraudulent claim. This statutory confirmation is particularly important in light of our recommendation to remove avoidance as a remedy for breach of good faith under section 17, leaving no statutory remedy for fraud.²¹

EXPLANATORY NOTES TO THE DRAFT CLAUSE

- 3.6 Clause 10(1) sets out the elements of an insurer's remedy where an insured makes a fraudulent claim under a policy.

Claims by the insured

- 3.7 The draft statutory provisions only apply where an "insured" makes a fraudulent claim.²² Our remit for this joint review is confined to insurance contract law. As such, our provisions do not cover circumstances where a fraudulent claim is made by a third party against an insured who then claims on its liability policy, or where a claim is made directly against an insurer by someone other than the insured (such as under the Third Parties (Rights Against Insurers) Act 1930 (or 2010 once in force)).

¹⁹ Law Commission and Scottish Law Commission, LCCP 201/SLCDP 152: *Insurance Contract Law: Post Contract Duties and other Issues*, December 2011.

²⁰ Law Commission and Scottish Law Commission, *Issues Paper 7: The Insured's Post-Contract Duty of Good Faith*, July 2010.
http://lawcommission.justice.gov.uk/docs/ICL7_Insureds_Duty_of_Good_Faith.pdf and
http://www.scotlawcom.gov.uk/index.php/download_file/view/208/107/.

²¹ We intend to retain the initial section 17 statement (insurance contracts as contracts of utmost good faith) as an interpretive principle. See clause 13 of the draft Bill and the short discussion below.

²² The "insured" is the party who enters the contract of insurance with the insurer (clause 1).

- 3.8 The short answer is that the common law will operate to determine whether parties other than the original insured are to be treated as the insured for this purpose (for example, where a policy has been novated).

A fraudulent claim

- 3.9 We have not sought to define fraud or fraudulent claim; whether a claim is fraudulent will be determined by the courts applying common law principles.²³
- 3.10 The courts tend to apply the remedy of forfeiture to the “whole claim” or the “entire claim” to which the fraud relates.²⁴ The courts generally give a wide meaning to the concept of a single claim or the whole claim, especially where different elements arise from the same incident. For example, an insured covered by buildings and contents insurance whose house burns down might exaggerate the value of their possessions when making the contents claim but claim accurately under the buildings cover. This would generally be treated as a single claim so that both elements would be forfeited.
- 3.11 Courts regularly address the question of whether related events or aspects of a claim should be treated separately or as part of the same claim having resulted from the same series of events. We have not heard any evidence to suggest that guidance is required on the face of the Bill.

No liability to pay the fraudulent claim

- 3.12 Under clause 10(1)(a) and (b), the insurer is not liable to pay the fraudulent claim and may recover any sums already paid in respect of it. This is the forfeiture rule from the standpoint of the insurer’s rights.

Option to treat the contract as having been terminated

- 3.13 Under clause 10(1)(c), the insurer will have the additional option of treating the insurance contract as having been terminated at the time of the fraudulent act. Although the insurer may not discover a fraud until some time after it has been committed, it may at the point of discovery exercise this right. This right will be exercisable whether or not the contract has expired before discovery of the fraud.
- 3.14 As set out in clause 10(2)(a), where the insurer elects to exercise this right, it may refuse to pay claims in respect of all relevant events occurring subsequent to the fraudulent act. As discussed below, this will generally mean the insurer can remove all claims in respect of losses occurring after the fraudulent act (unless, for example, the policy is written on a claims made basis).

²³ eg *Derry v Peek* (1889) LR 14 App Cas 337, whose definition has been held to apply equally to the Scots law of fraud: see *Boyd and Forrest v Glasgow and South-Western Railway Co* 1912 SC (HL) 93; *Romanes v Garman* (1912) 2 SLT 104 and *Robinson v National Bank of Scotland* 1916 SC (HL) 154.

²⁴ See, for example, *Aviva Insurance v Brown* [2011] EWHC 362 (QB) and *Yeganeh v Zurich Insurance* [2010] EWHC 1185 (QB).

- 3.15 The formulation of clause 10(2)(a) is consistent with the formulation of avoidance for deliberate or reckless misrepresentations under CIDRA which states that the insurer “may avoid the contract *and refuse all claims*”.²⁵ If any payments have already been made in respect of such claims, the ability to recover those funds will be a matter for the law of unjust enrichment.²⁶
- 3.16 Ideally, the insurer should make a decision about its clause 10(1)(c) option and let the insured know as soon as possible. However, this must be balanced against the insurers’ considerations given the difficulties inherent in investigating and proving fraud. This would be more appropriately dealt with as “best practice” in regulation or guidance rather than in the draft Bill. We think there would be scope for an insured to claim that an insurer had waived its right to rely on 10(1)(c) if it had not done so as soon as it discovered fraud – or had not made reasonable attempts to confirm its suspicions until a larger, genuine claim arose which it did not want to pay. The normal rules for establishing waiver would apply.²⁷
- 3.17 Where the insurer does not elect to exercise the clause 10(1)(c) right, it will continue to be liable to make payment under the policy in respect of losses after the fraudulent act.

The fraudulent act

- 3.18 This is the behaviour which makes a claim fraudulent. This concept is therefore distinct from the fraudulent claim, which, as discussed above, generally means the whole claim even where the fraudulent element is introduced later on in the claims process.
- 3.19 Using the five classes of fraud identified by Mance LJ in *Agapitos v Agnew*,²⁸ we identify below what we would anticipate to be the fraudulent act in each case:
- (1) No genuine loss or loss caused by deliberate act of insured. The fraudulent act is the submission of the claim (in the latter case, together with the failure to admit the cause of the loss). Although it may be a step towards the fraudulent claim, the commission of a deliberate act, such as setting fire to property, is not in itself fraudulent.
 - (2) Loss suffered but exaggerated (for example, overvaluation of property or adding additional items to the list of property lost). The fraudulent act occurs when the exaggerated element is communicated to the insurer. This could be at the initial submission of the claim or a later date.

²⁵ Schedule 1, para 2.

²⁶ Or, in Scots law, unjustified enrichment.

²⁷ See, for example, *Chitty on Contracts* (Thirtieth Edition, Volume 1) para 24-008. The effect of waiver by estoppel may be suspensory rather than of permanent effect. The Scots law on waiver is similar though it does not draw a distinction between waiver by election and waiver by estoppel. See Reid & Blackie, *Personal Bar* (2006), Chapter 3.

²⁸ (*No 1*) [2002] EWCA Civ 247; [2003] QB 556.

- (3) Subsequent discovery that there is no loss or loss of a smaller amount but insured continues to press for the original claim. The fraudulent act only occurs when the party has failed to advise the insurer of the new information within a reasonable time.²⁹ What is a reasonable time would be for the courts to decide in the circumstances.³⁰
- (4) Failing to advise the insurer that it has a defence to a claim. It has been queried whether it is really the case that an insured has to draw a defence to the insurers' attention if the insurers could have discovered it based upon the facts known to them. In any event, the fraudulent act is the failure to disclose the defence either at the point of submission of the claim or, if the defence is only discovered later, as in (3) above.
- (5) Use of a fraudulent means or device (for example, a false receipt) to support a genuine claim. The fraudulent act occurs when the fraudulent device is used / submitted.

Genuine losses before the fraudulent act

- 3.20 Clause 10(3) confirms that the insurer will continue to be liable in respect of relevant events (usually insured losses) occurring before the time of the fraudulent act.

The remedies applied

- 3.21 The order of events will be important in determining the validity of a genuine claim submitted around the same time as a fraudulent one. For example:

An insured has buildings and contents insurance.

- (1) January
 - (a) A fire occurs. This is an insured event under the contract.
 - (b) The insured makes a genuine claim for building damage and some contents.
- (2) February
 - (a) A flood occurs. This is an insured event under the contract.
- (3) March
 - (a) The insured fraudulently claims for additional contents allegedly lost in January's fire. This is a fraudulent act.

²⁹ *Agapitos v Agnew and others* [2003] QB 556. Maintenance (even by omission) of an initially innocent claim once it is discovered to be inaccurate is itself a fraudulent act. See also *Manifest Shopping Co Ltd v Uni-Polaris Insurance Co Ltd and Others (The Star Sea)* [2001] UKHL 1, [2003] 1 AC 469.

³⁰ In *The Michael* [1972] 2 Lloyd's Rep 1, the owners of a ship came into possession of information which they should have passed on to their insurer, having previously submitted a claim. They waited until their next meeting with their broker to pass on this information. The Court of Appeal found that they had not acted fraudulently in doing so.

- (4) April
 - (a) The insured makes a genuine claim for damage caused by February's flood.
 - (b) A burglary occurs. This is an insured event under the contract.
 - (c) The insured makes a genuine claim for loss suffered in the burglary.
- (5) May
 - (a) The insurer discovers March's fraudulent act.

The consequences

- (1) The insurer has no liability to pay anything in respect of the fire claim (January and March elements): it is forfeited in its entirety due to the fraudulent act committed in March.
- (2) The flood claim (occurring in February; claim made in April) is valid and the insurer is liable to pay out. This is because the loss pre-dates the fraudulent act.
- (3) If, on discovery of the fraud, the insurer elects to exercise its rights under clause 10(1)(c) and gives notice to the insured, the insurance contract will be treated as having terminated at the point of the fraudulent act in March.
- (4) The burglary (arising and claimed for in April) is after the effective date of "termination" of the contract and the insurer therefore has no liability to pay. If the insurer has paid out, or partially paid out, before discovering the fraud, any right to recover such payments is a matter for the law of unjust enrichment.³¹

Return of premium

- 3.22 Clause 10(2)(b) confirms that, where the insurer elects to treat the contract as having terminated, the insured is not entitled to repayment of any premium paid.

Losses occurring and claims made policies

- 3.23 The drafting is intended to accommodate both "losses occurring" and "claims made" policies. Under a losses occurring policy, if the insurer exercises its clause 10(1)(c) rights, it will have no liability to pay claims in respect of any loss suffered after the fraudulent act. Under a claims made policy, we intend that the insurer would have no liability to pay in respect of any claim or circumstance notified after that time. The occurrence of the loss or the notification of a claim (as the case may be) would constitute the "relevant event" for the purposes of clauses 10(2) and 10(3).

³¹ Or, in Scots law, unjustified enrichment.

- 3.24 Clause 10(4) defines “relevant event” as the thing which gives rise to the insurer’s liability under the particular insurance contract, and we have included examples to demonstrate the distinction between, for example, losses occurring and claims made policies.

PROPOSALS WE HAVE DROPPED

Co-insurance

- 3.25 We initially consulted on the situation of co-insureds, where two or more insureds are insured under the same policy, and one commits fraud or a deliberate destructive act.³² A common example of co-insurance is insurance of a family home by spouses or cohabiters. Generally, an innocent insured’s claim would be tainted by the fraud of their co-insured in situations where the interest is joint rather than several.
- 3.26 We accept that, if we wanted to be sure that courts have an opportunity to protect an innocent party, we would have to create this in statute. However, when we began to consider the details of such a provision we immediately came upon a number of difficulties, including:
- (1) We would not want every case involving co-insureds to include an application by one co-insured to disapply the statutory remedies on the basis that, for example, they had not checked whether their spouse’s inventory of goods lost in a genuine fire was accurate. We think that in most cases, co-insureds making a claim on a joint policy should be taken to have joint interests so that one’s fraud taints the others. This is a risk of co-insurance/agency which must be accepted in normal cases.³³ We were primarily concerned with cases where the interests of the co-insureds are no longer aligned (that is, they are composite rather than joint, albeit that they were joint when the policy was purchased). The classic example is where one co-insured has set fire to the shared house to spite, punish or harm the other. We would therefore have to carefully define the circumstances in which judicial discretion was permitted.
 - (2) In many of the cases we would want to catch, the claim would not actually be fraudulent. Where it is clear that one spouse set fire to the house, for example, the other is not making a fraudulent claim if they try to recover their share on the basis that they were innocent. Rather, their claim is likely to be excluded because policies usually provide that the insurer is not liable to pay if one of the insured parties, or a friend or family member, brings about the loss / damage intentionally. Disapplying the statutory remedies for fraud would therefore make no difference.
- 3.27 Given that we received almost no evidence from consultees that these cases are a problem in practice and that the majority of consultees agreed that we should not legislate on this, we have decided not to address this matter in statute. We are aiming for a relatively short, non-controversial bill and we do not think that the provisions we would have to produce would fit with this aim.

³² See Consultation Paper 2, page 90 and following.

³³ The court employed an agency argument in *Direct Line v Khan* [2001] EWCA Civ 1794.

3.28 We accept that this may leave innocent co-insureds without compensation (although in the case of consumer insurance the FOS would be able to require the insurer to pay up to £150,000 and may recommend that they pay more). We think there is still a chance that the courts would contrive to manipulate the concepts of joint and composite insurance if they felt it was necessary to protect an innocent party. We accept that this is not a discretion which could be relied upon, and that the courts would be stretching their powers. However, this approach has been adopted in other jurisdictions and the UK courts have begun to suggest that they might take the same approach.³⁴

Recovery of costs of investigation

3.29 In CP2, we tentatively proposed that the insurer could have a statutory right to claim damages to recover the costs of their investigations where a fraud is discovered. Consultees suggested that this could be overly complicated and was probably not necessary. Currently, insurers cannot recover these expenses in contract,³⁵ although they might recover under a claim for deceit.³⁶ Many consultees felt that it would be too difficult to assess these costs where the investigations are carried out internally. Insurers would be incentivised to outsource these investigations to third parties in order to be able to present the court with an invoice setting out the full costs of the investigation. This could have the effect of increasing overall investigation costs, which would be passed on in increased premiums. We do not consider that the recovery of investigation costs will significantly disincentivise fraud. As such, we are no longer proceeding with this proposal.

³⁴ See eg *Parker v National Farmers Union Mutual Insurance* [2012] EWHC 2156 (Comm), in which the policy was found to be composite – although in that case the title to the house was held by one of the co-insureds.

³⁵ *London Assurance Co v Clare* (1937) 57 Ll L Rep 254.

³⁶ *Insurance Corporation of the Channel Islands Ltd v McHugh* [1997] 1 LRLR 94.

PART 4 : DAMAGES FOR LATE PAYMENT

BACKGROUND AND POLICY

- 4.1 In English law, policyholders are not entitled to damages for losses suffered as a result of an insurer's failure to pay valid insurance claims within a reasonable time (or at all). This rule is out of line with ordinary contract principles, under which damages are payable for failure to pay a contractual debt.
- 4.2 The position in insurance contract law is the result of a technical legal fiction – the “hold harmless” principle – which says that an insurer's primary obligation is to prevent the insured party from suffering any loss in the first place. This is at odds with contracting parties' practical understanding of the insurance relationship. When the insured suffers an insured loss, the insurer is in breach of its contractual obligation. Any insurance monies payable are therefore damages for breach of contract. As the courts have held that claimants are not entitled to damages for the non-payment of damages,³⁷ a policyholder had no way of recovering losses suffered as a result of an insurer failing to pay a valid claim.
- 4.3 The rule also appears unique. It has not been followed in Scotland, where the “hold harmless” principle does not apply, or in other common law jurisdictions. Nor is it applied in contracts for life insurance or where an insurer undertakes to reinstate property.
- 4.4 In Issues Paper 6³⁸ and CP2³⁹ we argued that the unavailability of late payment damages is unprincipled and unfair, and proposed that the law should be reformed. We considered other possible, non-statutory routes to redress and explained why they are not an adequate substitute for law reform in this area.

Summary of recommendations

- 4.5 We make the following key recommendations:
 - (1) It should be an implied term of an insurance contract that insurers will pay sums due within a reasonable time. An insured who suffers loss as a result of breach of that term should be able to recover contractual damages from the insurer.
 - (2) “Reasonable time” should be assessed by reference to all the circumstances, including the size and complexity of the claim, and any matters beyond the insurer's control. A “reasonable time” should always include time to investigate and assess the claim.

³⁷ *The President of India v Lips Maritime Corporation (The Lips)* [1988] 1 AC 395, by Lord Brandon at 425.

³⁸ Law Commission and Scottish Law Commission, *Issues Paper 6: Damages for Late Payment and the Insurer's Duty of Good Faith*, March 2010. http://lawcommission.justice.gov.uk/docs/ICL6_Damages_for_Late_Payment.pdf and http://www.scotlawcom.gov.uk/index.php/download_file/view/192/107/.

³⁹ Law Commission and Scottish Law Commission, LCCP 201/SLCDP 152: *Insurance Contract Law: Post Contract Duties and other Issues*, December 2011.

- (3) Insurers should have a defence to a claim for late payment damages where they incorrectly refuse to pay a claim but can show that they acted reasonably in doing so. This protects the ability of insurers to take a robust approach to decision making where they suspect fraud or non-compliance with policy terms or where the precise circumstances of the loss are not clear. Our recommendations are intended to catch bad claims handling practices, not prevent legitimate investigations by insurers.
- (4) The normal limitation and prescription rules should apply. In England and Wales, the limitation period for insurance claims will continue to run from the date of the original loss, while the period for late payment claims should run from the point at which the obligation to pay within a reasonable time is breached. In Scotland, the prescriptive period for insurance claims will run from the date of the casualty. For late payment claims it will run from the point at which the loss flows to the insured from the insurer's failure to pay the claim within a reasonable time.
- (5) The hold harmless principle need not be repealed in England and Wales, nor should it be extended to Scotland. Our aim is to make it possible for insureds to recover damages for late or non-payment of claims. Fundamental change to the structure underpinning insurance contract law would unnecessarily complicate these proposals for little practical benefit.

EXPLANATORY NOTES TO THE DRAFT CLAUSE

Clause 12(1): contractual obligation to pay claims within a reasonable time

- 4.6 Clause 12(1) implies into every contract of insurance a contractual obligation on the insurer to pay sums due in respect of claims made by the insured within a reasonable time. Remedies will be available for breach of that term.

Claims by insured only

- 4.7 The obligation to pay claims within a reasonable time only applies to claims by the insured.⁴⁰ It does not apply to any third party who has an interest in the policy. This would also tend to exclude members under group insurance policies. Where there is a question around who benefits from the provision, the common law should provide the answer. However, we have considered a small number of situations as set out below.
- 4.8 In third party liability situations where the insured makes a claim under a liability policy, such as motor or employers' liability, the insured's obligation to the third party is a tortious or delictual liability to pay damages. The insured does not have contractual liability to the third party as to timing of payment and the third party could not therefore inherit a right to make a late payment claim against the insurer.

⁴⁰ Elsewhere in the draft Bill, "the insured" is defined as the party who enters the contract of insurance with the insurer.

- 4.9 Where a third party legally becomes “the insured” (as in the case of an assignment/assignation or novation of the policy, though not of an assignment only of the right to receive insurance monies) we would expect them to benefit from the statutory provision. Similarly, there may be circumstances in which a third party is able to make or continue a late payment claim on behalf of the insured (such as an executor, or a liquidator).

A valid claim

- 4.10 Any “sums due” in respect of a claim must be paid out within a reasonable time. Where an insurer has no liability to pay out on a claim - such as where the incident is not covered by insurance, or where the claim is fraudulent - there is no implied obligation to make such assessment quickly and no damages are payable for a failure to do so.
- 4.11 “The sums due in respect of the claim” encompasses sums which are “due” either by virtue of an agreement between the parties or because they have been determined by a court to be payable by the insurer.
- 4.12 Where there is a written settlement agreement this is likely to provide that the insured has no more rights against the insurer in respect of the claim. This would tend to preclude a late payment claim by the insured. In any case, timing of payment would likely be dealt with by the settlement agreement taking any late payment claims outside the remit of our proposals.
- 4.13 However, in many cases there will be no settlement agreement as such. “Settlement” is a tricky term as most payments of insurance claims will not be by way of settlement, through a contract of settlement, but pursuant to the insurance contract itself.⁴¹
- 4.14 Putting aside settlement agreements which deal with these matters expressly, damages for late payment may still be payable even where an agreement as to quantum has been reached between the parties and where the question of quantum itself is not to be re-opened. The delay in reaching agreement, or delay in making the agreed payment, or both, may have been unreasonable.
- 4.15 We have considered whether “the sums due” would include interest on the substantive insurance sum.⁴² We think it would be better not to address interest directly in the drafting, and to allow the courts to consider this. We think that, in the absence of specific provision, the interest due would be calculated first (from the date of the loss until ultimate day of payment). We then think that while the interest due/received would be taken into account in any award of damages (so as to prevent double recovery), damages would not be available for the late payment of interest.

⁴¹ M. Clarke, *The Law of Insurance Contracts* (5th ed 2006) 30-6; see also W W McBryde, *The Law of Contract in Scotland* (3rd Ed 2007) at 6-84. Also consider whether insurance payments in England and Wales are truly made under the contract in any situation, given that they are characterised as damages rather than a contractual debt.

⁴² The right to receive interest is explicitly preserved by clause 12(5); see notes at 1.34 and 1.35 below.

Contractual damages

- 4.16 Because the obligation to pay claims within a reasonable time will be a contractual one, any damages for breach of that term will be contractual damages. This means they will be calculated according to the general calculation of contractual damages, based on the *Hadley v Baxendale*⁴³ requirements of actual loss, foreseeability at the point of contracting, and mitigation.

Clauses 12(2) and (3): determining a “reasonable time” for payment

- 4.17 The meaning of “reasonable time” was a key concern for respondents to the consultation. In CP2 we acknowledged that insurers need enough time to investigate claims fully and to challenge claims which they believe to be unfounded. Insurers may be dependent upon third parties, or insureds themselves, to provide the information necessary to fully assess a claim.
- 4.18 In CP2 we approached the overall timescale in three stages, but consultees felt that this was overly complex and could lead to artificial results. Some respondents said that the concept of a “reasonable time” was too uncertain without further definition but others felt that introducing specified time periods for responses would be too arbitrary. Several consultees said that any legislation should contain a definition or clear guidance as regards a “reasonable time”. While we are conscious of the need to obtain a balance between certainty and flexibility, we consider that the question of whether a claim has been assessed and paid within a reasonable time must depend on all the circumstances of the case. However, the draft Bill does contain some guidance in this regard.
- 4.19 Clause 12(2) makes it explicit that a reasonable time will always include a reasonable time for investigating and assessing a claim. The long term stability of the insurance market is dependent on insurers having strong incentives to investigate claims and root out fraudulent and invalid claims. This incentive would be weakened if insurers did not feel they had adequate time to do this. Once a claim has been investigated and valued, payment should be reasonably swift.
- 4.20 Clause 12(3) contains a non-exhaustive list of factors which might be relevant in considering whether the insurer has acted within a reasonable time. The factors listed are:
- (1) The type of insurance. Claims under business interruption policies usually take longer to value than, for example, claims for property damage.
 - (2) The size and complexity of the claim. Larger, more complicated claims will usually take longer to assess than straightforward claims. A claim may be complicated by its location, for example: if an insured peril occurs in China, it is likely that investigation will be more difficult.

⁴³ (1854) 156 ER 145.

- (3) Compliance with any relevant statutory or regulatory rules or guidance. We have in mind, for example, the FCA Handbook, and paragraph 27 of schedule 1 to the Consumer Protection from Unfair Trading Regulations 2008 which makes it an offence for an insurer to ask for irrelevant information or to fail systematically to respond to correspondence.
- (4) Factors outside the insurer's control. An insurer should not be penalised where, or to the extent that, its investigations are delayed because an insured or any third party fails to provide relevant information in a timely manner. This factor will also be relevant when an insurer's decision is dependent on the actions of another insurer; for example, the interaction between business interruption and property insurance.

Clause 12(4): a reasonable but wrong refusal

- 4.21 There may be circumstances in which an insurer genuinely and for good reason considers that it is not liable to pay a claim – perhaps because there is some evidence that the claim is fraudulent, it believes there has been a non-disclosure or misrepresentation at placement which allows it to avoid the policy or because it believes the damage to have been caused by an event which the policy does not cover.
- 4.22 Consultees were concerned that our proposals might never allow an insurer in these circumstances to dispute a claim all the way to court without becoming liable for consequential losses as a result of so disputing. As we have already said, it is in the interest of the wider insurance market that insurers are in a position to challenge potentially invalid claims or to question the amount claimed by an insured. We accept that it may take time to investigate a claim which eventually does turn out to be valid, and we do not consider that late payment claims should be a regular occurrence in such cases.
- 4.23 Clause 12(4)(a) therefore provides that, where an insurer can show that it had reasonable grounds for disputing the validity or quantum of a claim, failure to pay the claim (or the disputed part of it) while the dispute is continuing does not in itself amount to a breach of the implied term in 12(1). More must be shown before an insurer who makes a reasonable but ultimately wrong refusal can be found to be in breach.
- 4.24 Clause 12(4)(b) provides that the conduct of the insurer in handling the dispute may be a relevant factor in deciding whether the term was breached and, if so, when. An insurer who has a reasonable basis for disputing a claim or at least conducting further investigations may still therefore be in breach of the obligation to pay within a reasonable time if, for example, it conducts its investigation unreasonably slowly, or is slow to change its position when further information confirming the validity of the claim comes to light.

- 4.25 Under the current Scots law, it appears that late payment damages could be awarded on the basis of a reasonable but wrong decision to refuse a claim even where the insurer's conduct was also reasonable.⁴⁴ We are not aware that the courts have ever made such an award. We think clause 12(4) as drafted is close to the position which the Scottish courts would realistically adopt so that the proposed drafting changes little in Scots law.

Clause 12(5): claim for late payment separate from main insurance claim and claim for interest

- 4.26 Clause 12(5) preserves the distinction between claims for breach of the implied term in 12(1) and claims for (a) the substantive insurance claim and (b) interest, whether contractual, statutory or otherwise. Breach of the implied term must be argued and proven separately.
- 4.27 This provision makes clear that insureds will still be entitled to claim interest on their payments if they have a contractual right to do so, or where they are entitled to enforce a statutory right to interest. Examples are section 35A of the Senior Courts Act 1981 (power to award simple interest on debt and damages claims) and the Interest on Damages (Scotland) Acts of 1958 and 1971.

MISCELLANEOUS

Limitation and prescription

- 4.28 We do not recommend any special provisions in relation to the limitation and prescription of actions, so the general rules will apply.
- 4.29 The issue has been a difficult one since the inception of the proposals for this new cause of action. The law, in England and Wales, requires that a claim is brought with six years of a breach of contract and, in Scotland, within five years of the date of the loss flowing from a breach of contract.⁴⁵
- 4.30 In English law, under the "hold harmless" principle, the insurer is considered to be in breach as soon as the harm occurs and thus the limitation period for the substantive insurance claim begins to run from the date of the loss.⁴⁶ In Scotland, where the law operates on the basis of prescription rather than limitation, it is generally thought that the prescriptive period of five years runs from the date of the occurrence of the loss to which the insurance cover relates.⁴⁷

⁴⁴ See *Strachan v The Scottish Boatowners' Mutual Insurance Association* 2010 SC 367 and *Alonvale Ltd v Ing* 1993 GWD 36-2345.

⁴⁵ Limitation Act 1980, s 5; Prescription and Limitation (Scotland) Act 1973, s 6.

⁴⁶ *Callaghan v Dominion Insurance Co Ltd* [1997] 2 Lloyd's Rep 541 (QBD).

⁴⁷ D Johnston, *Prescription and Limitation* (2nd ed 2012), para 4.14.

- 4.31 In respect of the recommended independent contractual duty to pay claims within a reasonable time, in Scotland the normal rules of prescription will apply so that the prescriptive period for late payment claims will run from the point at which the insurer fails to pay the claim within a reasonable time.⁴⁸ The limitation rules in E&W have the same effect. Limitation would therefore run from the last point at which an insurer could have paid a claim and still been within the reasonable time period. In CP2 we commended this option for its logic and its reliance on the general law, despite the result that there will be different limitation periods for the substantive insurance and late payment claims.
- 4.32 In general, the Law Commissions are critical of any suggestion to create another special limitation or prescriptive period and there must be very good arguments in favour of it in order to dislodge the presumption in favour of following the general law. Importantly, we do not think that a late payment action will allow an insured to resurrect a time-barred substantive insurance claim.

Contracting out

Consumer contracts

- 4.33 There will be a blanket prohibition on excluding or limiting liability for late payment claims in consumer contracts.

Business contracts

- 4.34 In non-consumer contracts, insurers will be able to contract out of our new duty (effectively exclude or limit their liability for breach of the duty to pay within a reasonable time) provided they comply with our contracting out requirements.
- 4.35 We propose a further limitation in the context of damages for late payment, that insurers may limit/exclude liability for breaches or exclude the application of the duty entirely but only where the failure to pay within a reasonable time was not deliberate or reckless. We do not yet have drafting on this point.

⁴⁸ There may be a concurrence in point of time of injuria with damnum, but there need not be. D Johnston, *Prescription and Limitation*, (2nd ed 2012) at 4.16 – 4.21.

PART 5 : GOOD FAITH

BACKGROUND AND POLICY

- 5.1 Section 17 of the Marine Insurance Act 1906 (the 1906 Act) imposes a duty of good faith on both parties. It states:

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

- 5.2 This is an overarching principle. In the course of our review, we have considered section 17 on several occasions. Sections 18 and 20 of the 1906 Act are specific pre-contract examples of the duty of good faith in relation to non-disclosure and misrepresentation. The duty also applies throughout the life of the policy. The clearest example of a breach of good faith, post-contract, would be the making of a fraudulent claim.⁴⁹
- 5.3 The duty is a reciprocal one: it must be observed by the insurer as well as the insured. The main problem with section 17 is that it only provides one remedy: avoidance of the contract. This rarely helps an insured who seeks a remedy against the insurer and who generally wants their claim paid. Where the insured is at fault and the insurer seeks a remedy, avoidance is often a harsh consequence. It is not compatible with the regime of proportionate remedies that we are proposing in relation to non-disclosure or with our proposed remedies for fraudulent claims.
- 5.4 We think that the duty of good faith is important as a general interpretive principle. However, we do not think breach should give rise to the remedy of avoidance. We think that a general interpretive principle will permit the courts to develop the law to meet new challenges in the insurance context that are not otherwise prescribed for (either in our reforms or elsewhere).

Summary of recommendations

- 5.5 We propose to amend section 17 of the 1906 Act to remove the following statement:
- ...and, if the utmost good faith be not observed by either party, the contract may be avoided by the other party.
- 5.6 Good faith would remain a general principle, with section 17 and the common law still providing that insurance contracts are based upon the utmost good faith.

⁴⁹ Although, as we have mentioned, the courts in recent years have not tended to apply the section 17 remedy of avoidance in the event of fraudulent claims.

- 5.7 In CP2, we summarised a series of cases in which the courts have prevented an insurer from exercising an apparent right because it was not exercised in good faith.⁵⁰ We think that the courts should continue to allow the use of good faith in this and similar ways: it should be seen as a “shield rather than a sword”.⁵¹ The courts have shown no appetite for awarding damages for breach of good faith and we would not expect the principle to be used in that way.

EXPLANATORY NOTES TO THE DRAFT CLAUSE

- 5.8 Clause 13(1) abolishes any legal rule allowing a party to avoid an insurance contract where the other party has not acted in good faith. This catches statutory provisions (ie section 17) and any common law rule.
- 5.9 Clause 13(3)(a) makes the consequential amendment to section 17 of the 1906 Act to remove the reference to the remedy of avoidance.
- 5.10 Clauses 13(2) and 13(3)(b) provide (respectively) that the common law good faith rule and section 17 are subject to the provisions of CIDRA and this new Bill.
- 5.11 Clause 13(4) repeals section 2(5) of CIDRA, which is no longer required as a result of our further reforms in this Bill.

⁵⁰ Insurance Contract Law: Post Contract Duties and other Issues (2011) LCCP 201/SLCDP 152, paras 3.9 to 3.15.

⁵¹ Insurance Contract Law: Post Contract Duties and other Issues (2011) LCCP 201/SLCDP 152, para 4.40.