General Insurance

Background Paper 14

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1.1. This background paper deals with some general insurances. It does not cover health insurance or life insurance. It does not cover specific types of insurance, including workers’ compensation and compulsory motor vehicle third party.

1.2. There is some, but limited, discussion of the work and function of insurance agents and brokers. The majority of the discussion relates to insurers.

1.3. The aim of the paper is to give the reader a guide to the law, regulation and practices in general insurance in Australia. It is a large topic. We have indicated some further reading where appropriate. The importance of regulation in the work of the Commission means that the part dealing with regulation is much longer than the others.

1.4. A number of insurance or unusual words and expressions are described or defined in the Glossary.
This introduction to the purpose and nature of insurance is discussed below under the following headings:

1. Purpose of insurance;
2. Characteristics and definition of insurance;
3. Risk in insurance;
4. Effect of insurance – moral hazard.

1. Purpose of insurance

Spreading risk

1.1. The fundamental and honourable purpose of insurance is to spread risk. Michael Kirby said, ‘The sharing of risk is the essential brilliant idea of insurance’.  

1.2. There are risks to life, health, homes, property, goods and income. The risk is spread among individuals, families, businesses, corporations, insurers and government. We help to bear each other’s burdens. The risk is spread across a number of years: an individual life, generations of families and community eras.

1.3. A large number of policyowners (sometimes called the insured or policyholder but we will use policyowner mostly and, when it’s clearer, the insured) with similar risk profiles each privately insure the same class of risk with the one insurer or group of insurers. The premium is usually a very small amount in proportion to the amount the insurer will be obliged to pay the policyowner if he or she suffers a loss. The Elizabethan marine statute captures this concept: ‘upon the loss or perishing of any ship, there followeth not the undoing of any man, but the loss lighteth rather easily upon many than heavily upon few’. This is the corollary of the purpose of insurance as the spread of risk among persons and over time. In this way, an insurer or group of insurers spread amongst the many the cost of the losses that will happen to the few. The basic principle of all insurance is that the losses of the unfortunate few should be paid from the contributions of the many.

Community risk

1.4. Spreading loss through insurance benefits the community by:

a) insurers absorbing financial loss that would otherwise be randomly distributed throughout the community;

b) insurers managing risks by:

i. setting premiums having regard to the magnitude and nature of the risks and the likelihood of them occurring;

1 Pynt, paras. 1.18-1.23; Senate Economics References Committee, *Australia’s general insurance industry: sapping consumers of the will to compare*, August 2017, paras. 1.9-1.12; Ch 2.


3 *Statute of Assurances 1601 (UK) (43 Eliz c 12)*, preamble.

4 *Todd v Alterra at Lloyds* (see fn 3 at [38] (Allsop CJ and Gleeson J).

5 In *Callery v Gray* [2001] EWCA Civ 1117; Lloyd’s Rep IR 743, the Court of Appeal said (at [67]) that it ‘is a basic principle of insurance that the many pay for the few’.
ii. including conditions in insurance policies rewarding policyowners who do not make claims on their policies (for example, by providing a ‘no claims bonus’ in a motor vehicle policy);  
iii. requiring policyowners to reduce risks as a condition of offering insurance (for example, by making it a condition of a home and contents insurance policy that the policyowner fit a burglar or fire alarm or a sprinkler system); and  
iv. including conditions in insurance policies requiring policyowners to take reasonable precautions to protect their property or to avoid personal injury;

c) allowing policyowners to save, spend or invest funds that might otherwise have been set aside for a catastrophe. For example, by taking out insurance, a business does not need to keep in reserve sufficient money to repair or replace premises, plant, equipment or products that might be damaged or destroyed by insurable risks at some time in the future. It only needs to fund a relatively small insurance premium to protect against the financial consequences of any of these risks eventuating.

1.5. Insurance benefits individual policyowners by assisting them to manage their financial risk and giving them some peace of mind.6 Insurance will work for a policyowner if:

a) the premium for the insurance is substantially less than the financial loss the policyowner would suffer if the worst, or a run, of the risks specified in the insurance arrangement eventuates; and

b) the policyowner is confident that the insurer will promptly pay a claim if the policyowner suffers a loss covered by the insurance arrangement.

1.6. Insurance will be viable for a commercial insurer if it can create a premium pool large enough for it to be confident about making a profit after prompt payment of all proper claims. The insurer will make a profit if it:

a) collects enough premium to pay all proper claims promptly as and when they fall due; and

b) successfully invests the premium it collects until claims are paid.

Spread among people

1.7. If the risk occurs and a person suffers a financial loss, the person will bear the loss unless responsibility for it is shifted to someone else, for example to:

a) the Commonwealth Government through the social security or health systems;

b) a contractor who is obliged by a term in a contract to indemnify the person against the person’s loss;

c) another person upon whom the law of tort imposes the burden of the person’s loss;

d) an employer, pursuant to workers’ compensation legislation; or

e) an insurer, pursuant to an insurance arrangement made by the person or for the person’s benefit.

1.8. The person who has the risk, the policyowner, pays a proportionately small premium to the insurer to cover the risk. The insurer promises to pay an amount to compensate the policyowner if an insured event occurs. The policyowner remains responsible for the risk. The value of the cover depends on the enforceability of the insurance contract and on the insurer having sufficient financial assets to perform the contract.

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6 Spencer v Aetna Life & Casualty Ins Co 611 P 2d 149, 152; 227 Kan. 914, 918; (Supreme Court of Kansas 1980 Herd J).
Spread over time

1.9. The person who has the risk and enters into an insurance contract, or who has a statutory right to insurance, pays a premium (or contribution like a tax) at a given point in time. If the insured event occurs during the period of that contract or arrangement, the policyowner is covered for that risk. The period of the arrangement can be annual (as it is for most general insurance contracts), long-term (as it is for most life insurances) or for a lifetime like Medicare. The spread of risk in this sense is across time so that the premium or contribution is paid gradually and when an insured loss occurs, the insurer covers it. The policyowner is not required to pay a large amount at a future date because the payment of premium or contribution over time spreads the risk over time.

2. Characteristics and definition of insurance

2.1. The function of insurance in spreading risk among persons, around our community and over time is the source of the precepts and then the legal rules and insurer practices about insurance. These ideas emerge through a consideration of the characteristics and definition of insurance.

Definition

Summary

2.2. A contract of insurance has been described as ‘a contract upon speculation’. An insurance policy is a contract comprising a promise by an insurer to indemnify, pay or provide a benefit to a policyowner, if that policyowner suffers loss defined under the policy, in return for the consideration of the payment by the policyowner of, or the policyowner’s promise to pay, an amount of money, called the ‘premium’, to the insurer. This definition is elaborated in the following criteria.

Obligation

2.3. There must be a legally enforceable obligation. The source and status of the obligation is important. The existence of a contract is of itself not essential to the legal concept of insurance. In R v Cohen; Ex parte Motor Accident Insurance Board, the Court said that the essence of the concept was the relationship of indemnity between insurer and policyowner, rather than the source of that relationship. It does not matter whether the relationship arises by statute or by contract. The Court in Cohen acknowledged that, ‘insurance ordinarily results from a contract under which the insurer assumes his obligation to the insured in return for a money consideration

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7 Sutton, para. 2.20; Pynt, paras. 1.1-1.5.
8 Carter v Boehm (1766) 3 Burr 1905; 97 ER 1162 at 1909 (Burr), 1164 (ER); Re Commonwealth Homes & Investment Co Ltd [1943] SASR 211 at 231.
10 Sutton, para. 2.30-2.50; Pynt, paras. 1.15-1.16.
11 R v Cohen; Ex parte Motor Accident Insurance Board (1979) 141 CLR 577; 1 ANZ Insurance Cases 60-036 at 588 (CLR).
called the premium’. But while it is true that ‘traditionally, insurance arose from a contract’, it is equally true that ‘these days it may arise from legislation’.12

2.4. If the policyowner has no right to be indemnified or to receive a payment or benefit, by or from the insurer, the arrangement will not be an insurance:13 for example, if the insurer has a discretion whether or not to pay the policyowner. Where there was no enforceable right to recover under a contract, in the absence of exercise of discretion by the insurer, so that there was ‘merely the possibility of what one might regard as an ex-gratia payment’, there was said to be no contract of insurance.14 If the policyowner’s only contractual right is ‘a right to have a claim fairly considered’15, there is no insurance.16

Unertainty, fortuity and adversity17

2.5. The event covered by the insurance must be uncertain in one of two respects: first, whether it will happen or not; or second, as to the time at which it will happen.18 On this basis, the event ought to be one outside the control of the insurer.19 It would seem that the element of uncertainty must also be outside the control of the policyowner, because if the risk insured against is within the policyowner’s control, the elements of risk and speculation are removed.20

2.6. An insurance against an event which is within the control of the policyowner may not be regarded as an insurance on the basis that a person may not insure against the consequences of that person's own intentional, wilful or deliberate act or omission.21 It follows that, at least in indemnity insurance, the policyowner cannot insure against loss from an event which the policyowner knows is certain to occur. Nevertheless, the Courts have said that the policyowner may be able to recover for a loss which has become inevitable due to the act of a third party while the insured property is

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14 CVG Siderurgica del Orinoco SA v London Steamship Owners' Mutual Insurance Association (The Vainqueur José) [1979] 1 Lloyd's Rep 557 at 580.
15 Medical Defence Union Ltd v Department of Trade [1980] Ch 82 at 95; McAll v Brooks [1984] RTR 99; See also Oswald v Bailey (No 1) (1985) 4 ANZ Insurance Cases 60-704 (SC NSW); revsd (1987) 11 NSWLR 715 (CA).
16 Sutton, paras. 2.40-2.50.
17 Sutton, para. 2.60; Pynt, paras. 1.6-1.10.
19 See Medical Defence Union Ltd v Department of Trade [1980] Ch 82 at 89; Department of Trade and Industry v St Christopher Motorists Association Ltd [1974] 1 WLR 99 at 106; McAll v Brooks [1984] RTR 99; Card Protection Plan Ltd v Customs and Excise Commissioners [1994] STC 199.
20 The issue was raised but not decided in Department of Trade and Industry v St Christopher Motorists Association Ltd [1974] 1 WLR 99 at 106, Medical Defence Union Ltd v Department of Trade [1980] Ch 82 at 89, and Motorcycle Specialists Ltd v Attorney-General (1988) 5 ANZ Insurance Cases 75, 611 (HC NZ) at 75,614. In Dix v Townend [2008] EWHC 90117 (Costs), a solicitor’s indemnity to a client against costs if the case was lost was regarded as a sufficiently uncertain event even though it was to some extent in the hands of the solicitor. The arrangement itself was not overall, however, one involving insurance business.
21 Ikerigi Compania Naviera SA v Palmer (The Wondrous) [1991] 1 Lloyd's Rep 400 at 415–417; see Ch 3 ([3.10]) at [3.620].
out of the control of the policyowner. It also follows that insurance would not, in the absence of express contract terms, cover ‘wear and tear’ or ‘inherent vice’.23

2.7. In *Prudential Insurance Co v Inland Revenue Commissioners*24, Channell J added that the remaining essential for a contract of insurance was that the policyowner should have an interest in the subject matter, that is to say, that the uncertain event necessary to make the contract amount to an insurance must be one which was of a character more or less adverse to the interest of the policyowner. The policyowner must in the ordinary course of events stand to suffer loss by the occurrence of the uncertain event, and the usual undertaking of the insurer was to make good the loss within the limits prescribed by the contract. The contract is therefore a personal one between insurer and policyowner to protect the latter against loss arising out of her or his connection with the subject matter of the insurance.

2.8. The insured event must also ‘be of a character more or less adverse to the interests of the person effecting the insurance’.25 There is only slender Court authority for this view but it follows, certainly for most types of insurance, from two other principles. First, an insurance against an event which is either favourable or inert to the interests of the policyowner is likely to be a wager and not insurance.26 Second, the principle of indemnity, which holds that in an indemnity insurance the policyowner may not recover from the insurer more than the loss, logically depends on the occurrence of a ‘loss’ and this is incompatible with the insurance being on a favourable or inert event; the indemnity principle does not apply to life insurances and policies where the loss is defined as a fixed dollar amount (valued policy).

2.9. The reference by Channell J to adversity for the nature of a contract of insurance is not entirely accurate, because the contingency insured against need not necessarily be adverse to the interest of the policyowner – as for instance is the case in a contract of life insurance containing endowment provisions27; and further, not every contract of insurance is a contract of indemnity.28

*Benefit*29

2.10. The insurer must supply a benefit to or for the policyowner. Money, money’s worth or benefit is sufficient for the indemnity or payment by the insurer to the policyowner.30 A payment or benefit is characteristic of life assurances and valued policies; these are not indemnity insurances.31 It is

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23 Pynt, para. 1.14.
24 *Prudential Insurance Co v Inland Revenue Commissioners* [1904] 2 KB 658 at 663, 664; *Maurice v Goldsborough Mort & Co* [1939] AC 452 (PC) at 460; *Bennett v Tugwell* [1971] 2 QB 267 at 269.
25 Prudential Insurance Company v Inland Revenue Commissioners [1904] 2 KB 658 at 664; except perhaps for endowment policies: *Gould v Curtis (Surveyor of Taxes)* [1913] 3 KB 84 at 95, 98-99; the comments at 92 are probably limited to life assurance: *Department of Trade and Industry v St Christopher Motorists Association Ltd* [1974] 1 WLR 99 at 105-106. But see *Medical Defence Union Ltd v Department of Trade* [1980] Ch 82 at 94; *McAll v Brooks* [1984] RTR 99; *Card Protection Plan Ltd v Customs and Excise Commissioners* [1994] STC 199. See also *Newbury International Ltd v Reliance National Insurance Co (UK) and Tyser Special Risks* [1994] 1 Lloyd’s Rep 83 at 92-93.
26 *Newbury International Ltd v Reliance National Insurance Co (UK) and Tyser Special Risks* [1994] 1 Lloyd’s Rep 83 at 92.
27 *Gould v Curtis (Surveyor of Taxes)* [1913] 3 KB 84 at 95, applied in *Medical Defence Union Ltd v Department of Trade* [1980] Ch 82; [1979] 2 All ER 421. See also *Australian Health Insurance Association Ltd v Eso Australia Pty Ltd* (1993) 41 FCR 450; 7 ANZ Insurance Cases 61-195 at 487 (FCR), 78, 238 (ANZ Insurance Cases).
28 Pynt, paras. 1.6-1.10.
29 Sutton, para. 2.70; Pynt, para. 1.17.
31 See *Gould v Curtis (Surveyor of Taxes)* [1913] 3 KB 84 at 85. It may be arguable that the provisions of the *Financial Services Act 1986 (UK)* cleave a further distinction between life assurance and indemnity insurance by defining and treating the former as investment.
characteristic of indemnity insurances that the insurer promises to indemnify the policyowner, ‘to make good the loss’: this is called the principle of indemnity. Thus, even though an indemnity insurance may result in a payment, this is not necessarily so; in this sense ‘indemnity’ will naturally include benefits other than payments. In first party insurance, the benefit might be services, work, goods or things.32 For example, under many home contents policies, the insurer has the option to supply household goods when they have been lost or damaged. Similarly, under many home buildings policies, the insurer has the option to engage a builder to rebuild the home when it has been lost or damaged. A motor vehicle insurer might lend the policyowner a car while the car is being repaired. In third party liability insurance, the insurer's indemnity to the policyowner, which is one of the essential features of indemnity insurance33, may be by: protecting the policyowner from loss; defending the claim against the policyowner by the third party; or a payment to a third party in satisfaction of a claim by that third party.34

2.11. The policyowner must provide some consideration for the insurer's promise. This will usually be the promise to pay, or the payment of, an amount of money as premium, but it may be any form of valuable consideration.36 The payment of the premium may be a benefit due to the insurer under the contract, in which case the policyowner must discharge the obligation to provide that benefit by paying the agreed amount of premium. The payment of the premium may also be a condition precedent to the insurer having any liability to the policyowner; in this case the policyowner must fulfil this condition by payment of the premium. However, it cannot be the case that payment of a premium is a condition precedent to a finding that a contract is one of insurance: if that was the case, it would be easy to sidestep regulatory requirements.37

2.12. The premium is usually a very small amount in proportion to the amount the insurer will be obliged to pay the policyowner if he or she suffers a loss. This is the corollary of the purpose of insurance as the spread of risk among persons and over time. Most policies provide for a fixed amount that is paid once as the premium, but others provide for a premium that depends on the number of claims or the aggregate amount paid to the policyowner over the period of the policy. The insurer's underwriting should be calculated to take enough premium to pay for all claims on policies and leave it with an amount as profit. However, at various points on the cycle of insurance business it has become more or less popular to depend not just on an underwriting profit but on investment income and capital appreciation on the premium as well. Thus, even if all the premium is used to pay claims, if the capital gain and investment income on the premium between the time it is received by the insurer and the time the policyowner is paid in relation to a claim, is sufficient, then the insurer's underwriting losses will be, to that extent, of less significance. It may occur that the claims will exceed the sum of premium, capital gain and investment income.


33 See Re Allobrogia Steamship Corp [1978] 3 All ER 423 at 427-428.


35 Sutton, para. 2.80.

36 For example, the use of certain credit cards for travel tickets brings certain life insurances and accident insurances with it.

37 Dix v Townsend [2008] EWHC 90117 (Costs).
Hybrid or bundled contracts

2.13. The contract may be partly for insurance and partly for other purposes. There is an issue whether, for a contract which has more than one purpose, the principal purpose must be insurance for the whole of the contract to be properly categorised as a contract of insurance. 38

2.14. It is possible for there to be a hybrid contract which is for insurance and for other matters. The Courts 39 have suggested that the fact that a ‘non-insurance’ provision 41 is contained within a contract of insurance does not result in the policyowner being ‘insured’ in respect of the matters the subject of the non-insurance provision; this approach tends to support the ‘hybrid’ view, although the contract in question may have had insurance as its principal objective.

2.15. A contract that contains insurance and non-insurance type provisions is an insurance contract if, taken as a whole, its primary purpose is to insure. 42 The view that the principal purpose of a contract must be insurance in order for the contract to be properly categorised as insurance would also introduce the possibility that the statutory regulation of insurance business could be evaded by an ‘insurer’ being obliged, under the contract, to provide a majority of other goods, services, benefits or monies, as well as a minority of insurance, under its contracts. 43

2.16. The Insurance Contracts Act 1984 (IC Act), section 10, contains a partial definition of ‘contract of insurance’. First, a contract of insurance includes a contract that ‘would ordinarily be regarded as a contract of insurance although some of its provisions are not by way of insurance’. 44 Second, even more opaquely, a contract of insurance also includes a contract ‘that includes provisions of insurance insofar as those provisions are concerned, although the contract would not ordinarily be regarded as a contract of insurance’. 45 The section sets two puzzles. The first puzzle is that where a contract includes ‘insurance provisions’ it seems that at least that part of the contract is regarded as a contract of insurance. The section, on that view, looks at a ‘part contract’ compared with section 10(1) which looks at the ‘whole contract’. This would seem to be a rational answer to the first puzzle. The second puzzle is that the reference to ‘ordinarily regarded’ seems to be a reference to the contract as a whole, but the first dimension seems to treat the insurance part of the contract as a ‘contract of insurance’. Section 10(3) deals with the position where a contract is not ‘ordinarily regarded’ as a contract of insurance. It applies where such a contract affects the operation of a contract of insurance to which the Act applies. The affecting provision is treated as a provision, or term, of a contract of insurance. The thrust of this section would seem to be that if there are, for example, subrogation arrangements in a non-insurance contract which affect an insurance contract then the subrogation provisions would attract the application of the Act. The section as a whole refers to ‘ordinarily regarded’ and is not clear as to which eye of the beholder

38 Sutton, paras. 2.90-2.220.
40 C.V.G. Siderurgicia del Orinoco SA v London Steamship Owners' Mutual Insurance Association (The Vainqueur Jose) [1979] 1 Lloyd's Rep 557.
41 C.V.G. Siderurgicia del Orinoco SA v London Steamship Owners' Mutual Insurance Association (The Vainqueur Jose) [1979] 1 Lloyd's Rep 557 at 580-581.
44 s. 10(1).
45 s. 10(2).
the section regards: a reasonable policyowner, an ‘ordinary person’ policyowner, a broker, a reasonable insurer, the ‘insurance industry’ or the Courts.46

2.17. The issue of characterising a contract as an insurance, or partly as an insurance contract, is important because there are many contracts that work like insurance or have insurance parts to them: wagers or gambling, guarantees, product warranties, extended warranties and indemnities in commercial agreements (e.g. services and leases).47

3. Risk in insurance48

3.1. The insurance industry has long maintained that it is, particularly in relation to its customer contracts, unique. The unique quality arises in two respects.

3.2. First, insurers buy risk. It is an industry in which the insurers buy risk but the calculation of the true price of the risk is a retrospective one. The insurance industry has a number of types or layers of risk and the relationship among these layers brings additional and unique difficulties. The original meaning of risk, in a commercial context, was a chance or hazard, or ‘exposed to the chance of injury or loss.’

a) One layer of risk is inherent in insurance. An insurer buys risk. At the time the risk is written or bought, the insurer does not know the correct price for the individual risk. The insurer will have some data about those types of risks generally and some data about the specific risk, through disclosure by the policyowner, but this data does not give the insurer anything like certainty about the price. There have been some responses: mutuals garnered some retrospectivity by making calls for future premium if the money ran out and the rise of claims made insurances reduced the time factor.

b) A second layer of risk for the business of insurance – buying risk at an uncertain price – is that the demand for insurance is created by a timing mismatch of data. It is a part of the commercial idea and legal definition of insurance that, at the time the insurance contract is entered into, the event insured against is uncertain. Further, the policyowner and the insurer have different types and amounts of data. The policyowner will have data specific to his or her own circumstances. The insurer will have data aggregated from many individual circumstances and might have higher levels of predictability based on powerful analysis of that data. Third, both parties are using past data at a present risk acceptance and rating time to predict the economic cost of a future event.

c) A third layer is the risks involved in the insurer's risk acceptance and claims management. There is a unique set of legal principles and laws that apply to insurance: insurable interest; utmost good faith and disclosure; contribution and subrogation. The purpose and origins of this set of laws are the management and reduction of the insurer's risk profile and the management, on a claim, of the price adjustment of the accepted risk. These are the specialist tools used to manage insurance risk.

3.3. Second, the traditional common law and equitable principles that fashioned and arose for insurance contracts – insurable interest, utmost good faith, non-disclosure, indemnity, contribution and subrogation – are, at least in combination, unique. The principle of utmost good faith is the soul of these characteristics in relation to risk. It was thought that the doctrine of utmost good faith for insurance contracts would, in the IC Act be a panacea for unfairness. It is necessary to look at the origins and development of the doctrine to put its modern work in context.

46 See the Explanatory Memorandum to the Insurance Contracts Amendment Bill 2013, pp 16-17; Mann, paras. 10.10-10.50.
47 Sutton, paras. 2.110-2.180; Pynt, paras. 1.5, 1.29-1.34.
48 Sutton, para. 2.10.
3.4. The utmost good faith doctrine, first stated by Lord Mansfield in *Carter v Boehm* 49 in 1766, sets out an important precept for insurers to manage their risk and to reduce the moral hazard—see below—of that risk. The common law doctrine required the policyowner to disclose his or her material knowledge that is relevant to the risk to the insurer before an insurance contract is made, so that the insurer can assess the risk and decide on appropriate terms and a price for accepting the risk. Under the IC Act the duty of utmost good faith and the duty of disclosure are separate duties: see below in Parts 8 and 9. At common law the precept of utmost good faith required more than the measured honesty in narrow particulars familiar to lawyers; it required an openness, a reliable honesty. The word ‘faith’ then altered the balance away from the word or conduct of the proponent and takes us into the mind of the listener, into the listener’s consideration and belief.

3.5. This risk management precept evolved into the pre-contractual duty of the policyowner to make a fair presentation of the risk: to disclose, and not to misrepresent, matters which are relevant to the risk. The law demands a higher standard of good faith between the parties to an insurance contract: ‘there is no class of documents as to which the strictest good faith is more rigidly required in courts of law than policies of assurance’. 50 The traditional approach was that the underwriter knows nothing and the proposed policy owner knows everything about the risk to be covered: the proposed policy owner has a duty to make a full disclosure to the underwriters without being asked of all the material circumstances.

3.6. Consequently, at common law, a party to a contract of insurance 51 was under the ordinary duty to avoid making misrepresentations, which will be broken if the statement is untrue even though the policyowner was unaware of the falsity and unaware of the significance of the statement for the insurers. Additionally, at common law, the policyowner was under the extended duty to disclose all material facts which are or ought to be known by him or her and which are material to the formation of the contract even though no express questions have been asked. 52 The duty of disclosure is not based on concealment: it is well established that so far as the consequences are concerned ‘it is immaterial whether the omission to communicate a material fact arises from intention, or indifference, or a mistake, or from it not being present to the mind of the insured that the fact was one which it was material to make known’. 53

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49 (1766) 3 Burr 1905; 97 ER 1162; see *Rozanes v Bowen* (1928) 32 Ll L Rep 98 at 102, per Scrutton LJ.

50 *Mackenzie v Coulson* (1869) LR8Eq 368 at 375, per Sir James VC. Uberrima fides has been applied as a doctrine of equity or the common law to differing extents and with differing rules of application; most importantly to partnership agreements, company promotion, family settlements and title to land.

51 The doctrine applies to all kinds of insurance but does not apply to related contracts even if their effect is to leave the insurer exposed to insurance risks, e.g. binding authorities granted by insurers to brokers or contracts for the transfer of insurance or reinsurance portfolios: *Pryke v Gibbs Hartley Cooper* [1991] 1 Lloyd's Rep 602; *L'Alsacienne, Premiere Societe Alsacienne et Lorraine d'Assurances contre L'Incendie les Accidents et les Risques Divers v Unistorebrand International Insurance AS* [1995] LRLR 333. Framework contracts, such as non-obligatory reinsurance treaties, are also not contracts of insurance for these purposes: *HIH Casualty & General Insurance Ltd v Chase Manhattan Bank* [2001] 1 All ER (Comm) 719; [2001] 1 Lloyd's Rep 30; [2001] Lloyd's Rep IR 191, varied *HIH Casualty & General Insurance Ltd v Chase Manhattan Bank* [2001] Lloyd's Rep IR 703; [2001] 2 Lloyd's Rep 483; [2001] EWCA Civ 1250; and *HIH Casualty & General Insurance Ltd v Chase Manhattan Bank* [2003] 1 All ER (Comm) 349; [2003] 2 Lloyd's Rep 61; [2003] Lloyd's Rep IR 230; [2003] UKHL 6.


53 *Bates v Hewitt* (1867) LR 2 QB 595 at 607 adopted in *Saunders v Queensland Insurance Co Ltd* (1931) 45 CLR 557; 38 ALR 60; 5 ALJ 281 at 563 (CLR); *Dorset v New Zealand Insurance Company* (1890) 8 NZLR 308; *Dalgety & Co Ltd v Australian Mutual Provident Society* [1908] VLR 481; (1908) 14 ALR 299 at 500 (VLR); *Darrel Lea (Vic) Pty Ltd v Union Assurance Society of Australia Ltd* [1969] VR 401.
3.7. The IC Act in 1984 made utmost good faith an implied term of the insurance contract. The effect is that utmost good faith is an obligation, separate from a disclosure obligation. An insurer must deal with the policyowner ‘openly, honestly and fairly’.\textsuperscript{54} The High Court in \textit{CGU v. AMP} said:

\ldots we accept that utmost good faith may require an insurer to act with due regard to the legitimate interests of an insured, as well as to its own interests. The classic example of an insured's obligation of utmost good faith is a requirement of full disclosure to an insurer, that is to say, a requirement to pay regard to the legitimate interests of the insurer. Conversely, an insurer's statutory obligation to act with utmost good faith may require an insurer to act, consistently with commercial standards of decency and fairness, with due regard to the interests of the insured.\textsuperscript{55}

4. Effect of insurance – moral hazard

4.1. The insurance community is strongly influenced in its product development, marketing, pricing and underwriting by fear of ‘moral hazard’. Moral hazard is the expression used to refer to two elements.

4.2. First, it is the tendency that the availability of insurance will relax or dissipate the usual human and institutional energies which ought to be directed towards reducing the likelihood that the insured event or condition will occur. Moral hazard, in this sense, is defined as the likelihood that a person who is insured will take more risks and therefore make more claims than the person would without insurance cover. The policyowner’s reaction may be because the cover leads the policyowner to feel that whatever happens in the sphere of activities or property covered by the insurance, the insurance cover will take care of any losses. This was particularly so historically in relation to burglary insurances: it was thought\textsuperscript{56} that if burglary insurance was freely available there would be an increase in the number of burglaries by encouraging burglars and weakening the resolve of householders to take proper measurements to keep them out. Initially there were attempts to suppress third party liability insurance on the grounds of public policy, because it was thought to encourage carelessness which might endanger the lives and property of themselves and others. The insurer response is to balance the nature of the risk by providing cover for carelessness and at the same time encouraging care on the part of the policyowner. The carelessness factor can also be mitigated by tailoring the terms of the contract to maximise the promotion of a careful attitude, with penalties for non-compliance being usually in terms of deductibles, conditions or exclusions. The traditional means by which insurers control or mitigate the risk of moral hazard are: attaching a deductible to the premium; inserting a co-insurance provision into the policy, whereby the insurer pays less than 100\% of the remainder after the deductible has been subtracted; and placing an upper limit on payment of claim. These are all measures an insurer may use to manage the risk of moral hazard in order to sustain a viable capital base.\textsuperscript{57}

4.3. Second, moral hazard also refers to the effect that the personality of the policyowner has on the risk: is the policyowner naturally careful or careless, righteous or criminal? The term ‘moral hazard’ was first used in the seventeenth century with connotations of immoral behaviour and linked with the widespread idea of insurance as a form of gambling.\textsuperscript{58} An alternative and extreme

\textsuperscript{54} Pynt, para. 7.8.
\textsuperscript{55} \textit{CGU Insurance Ltd v AMP Financial Planning Pty Ltd} (2007) 235 CLR 1; 14 ANZ Insurance Cases 61-739; [2007] HCA 36; Sutton, para. 6.30.
\textsuperscript{56} Early in Cuthbert Heath’s time at Lloyd’s of London.
form of moral hazard is intentional risk taken in order to maximise financial gain through insurance payouts.

4.4. The insurance industry and our community face two other major risk factors in the current context: not only moral hazard but also its economic corollaries, adverse selection and underwriting hazard.

4.5. Adverse selection is the process that occurs when an insurer offers the same terms to both good and bad risk customers and is caused, according to the economists, by hidden information. Moral hazard, on the other hand, is caused by hidden actions.

4.6. Underwriting hazard\(^{59}\) is defined as the risk that some underwriters may be tempted to lower their standards, especially in relation to long-tail risk where the time between assumption of risk and payment of claim is long, and where the claim often relates to personal injury. For underwriters the greatest temptation would be to underprice the risks, in order to undercut competitors and to write long-tail risks which are essentially unquantifiable but which earn higher premium.\(^{60}\)

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\(^{59}\) Parsons, n 4, pp. 467-469

\(^{60}\) The latter often comprise policies relating to employers' liability especially in UK and usually involve diseases which make their appearance many years after the event, for example, mesothelioma and the James Hardie experience in Australia.
PART THREE – CATEGORIES OF INSURANCE

This introduction to the categories of insurance is discussed below under the following headings:

1. Introduction;
2. Indemnity and contingency insurance;
3. First and third party liability insurance;
4. ‘Occurrence’ and ‘claims made’ insurance;
5. Joint and composite (several) insurance.

There are different categories of insurance. Each provides a different type of cover. Each has different rules and operates in a different way.

1. Introduction

There are two types of people: those who divide people into two types, and those who don’t.61

1.1. Insurance can be divided into the four main categories of marine, general, life and health insurance.62

1.2. The *Insurance Contracts Act 1984* (IC Act) distinguishes between general insurance contracts and:

   a) marine insurance contracts by excluding from the operation of the IC Act insurance contracts to which the *Marine Insurance Act 1909* (MI Act 1909) applies: section 9(1)(d);

   b) life insurance contracts by defining:

      i. a ‘general insurance contract’ as ‘an insurance contract that is not a life insurance contract’ (section 11(6));

      ii. a ‘life insurance contract’ as ‘a contract that constitutes a life policy within the meaning of the *Life Insurance Act 1995*’: section 11(1).

1.3. General insurance can be divided into the following overlapping categories, all of which are discussed below:

   a) indemnity and contingency;

   b) first and third party (liability);

   c) ‘occurrence’ based and ‘claims made’.

1.4. Most insurance contracts fall into one of the two sub-categories of each category listed above. Which sub-category an insurance contract falls into can determine which legislation applies to it, how the contract or its individual terms are to be construed, and the particular common law principles that are relevant to the way in which it operates.

1.5. A general insurance contract can have cover joint or composite (several) interests and sometimes both. This is also discussed below.

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61 Barth’s distinction.
62 Health insurance only earns its own category because of the intense legislative regulation of it, making it an area of study on its own.
2. Indemnity and contingency insurance

2.1. General insurance, that is non-marine, non-life insurance, is either indemnity or contingency. Most insurance is indemnity. A home or car policy is an example of indemnity insurance.

2.2. By entering into an indemnity insurance contract, an insurer promises to indemnify against financial loss suffered by an insured as a result of the happening of a risk under the contract.

2.3. No insurance contract provides a perfect indemnity. The scope of the indemnity is dictated by the express terms of the contract. For example, an insurance contract that insures home contents might define indemnity by reference to the ‘as new’ replacement cost of destroyed goods, or by reference to the cost of replacing the destroyed items with items of like age, quality and condition. The presence of deductibles, excesses, sums insured and aggregate limits also limit the scope of the indemnity.

2.4. It is open to a policyowner to buy an indemnity insurance policy from more than one insurer, but between them, they will not be liable to pay more than the financial loss suffered by the insured. So a policyowner has nothing to gain by buying more than one indemnity insurance policy to cover the same risk.

2.5. Upon indemnifying or agreeing to indemnify an insured for their loss and subject to the express terms of the insurance contract, an insurer becomes entitled to the benefit of all potential rights its insured might have against a third party to be compensated for a loss that is at least partly insured by the contract. This benefit is an insurer’s right of subrogation.

2.6. The following is an ‘everyday’ example of how subrogation works.

_A’s vehicle is damaged in a motor vehicle accident caused by B’s negligent driving of another vehicle. A’s first party insurer pays A the cost to repair his vehicle and then exercises a right of subrogation by suing B in A’s name to recover A’s loss, and thereby diminish its own loss under the insurance contract._

2.7. By entering into a contingency insurance contract, the insurer promises to pay an agreed amount upon the happening of an event specified in the policy, irrespective of the actual financial loss that an insured would suffer if such an event happens.

2.8. Insurers offer contingency insurance to protect an insured against the adverse financial impact of an event specified in the policy that either:

a) cannot, or cannot easily, be calculated, for example, the loss of an eye; or

b) the insurer does not want to indemnify against, for example, actual loss of income as a result of sickness or accident.

2.9. A personal accident and sickness policy is an example of contingency insurance. In this type of insurance, the parties agree at the time the policy is issued how much the insurer will pay if the insured suffers any one or more of a set of listed injuries, or becomes unable to work, because of an accident or sickness. The amounts are set by reference, amongst other things, to the amount of premium the policyowner is prepared to pay for the policy and in the case of cover for loss of earnings, how much the insured is earning at the time the insurance is taken out. The amounts are not intended to indemnify the insured for the actual financial loss the insured will suffer if an event happens that entitles them to payment under the policy.

2.10. As a contingency insurance contract does not indemnify against financial loss, upon a claim being made, there is no reason for the insurer to investigate the amount of the insured’s actual financial loss as a result of the insured event.

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63 IC Act, s. 76(2).
2.11. Payment of a claim under a contingency insurance policy does not give the insurer a right of subrogation, except to the extent that the payment is by way of indemnity, for example, reimbursement of medical expenses.65

2.12. In summary, it is important to distinguish between indemnity and contingency insurance, amongst other things, because with indemnity insurance:
- the insured is indemnified for insured loss; no more, no less. With contingency insurance, the amount of the payment in the case of the happening of an insured event is fixed at the time the policy is taken out;
- it does not matter how many policies a policyowner buys, the insured will only be indemnified once for his or her insured loss;
- the insurer has a right of subrogation. There is no right of subrogation with contingency insurance, except to the extent the policy provides an indemnity, e.g. for medical expenses.

3. First and third party liability insurance

3.1. General insurance can also be divided into first party or third party liability.

3.2. First party insurance involves an insurance of the risk that an insured might be injured or might suffer loss of, or damage to, property in which the insured has a financial interest. That part of a house and contents policy that covers an insured for damage to, or destruction of, the insured’s house or its contents is an example of this type of insurance.

3.3. A first party property damage policy is indemnity insurance, and so it only compensates the insured to the extent they have suffered financial loss as a result of damage to the property which is the subject matter of the policy. Unless expressly stated otherwise, the policy covers the insured only for the actual damage to the property. It does not extend to any loss suffered by the insured as a consequence of the damage to property. For example, a first party motor vehicle policy will cover the insured for the cost of repairing damage to his or her vehicle caused by an insured event, but not for the cost of renting a hire car whilst his or her vehicle is being repaired. That is, unless there is an express extension in the policy to that effect.

3.4. On the other hand, third party (liability) insurance involves the insurance of the risk that the insured might be held legally liable to pay compensation to a third party for personal injury, property damage or financial loss suffered by the third party.

3.5. A liability policy will cover an insured for his or her liability for negligently damaging a claimant’s motor vehicle, including his or her liability to the claimant for the cost incurred by the latter in renting a hire car whilst the claimant’s vehicle is being repaired. That is, unless the policy expressly excludes that consequential liability.

3.6. First party insurance can be indemnity or contingency. In the case of indemnity insurance, there are only two relevant entities: the insurer and the insured.

3.7. Liability insurance is only ever on an indemnity basis. With liability insurance, there are three relevant entities: the insurer, the insured and the claimant (the person claiming that the insured is liable to her for his injury, for damaged property or for financial loss).

3.8. In summary, it is important to distinguish between first party and third party (liability) insurance, amongst other things, because:
- first party insurance can be indemnity or contingency insurance. Third party (liability) insurance is only ever indemnity insurance;

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b) subject to the terms of the policy:
   i. first party insurance only covers the insured for the injury or thing damaged, not for consequential loss such as loss of profits, loss of rent, cost of hire, etc.;
   ii. third party (liability) insurance indemnifies the insured for its liability to the third party claimant, including the cost to repair the thing damaged and consequential loss;
   iii. first party insurance involves two relevant entities: the insurer and the insured. Third party (liability) insurance involves three relevant entities: the insurer, the insured and a third party claimant (the person claiming that the insured is liable to her for his injury, for damaged property or for financial loss).

4. ‘Occurrence’ and ‘claims made’ insurance

4.1. General insurance is either ‘occurrence’ or ‘claims made’.

‘Occurrence’ based insurance

4.2. First party insurance is almost invariably ‘occurrence’ based. In ‘occurrence’ based insurance, the insurer’s promise to pay is triggered by the happening of an occurrence or the happening of a loss during the insurance period.

4.3. A motor vehicle first party property damage policy is an example of ‘occurrence’ based insurance. In this type of insurance, and subject to the policy wording, the insurer’s promise to pay is activated by either:
   a) the happening of an event that causes damage to the insured’s motor vehicle; or
   b) damage to the motor vehicle itself, occurring during the insurance period.

4.4. Liability insurance can be either ‘occurrence’ or ‘claims made’; most liability insurance is ‘occurrence’ based.

4.5. In ‘occurrence’ based liability insurance, the insurer’s promise to pay is triggered by the insured incurring a liability to a third party during the insurance period, even if the settlement, judgment or arbitration award that resolves the third party’s claim against the insured occurs after the insurance period has ended. For example a motor vehicle liability insurer’s promise to pay will be triggered when an insured negligently causes a motor vehicle accident during the period of the policy, even though the innocent party’s claim against him or her might not be settled or go to trial until some years after the policy period has expired.

‘Claims made’ liability insurance

4.6. Occurrence-based liability insurance works well when a third party’s injury or loss is immediately obvious and happens at about the same time, or soon after, an insured’s negligent act or omission; for example, a motor vehicle accident caused by an insured’s negligent driving. In this type of case, the insured usually informs their liability insurer about the accident shortly after it happens, enabling the insurer to set aside a realistic reserve for the claim within about a year of issuing the insurance policy (assuming, as is mostly the case, that the insurance period is 12 months).

4.7. However, ‘occurrence’ based liability insurance can be problematic if a liability is potentially ‘long tail’. In liability insurance, ‘long tail’ generally refers to circumstances in which a substantial amount of time can elapse between a third party suffering an injury or an insured incurring a liability and the insured becoming aware that they have incurred the liability. For example, this may be when a third party:
a) suffers not immediately obvious brain damage as a result of being medically mismanaged at birth, and does not make a claim for the brain damage against the insured medical practitioner until some years later; or

b) contracts malignant mesothelioma many years after being negligently exposed to the risk of that happening by the insured supplier of an asbestos product, and the insured (and the third party) does not find out about the third party inhaling asbestos fibres until it manifests itself as malignant mesothelioma after the latency period.

4.8. Some of the potential insurance problems for a ‘long tail’ claim include:

a) identifying the insurer that issued the policy and the details of the policy (including the policy wording and limits of liability), if, for example, the policyowner has lost or misplaced the schedule or certificate of insurance;

b) identifying the responsible insurer amongst a series of insurers. This is a problem if the policyowner changed insurers from time to time; it might then have difficulty proving which particular insurance policy or policies respond(s) to the claim. If nothing else, it will probably result in ‘finger-pointing’ between the insurers at risk;

c) the policy wording and limits of liability being ‘out-of-date’ by the time the third party’s claim against the insured is settled or decided in court or by arbitration. For example, a limit of liability of $1 million in a 1975 policy insuring against liability to pay compensation for personal injuries might be well short of an award in a personal injuries case resolved 30 or 40 years later;

d) an insurer setting aside an appropriate reserve for claims it does not know about but anticipates. Both under-reserving (underestimating the number of ‘as yet’ undisclosed claims) and setting aside excessive reserves (overestimating the number of ‘as yet’ undisclosed claims) are a problem. The first risks the insurer having set aside insufficient funds to pay claims when it finally finds out about the true number and magnitude of ‘as yet’ undisclosed claims. The second risks the insurer losing business by setting uncompetitively high premiums (to meet anticipated claims); and

e) an insurer not being able to ‘close its books’ on an insurance period until years or decades after the expiry of that period.

4.9. With a ‘claims made’ liability insurance policy, the insurer’s promise to pay is triggered by a claimant first making a claim against the insured during the insurance period. A variant on the ‘claims made’ policy is the ‘claims made and notified’ liability insurance policy. Subject to the policy wording and the IC Act, sections 40 and 54,66 with a ‘claims made and notified’ policy, the insurer’s promise to pay is triggered by:

a) a claimant first making a claim against the insured during the insurance period; and

b) the insured notifying the claim to the insurer during the insurance period, or in some policies, within a ‘grace period’ after the expiry of the insurance period.

4.10. In both types of policy, it does not matter when the insured incurred the liability or when the act or omission occurred that gave rise to the insured’s liability, unless it happened before a date nominated in the policy as the ‘retroactive date’. A ‘retroactive date’ in a policy indicates that the insurer will not be liable for a claim that arises out of an act or omission that occurred before the ‘retroactive date’. The ‘retroactive date’ is often the date the policyowner first took out ‘claims made’ insurance with that insurer.

4.11. ‘Claims made’ and ‘claims made and notified’ insurances have the following advantages over ‘occurrence’ based insurance in relation to the writing of ‘long tail’ risks:

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66 See Part Twelve.
a) the insurer and the policy details are usually more easily identified and retrieved;
b) policy wordings and limits of liability are more up to date;
c) the insurer pays claims closer to when premiums were set for the policies that respond to those claims;
d) the insurer ‘closes its books’ nearer to when the relevant policies were issued; and
e) the level of premium the insurer needs to charge is more accurately calculated having regard to the increased level of certainty achieved by the above.

4.12. Nowadays, the risk that an insured might be held liable to a third party for loss as a result of the supply of hazardous products, professional malpractice or a company director’s or officer’s errors or omissions, is usually written as ‘claims made’ or ‘claims made and notified’, rather than ‘occurrence’ based, insurance.

4.13. In summary, it is important to distinguish between ‘occurrence’ and ‘claims made’ insurance, amongst other things, because subject to the terms of the policy:

a) ‘occurrence’ based insurance only covers the insured for insured loss that occurs or is caused by an event that happens during the period of insurance;
b) ‘claims made’ insurance (almost invariably third party (liability) insurance) only covers the insured for a claim made against the insured during the period of insurance, irrespective of when the insured loss occurs or when the event that caused the insured loss happened. This is subject to the operation of the IC Act, sections 40 and 54, if the IC Act governs the policy.

5. Joint and composite (several) insurance

5.1. Insurance contracts often cover the interests of more than one person. In general terms, a joint insurance contract is a contract in which each insured has an identical interest in the subject matter of the insurance; a composite insurance contract is a contract in which the insureds have different interests in the subject matter of the insurance.

5.2. First party insurance covering the partners’ interests in partnership property is an example of joint insurance.\textsuperscript{67} First party insurance covering the interests of a lessor and a lessee in the lessor’s property is an example of composite insurance.

5.3. Each of the rights and obligations in an insurance contract that covers two or more insureds (co-insureds) is either joint or composite (several).

5.4. Subject to the IC Act, whether a particular right or obligation is joint or composite might determine:

a) the extent of a co-insured’s right to recover under a first party insurance contract for loss or destruction of, or damage to, the subject matter of the contract; or
b) the effect on an innocent co-insured’s rights of another co-insured’s pre-contractual non-disclosure or misrepresentation or post-contractual non-compliance with, or breach of, a contractual obligation.

5.5. In \textit{Scott v Wawanesa Mutual Insurance Co}\textsuperscript{68}, the Supreme Court of Canada considered circumstances in which an innocent co-insured’s ability to recover under an insurance contract might be detrimentally affected by the wrongful acts of another co-insured:

\begin{quote}
The decisions of the trial judge and the Court of Appeal, then, are representative of two divergent streams of jurisprudence dealing with the problem posed when an innocent insured seeks to recover for a loss occasioned by the wrongful act of a co-insured. The most common scenario in the case reports, and one that decidedly does
\end{quote}

\textsuperscript{67} \textit{Amaca Pty Ltd formerly known as James Hardie and Co Pty Ltd v CSR Ltd} [2001] NSWSC 324 at [116] (Bergin J).

\textsuperscript{68} (1989) 59 DLR (4th) 660.
not serve as an encomium to matrimonial bliss, sees husband or wife burn down the matrimonial home.\textsuperscript{69}

5.6. The IC Act does not distinguish between joint and composite obligations. The effect of a provision of the IC Act on the rights and obligations of the parties to an insurance contract is determined by the language of the provision, not by whether the relevant rights or obligations are characterised as joint or composite. For example, whether the duty of disclosure is characterised as joint or composite will not affect an insurer’s ability to avoid an insurance contract pursuant to section 28(2) of the IC Act for fraudulent non-disclosure or fraudulent misrepresentation by a co-insured.\textsuperscript{70}

**Joint insurance**

5.7. Insurance is ‘joint’ if it covers:

   a) jointly owned property for a joint loss;
   b) property, some of which is jointly owned and some of which is separately owned, as long as the policy applies indifferently to the joint and separately owned property and treats separately owned property as jointly owned.\textsuperscript{71}

5.8. Every right and obligation in a joint insurance contract (except perhaps a right to terminate) is joint, so that:

   a) if there is a loss, any co-insured can claim the full amount of the loss; and
   b) a co-insured’s pre-contractual non-disclosure or misrepresentation or post-contractual non-compliance with, or breach of, a contractual obligation will affect the rights of an innocent co-insured: *P Samuel and Co Ltd v Dumas*, in which Viscount Cave said (at 445–6):

   "... when two persons are jointly insured and their interests are inseparably connected so that a loss or gain necessarily affects them both, the misconduct of one is sufficient to contaminate the whole insurance."

**Composite insurance**

5.9. If the subject matter of a composite insurance contract is damaged or destroyed, the amount of a particular co-insured’s loss will depend:

   "... on the nature of his interest, and the covenant of indemnity which the policy gives must, in such a case, necessarily operate as a covenant to indemnify in respect of each individual different loss which the various persons named may suffer."\textsuperscript{72}

5.10. Just because an insurance contract is composite does not mean that all of the co-insureds’ obligations are composite; some might be joint.\textsuperscript{73}

5.11. Whether a particular obligation in a composite insurance contract is joint or composite is primarily a matter of construction, the rule being that the obligation will be construed to be joint or composite according to the respective interests of the parties.\textsuperscript{74}

\textsuperscript{69} At 664 (Dickson CJ, La Forest and Sopinka JJ).

\textsuperscript{70} *Advance (NSW) Insurance Agencies Pty Ltd v Matthews* [1989] HCA 22; (1989) 166 CLR 606 at [31] (Mason CJ, Dawson, Toohey and Gaudron JJ).


\textsuperscript{72} [1924] AC 431.

\textsuperscript{73} *General Accident Fire and Life Assurance Corporation Ltd v Midland Bank Ltd* [1940] 2 KB 388 at 405 (Sir Wilfred Greene). In *State of the Netherlands v Youell and Hayward* [1997] 2 Lloyd’s Rep 440, Rix J (at 447–8) described Sir Wilfrid Greene’s judgment as ‘the classic statement of the difference between a joint and a composite insurance’ which, although obiter, has ‘been regarded as authoritative for more than 50 years’.

\textsuperscript{74} *Advance (NSW) Insurance Agencies Pty Ltd v Matthews* [1989] HCA 22; (1989) 166 CLR 606 at [31] (Mason CJ, Dawson, Toohey and Gaudron JJ).
This introduction to Australian insurance law history is discussed below under the following headings:

1. English background;
2. Australian insurance market;
3. Australian insurance law.

1. English background

1.1. The precise origins of insurance law are uncertain, and there are plausible arguments to be made for ancient civilisations, including Roman, Greek, Phoenician and Chinese, as the inventors of marine insurance. As far as Europe is concerned, marine insurance appears to have originated with the Lombards. For our purposes it suffices to say that by the seventeenth century there was a thriving marine insurance market in London, important enough for a specialised court for the resolution of marine insurance disputes, to be established in 1600. The eighteenth century was the turning point. Marine insurance remained the most important form, although life insurance existed in embryonic form and a small market for buildings insurance developed after the Great Fire of London in 1666. There were two major developments in this era.

1.2. The first was the passing of the *Bubble Act 1719*, which sought to dampen speculation in fraudulent corporate flotations by banning all companies, and allowing marine insurance to be written only by two companies with Royal Charters: the Royal Exchange and the London Assurance. The Bubble Act did not prohibit individuals from writing insurance, and by the end of 1720 Edward Lloyd’s Coffee House became the focal point for merchants writing insurance. The Bubble Act was not repealed until 1825, by which time Lloyd’s underwriters had established a share of about 95% in the marine market. Lloyd’s initially did write life insurance, but that came to end in the middle of the eighteenth century, and Lloyd’s did not expand into non-marine insurance until late in the nineteenth century.

1.3. The second was the accession of Lord Mansfield to the role of Chief Justice in 1756. By that time there were some thirty or so decisions on key areas of marine insurance, although textbooks of the era refer largely to Continental theory. That changed under Lord Mansfield and his successor from 1788, Lord Ellenborough, so that by 1815 there were over 700 reported marine insurance decisions of the English and Scottish courts.

1.4. It should be borne in mind that from 1066 to 1815 England was at virtually constant war with European neighbours in general and France in particular, so the vast majority of marine authorities up until 1815 were based upon war conditions, including captures at sea and trading with enemies under licence. It is only from 1815 that peacetime conditions allowed for the development of principles in a relatively modern context. It is also important that vessels were not powered by steam or made of anything other than wood until the middle of the nineteenth century. A further point worthy of note is that, because until 1815 Lloyd’s was the only source of, or market for, insurance, virtually all of the decided cases were on Lloyd’s wordings and Lloyd’s underwriting, broking and claims-handling practices.

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1.5. The nineteenth century was critical. The growth of industrialisation – factories, transport, etc. – led to the development of a range of new risks. The repeal of the Bubble Act allowed other insurers to enter the market, and the pattern in the nineteenth century was for companies to be formed to address specific forms of cover, e.g., personal injury to passengers, employer’s liability and, at the end of the century, motor. Life insurance also became more important, and in 1870 it proved necessary to introduce prudential controls over life companies (extended to six other specific forms of insurance in 1909).

1.6. There was little substantive insurance legislation until the turn of the twentieth century. Marine insurance had been used as a cover for wagering in the first half of the eighteenth century, and that was banned by the Marine Insurance Act 1745 (MI Act 1745) by the introduction of an insurable interest requirement. The practice of gambling spread to life, requiring an equivalent measure requiring insurable interest, in the Life Assurance Act 1774. The first major piece of legislation was the Marine Insurance Act 1906 (MI Act 1906), the last of Sir Mackenzie Chalmers’s great codifying measures. The MI Act 1906 was never intended to be more than a statement of the principles set out in the three thousand or so marine cases decided up to that point. By its nature the measure reflected primarily the curiosities of the Lloyd’s market, but much of what it codified had even at that time been overtaken by changing market practice and new policy wordings. There was no attempt to find solutions to unresolved issues. The MI Act 1906 was, when it was passed, and has proved in practice, to be a limited measure that has not removed the need to revert to the actual earlier cases (which had been the purpose of the codification). It is also erroneous in a number of respects, and it has been said that Chalmers’s efforts would, in a university, have achieved ‘a good third’. The 1745 Act was repealed and incorporated into the 1906 Act, and it is somewhat curious that a measure developed to deal with a specific and long-extinct problem remains a crucial part of the law.

1.7. The MI Act 1906 was nevertheless incorporated into the law of Australia by the Marine Insurance Act 1909 (MI Act 1909), and remains the law in unamended form in some eighty jurisdictions, although much of its content has been ousted by market practice and agreement. The most damaging feature of the 1906 Act was the judicial assumption that its principles should be extended to the new forms of insurance that had developed in the second half of the nineteenth century onwards. For that reason, eighteenth century warranties requiring unarmed vessels to sail in convoy or to carry papers of neutrality, failing which there was no recovery even if loss was by sea perils, were extended to consumer insurance. Equally, the obligation of pre-contract disclosure, designed for an era where there was little expertise in underwriting and information was at a premium (indeed in many of the cases the losses had, unknown to the parties, actually occurred before the insurance was written) was smoothly incorporated into twentieth century non-marine law. There was only limited legislative reform: the Life Assurance Act 1774 continued in force (and, in most common law jurisdictions other than Australia and NZ, has an extant counterpart), and the only important changes were: the introduction of cut-through legislation in 1930 whereby the victim of an insolvent policyowner could sue the policyowner’s liability insurers; compulsory insurance for motor vehicle users and employers in 1930 and 1969; and enhanced prudential supervision.

2. Australian insurance market

2.1. The Australian insurance industry as a whole was described by Knibbs in 1910 as ‘fragmentary and voluntary’. By then the general insurance industry had been in existence in Australia since about the 1830s, with most non-life companies beginning as agents of a British parent. Marine, fire and life were, as in England, the early focus, although classes of insurance expanded along with risk. In 1888, ten British companies had aggregate paid up capital of £3.9 million with £12.5 million in reserves, whereas local companies for both marine and fire insurance had only £1.5 million paid up capital and reserves of £1.3 million. Three of the larger insurers in Australia in the next fifty years were: Commercial Union, whose fire agent was sent to Sydney in 1864; the Norwich Union Fire whose agent arrived a year later; and General Accident which began in Melbourne in 1903. Commercial Union flourished such that by 1969 it owned fourteen subsidiaries. General Accident had a colourful, expansionary and technically innovative history. In 1907 it took on motor vehicle, plate glass and burglary, employers' liability and personal accident insurance business. By 1928 General Accident had extended its business to include livestock and marine and had offices in Sydney, Melbourne, Brisbane, Adelaide and Perth. By 1951 sub-branches had been set up in many country towns. In 1968 General Accident acquired the Yorkshire and two life companies. Ultimately in 1998 General Accident and Commercial Union merged to form CGU and in 2002 CGU was bought by the Insurance Australia Group Ltd. In 2003 Norwich Union Australia changed its name to Aviva Australia.

2.2. From the 1870s there was rapid growth in the commercial insurance industry in Australia. The gold rushes in the 1850s in New South Wales and Victoria increased the population, but lack of transport and unemployment combined to slow down economic progress. Fortunately small farmers and graziers were able to employ more workers between 1850 and 1870, and with both Sydney and Melbourne expanding, the openings for insurance companies widened. Competition in the industry increased while rate wars and discounting were a common feature of the landscape. However the depression of the 1890s dramatically changed the situation and many companies went out of business. In 1904 there were 37 insurance companies in Australia – 22 British, 11 Australian and 3 New Zealand based. Many of those are now part of the Aviva group.

2.3. In 1884 Victorian and New South Welsh Insurance Institutes were formed. Conflict and competition in rates wars amongst the insurance companies were part of the motivation in establishing the institutes to which anyone irrespective of their seniority could belong. In time the institutes undertook educational activities for members but the initial thrust was ‘the promotion of good feeling and friendly intercourse’ among members. Marine and fire covered all of the non-life insurance, accident insurance only being relevant at the end of the nineteenth century with the introduction of the automobile and workers’ compensation laws.

2.4. In response to the declining economy, the fire tariff was established in Victoria in 1897 and supervised by the Fire Underwriters Association. This led to the proliferation of other tariff associations in the colonies. A system of rate collusion meant that companies could combine to share knowledge at a low cost to each, set the rates for premiums and control product supply. From its origins in fire insurance the tariff eventually broadened its sphere of operation to include household and business, marine and motor vehicle so that by 1909 the Fire and Accident Underwriters Association had been established and some stability had been restored to the industry. Federation in Australia in 1900 marked the creation of the Australian Constitution and within it, section 51 which refers, amongst other things, to the powers of the Commonwealth Parliament to make laws in regard to ‘insurance, other than State insurance; also State insurance extending beyond the limits of the State concerned.’ This was just after the Australasian Convention Debates took place in 1897, during which the matter of New Zealand establishing its own government insurance office was enthusiastically received, the implication being that
Australia might follow suit, specifically with regard to state insurance for employers' workers' compensation liabilities.

2.5. Twenty-first century Australia now has in Medicare a national health insurance scheme, co-funded by the government and the taxpayer, and the National Disability Insurance Scheme which is being rolled out pursuant to the National Disability Insurance Scheme Act 2013 and likewise co-funded by the government and the taxpayer. Centrelink, a federal body, administers the old age pension and unemployment benefits, as well as other community benefits such as carers' payments. By 1970 Australia had a very long and complex history of workers’ compensation. Law in this field varied from state to state and Federal law differed again, whilst common law precedents were often overlapping and inconsistent. There had been no successful Federal reform package to compare even remotely with the German system. The Royal Commission headed by Justice Owen Woodhouse 1973-1974 during the Whitlam government era recommended the model established in New Zealand some years earlier as a result of his enquiry, which combined workers’ compensation, motor and domestic accident insurance into one scheme funded by taxpayers, employers and motorists. This of course, curtailed lawyers' actions in common law and rendered insurance companies irrelevant in this field. The recommendations were rejected by the Liberal party.

2.6. It was mentioned during the Federal Convention debates in 1897 that colonies might undertake state insurance as was done in New Zealand. This has eventuated with state insurance (non-tariff) companies being formed. All of these except Queensland self-insure against loss of state property and also reinsure through external companies to manage risk better. The first to be established in Australia in 1915 was the State Insurance Office Victoria. In Queensland, the State Government Insurance Office was established in 1916 and by 2002 had become Suncorp and no longer had any state government shareholding. It expanded over the years to write not only workers’ compensation but also life and general insurance and banking. Similarly in New South Wales, GIO was established in 1927 to undertake workers’ compensation and now writes all varieties of insurance business under the Suncorp umbrella, whilst retaining its original name. Other states followed along similar lines.

3. Australian insurance law

3.1. States have introduced limited pieces of legislation regulating the terms of insurance contracts. However, leaving aside the MI Act 1909, Federal intervention did not take place until the passing of the Insurance Contracts Act 1984 (IC Act). In 1978 the Australian Law Reform Commission (ALRC), then chaired by Michael Kirby, was tasked to review the law of insurance. Its Report, ALRC 20 published in 1982, contains a detailed analysis of the common law and also a series of almost revolutionary recommendations for reform. The vast majority of those were accepted by the legislature, and the IC Act came into force on 1 January 1986. The IC Act provides a comprehensive code for insurance contracts falling within its ambit, although that code has not eliminated disputes: insurance generates more court cases than almost any other area of commercial law, and they tend to be complex in the extreme. The IC Act has been amended on numerous occasions – the most recent comprehensive amendments being in 2013 – to clarify or correct issues that had arisen in the courts and in practice. Superimposed upon the IC Act is the General Insurance Code of Practice (the Code), which establishes basic principles for insurers, and also the Financial Ombudsman Service (FOS), which provides a speedier, cheaper and flexible approach to dispute resolution.88

88 See Part Six.
3.2. The IC Act does not apply to motor or workers’ compensation, which remain subject to state legislation. Further it does not extend to marine insurance, so the MI Act 1909 remains in place. The differences between the two pieces of legislation could not be more pronounced, with the MI Act 1909 applying draconian and largely ‘all or nothing’ principles whereas IC Act is nuanced, adopted for the modern market and focuses on ‘proportionality’ so that the consequences of a policyowner breach is proportional to the insurer’s detriment. In 2001 ALRC 91 published a review of marine insurance law, and made a series of recommendations for aligning – or at least bringing closer together – the two regimes, but the proposals have not been implemented other than to the extent of bringing pleasure craft within the scope of IC Act so that consumer holders of marine policies at least get the benefit of the more benign legislation.\(^{79}\)

3.3. Prudential regulation of insurers has developed separately, under the Insurance Act 1973 (general insurance) and the Life Insurance Act 1995 (life). Superimposed is the Corporations Act 2001 (Corporations Act) which regulates financial services and markets generally. One of the features of the growth in prudential supervision has been an increasing interaction between financial security and substantive conduct. Amendments to IC Act have given the Australian Securities and Investments Commission (ASIC) power to intervene in dealings between policyowners and insurers.

3.4. Insurance intermediaries, and in particular brokers, have immense power and influence in the insurance market. The big international brokers are at least the financial equal of most insurers, and their placement decisions and wordings dominate much of what goes on in practice. Brokers had that role from the very earliest days of Lloyd’s. Brokers are now regulated by the Australian Securities and Investments Commission Act 2001 and the Corporations Act, and are self-regulated by the General Insurance Brokers Code of Conduct and FOS.\(^{80}\)

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\(^{79}\) See Part Six.

\(^{80}\) See Part Four.
PART FIVE – OVERVIEW OF INSURANCE RELATIONSHIPS

This section is mainly about retail products and clients, discussed under the following headings:
1. Introduction;
2. Retail and wholesale products and clients;
3. Process;
4. Selling – channels;
5. Parties – sales process;

1. Introduction
1.1. The relationship between a policyowner and the insurer is based on the insurance contract, which is usually set out in a policy schedule or certificate and a policy wording, with perhaps some endorsements to the policy wording. The background and development of that relationship depends on the sales process, whether the insurance is wholesale or retail and the extent to which other parties are involved in it. This Part describes the relationship and the involvement of other parties in the relationship.

1.2. The processes and arrangements for wholesale insurances, particularly as the insurances increase in financial size and complexity, tend to be specific to the particular insurance transaction.

2. Retail and wholesale products and clients
2.1. The following criteria must be met before an intending policyowner is classified as a ‘retail client’ for general insurance contracts:
   a) the policyowner is either an individual, or the insurance is for use in connection with a small business, defined to mean one employing fewer than 100 people in the case of a manufacturer of goods, or one with fewer than 20 people in other cases; and
   b) the contract of insurance is one or other of 7 specified types, 6 of which correspond to the description of prescribed contracts in the Insurance Contracts Act 1984 (IC Act) and its regulations, namely, motor vehicle, home building, home contents, sickness and accident, consumer credit, travel and medical indemnity insurance. There is provision for further kinds of contract to be prescribed by regulation.

2.2. The description of the cover provided by each of the types of insurance is set out in regulations.

There are specific exclusions of insurance to which the Marine Insurance Act 1909 (MI Act 1909) applies or which is entered into for the purposes of a law relating to workers' compensation or motor vehicle compulsory third party cover, and in the case of home building insurance, the exclusion of insurance for the purposes of a law that relates to building or construction work in

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81 Sutton, paras. 5.540-5.650.
82 See Corporations Act, s. 761G(5) in relation to general insurance contracts.
83 These are defined in the Corporations Act, ss. 761A and 764A(1)(d), in broad terms as contracts of insurance that are not life policies or sinking fund policies. within the meaning of the Life Insurance Act 1995.
84 Corporations Act, s. 761G(12).
85 Corporations Act, s. 761G(5).
86 rr. 7.1.11 to 7.1.17 of the Corporations Regulations 2001.
87 Compare IC Act, ss. 9(1)(d)(e).
respect of the building. Personal and domestic property insurance is described as cover in respect of loss or damage to property that is:

a) wholly or predominantly used for personal, domestic or household purposes by the policyowner, a relative, or a person with whom the policyowner resides; and
b) ordinarily used for that purpose. Both ‘property’ and ‘relative’ are widely defined, the formed including a mobile home, trailer, marine pleasure craft, horse, pet and mobile phone.

3. Process

3.1. The insurer’s marketing is highly regulated. The insurer must supply the proponent with a number of documents.

3.2. Among the most important documents is a product disclosure statement (PDS). A PDS is used for general insurance retail insurance products – see below. It is a part of the regime under Australian law for disclosure about a general insurance product during the sales process. A PDS contains information required by law, some of which is not specific to the product, insurer marketing, the insurer’s standard terms for the insurance contract and a proposal form for completion by the proponent. The PDS is a long document for most insurances. A PDS for life insurance or for home and contents insurance is normally over 100 pages.

3.3. An insurer must issue a PDS to a retail client before the parties enter into a contract of insurance. An insurer must provide a PDS to a proponent who is a retail client if the insurer is an AFS licence holder or its authorised representative:

a) An insurer, an AFS licence holder or its authorised representative gives personal advice recommending that the prospective policyowner should obtain a specified contract of insurance. The PDS must be given at or before the time when the advice was provided.

b) An insurer, AFS licence holder or its authorised representative offers to issue, or to arrange for the issue, of a contract of insurance to the prospective insured.

3.4. The PDS must be given at or before the time when the offer was made.

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88 A signed statement by the policyowner as to the intended purpose will suffice: r. 7.1.17.
89 See Sutton, Ch 5, and Pynt, Ch 5, for a more detailed treatment of the content, supply and function of the PDS.
90 See Sutton, Ch 5, and Pynt, Ch 5.
91 Or a person who is licensed to do so in relation to the insurer’s product.
92 See Sutton, Ch 5, and Pynt, Ch 5, for a more detailed treatment of the intermediary’s role, work and liabilities.
94 Sutton, Ch 4, Regulation, paras. 4.170, 4.770; Corporations Act, Pt 7.9 Div 2 Subdivision B.
95 A financial services licensee may authorise an ‘authorised representative’ in writing to provide specified a financial service or financial services on its behalf that are covered by its licence: Corporations Act, ss. 761A, 916A and 916B. Note that a financial services licence holder authorised to deal in ‘general insurance products’, as defined in Corporations Regulations 2001, r 7.1.15, may appoint a distributor for these products without satisfying the requirements of making them an authorised representative: ASIC Corporations (Basic Deposit and General Insurance Product Distribution) Instrument 2015/682.
96 A financial services licensee may authorise an ‘authorised representative’ in writing to provide specified a financial service or financial services on its behalf that are covered by its licence: Corporations Act, ss. 761A, 916A and 916B. Note that a financial services licence holder authorised to deal in ‘general insurance products’, as defined in Corporations Regulations 2001, r 7.1.15, may appoint a distributor for these products without satisfying the requirements of making them an authorised representative: ASIC Corporations (Basic Deposit and General Insurance Product Distribution) Instrument 2015/682.
97 Corporations Act, ss. 1012A, 766B(3); Compare ss. 766A(3), 766B(4), 766B(6), 766B(7).
98 Corporations Act, s. 1012A(3).
99 Corporations Act, s. 1012B(3).
3.5. An insurer must also provide a PDS to a proponent who is a retail client in the converse situation to b), where the prospective policyowner makes an offer to an insurer, AFS licence holder or its authorised representative, for a contract of insurance cover to be issued to him or her. The PDS must be given to the policyowner before there is any legal obligation to take out the cover, that is, before the offer is accepted.100

3.6. There are exceptions to the above circumstances being, relevantly, generally where:101
   a) The client has already received a PDS or has all of the information contained in the PDS;
   b) The policy is an interim policy of insurance, as defined in the IC Act.

3.7. If a quote for a general insurance product that is not unsolicited and made in the course of a telephone conversation certain information is provided to the prospective policyowner, a PDS may not need to be provided or may be provided after the quote is provided.102

3.8. The proposal form has questions about the proponent, the risk to be covered and the insurance the proponent is asking for. The proponent is obliged by law to make accurate and truthful statements in answer to the insurer’s questions and to disclose relevant and material matters to the insurer about the proponent and the risk to be covered – these aspects are discussed later in this Background Paper.103

3.9. The insurer uses its pricing and underwriting models104 and the proponents answers in the proposal to decide whether to offer insurance cover to the proponent and, if so, on what terms. The terms would be the insurer’s standard insurance contract terms for the product (in the PDS), perhaps endorsed with amendments to the standard terms to meet the particular circumstances of the proposed policyowner. The insurer might also increase the premium from its standard premium.

3.10. A proponent will usually obtain a quotation for the insurance cover from a number of different insurers and make a choice from among those quotations.

3.11. Once the proponent accepts the insurance cover from the insurer, the insurer records the details of the insurance on a schedule or certificate which will describe the general nature of the policy; the premium to be paid; the minimum (excess) and maximum amount of monetary value covered under the policy; and perhaps, in note form, some of the main terms or usual optional terms of the policy. The schedule or certificate is supplied to the proponent, now a policyowner.105

3.12. The terms of the insurance contract between the policyowner and the insurer are set out in the PDS (or a separate policy wording) and the schedule or certificate.

3.13. The process will be different depending on the type of insurance (retail or wholesale), the way in which the insurer sells the insurance and the other parties involved.

4. Selling – channels

4.1. The process described above varies depending on how the general insurance cover is sold. There are some variations to the above account of the usual process.

4.2. First, the process might be conducted at the insurer’s office and be mostly on paper.

4.3. Second, the process might be conducted by telephone. The communication of information between the proponent and the insurer is oral and aural. There tend to be fewer disclosure

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100 Corporations Act, s. 1012B(4).
101 Corporations Act, s. 1012D to 1012G.
102 CO 11/842.
103 See Part Eight.
104 See Part Two.
105 Sutton, para. 9.10; see Part Eleven for insurance contract formation.
questions by the insurer – see above. The insurer takes notes and the notes form a part of the insurer’s records and the customer’s record with the insurer. The insurer will send the proponent a summary of the important information communicated by the proponent and by the insurer.

4.4. Third, the process might be conducted online. The proponent applies for insurance through the insurer’s website. There is a record of the communication. There are fewer questions and answers.

4.5. Fourth, the process might be automatic: for example, a credit card purchase might bring with it automatically insurance to cover the purchase without the proponent doing anything to buy or take the insurance. The insurance facility would be a benefit of the credit card and would be made available by an arrangement between the credit card provider and the insurer.

4.6. Fifth, the process might be conducted through other parties. The proponent through an insurance broker and the insurer though its agent.

5. Parties – sales process

Intermediary

5.1. An insurer often sells insurance through the agency of another: an employee, agent or intermediary. The insurance agent or intermediary supplies various services to one or more of the parties to the transaction. The mirror image is that the proponent or policyowner often buys insurance through an agent or intermediary. In some situations, an agent or intermediary of the insurer or policyowner can itself use the services of another agent or intermediary.

5.2. An insurance intermediary is a broad term used to describe an agent, whether acting for the policyowner, insurer or their agents. An insurance intermediary may be engaged to do one or more of the following: market or source; negotiate or arrange; effect and enter into; vary or cancel; handle or settle claims in relation to, insurance contracts. The scope of the authority varies greatly and is determined by the agreement with the principal and the intermediary’s role in the insurance transaction.

5.3. An insurance agent or intermediary may act for one or more of the proponent, the policyowner and the insurer. The agent or intermediary who acts for the first two is normally called a broker and the agent or intermediary who acts for the third is normally called an agent. An insurance agent may be the agent of another agent (sub-agent).

5.4. The idea that insurance agents and brokers are intermediaries in relation to concluding insurance contracts is picked up by the IC Act which defines an insurance intermediary (section 11(1)) as a person who:
   a) for reward; and
   b) as an agent for one or more insurers or as an agent for intending policyowners; arranges contracts of insurance in Australia or elsewhere, and includes an insurance broker.

5.5. This Background Paper uses the expression ‘insurance broker’ to refer to an intermediary who is the agent of the policyowner or proponent. However, an insurance broker can in fact act in a number of other roles depending on the circumstances. For example, an insurance broker may act for policyowners in some types of insurance business, as agent for an insurer in other types of insurance business or even in a mixed capacity.

106 Sutton, para. 5.10.
108 Pynt, Ch 5.
5.6. This Background Paper uses the expression ‘insurance agent’ to refer to an intermediary who is the agent of an insurer. The expression can include an insurance broker when acting as agent of the insurer either generally or in respect of specific elements of a particular transaction, for example, in obtaining reports on losses.

**Policyowner’s insurance broker**

5.7. The proponent usually will approach a broker to discuss the various aspects of the proponent’s insurance needs: the maximum cover and the excess, the premium required, the risks covered and the terms of the policy. The broker then will approach underwriters for a quotation either in the insurance company market or at Lloyd's of London, or in a combination of both. There may be a number of negotiations between the broker on behalf of the policyowner and the insurer or its underwriting agent and the end of this initial phase of negotiations is usually marked by the issue of a quotation by the insurer or its agent.110

5.8. An insurance broker's traditional function is to negotiate, place, administer and make claims under insurance policies on behalf of its client and to give advice in relation to insurance in certain circumstances. An insurance broker is able to act in a variety of capacities, including as agent of the insurer.

5.9. With the advent of the Corporations Act 2001 (Corporations Act), Chapter 7, and the special obligations that apply in relation to ‘retail clients’, insurance brokers have given more thought as to whether to provide a ‘personal advice’ service or a more limited ‘general advice’, or ‘no advice’ (factual information type) service given the additional obligations that come with it.

5.10. The following describes what can be referred to as the traditional insurance broker model. A client may interview a number of prospective insurance brokers before selecting one as his or her intermediary for his or her insurance. Larger and more influential clients may select their broker by asking various brokers to submit tenders for the particular insurances that they require. An insurance broker is usually appointed by the policyowner to advise on and/or to ‘arrange’ and ‘effect’ insurance cover for the policyowner.

5.11. An insurance broker acting for the potential policyowner is now often first a risk manager, advising the client about the risks inherent in its business and how to minimise or mitigate those risks by internal controls and operational measures. The core of an insurance broker's activities is then the development and implementation of an insurance program, which can be devised to cover those risks which should be insured against, and identifying the appropriate insurer who is able to provide the best type of cover for the client's needs at a competitive rate.113

5.12. When arranging insurance the insurance broker will typically be asked to give a quotation for the premium that will purchase a specified maximum level of cover, a specified minimum claim or

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109 Sutton, para. 5.20.
110 Sutton, para. 9.10.
111 In the Corporations Act, Ch 7, there are now two types of advice, general advice and personal advice with personal advice being the traditional type of advice a broker would give based on the client's needs, objectives and personal situation. The National Insurance Brokers Association Code of Practice requires insurance brokers to inform clients of the scope of services, and whether they are providing personal or general advice: Service Standard 4. Under the Code, if an insurance broker is providing personal advice, they are required to act in the clients’ best interests: Service Standard 5.
112 The expression used in the Insurance (Agents and Brokers) Act 1984 which has been superseded by the expression ‘deal’ borrowed from the language and practice of securities markets and funds management. The term ‘arrange’ is a sub set of ‘dealing’ under the Corporations Act, Ch 7. Most insurance brokers have an Australian Financial Services (AFS) license authority to do both. The concept of ‘arrange’ does not allow for the broker to bind its client, merely arrange for the client to agree or not itself whether to enter into the insurance. If the broker can effect the policy for its client it will have an authority to ‘issue’ under the Corporations Act, Ch 7.
113 For a recent example see Strategic Property Holdings No 3 Pty Ltd v Austbrokers RWA Pty Ltd (2012) 17 ANZ Insurance Cases 61-958; [2012] NSWSC 1570.
excess and an indication of the usual or likely terms that one or more insurers would agree to for such a risk. The insurance broker may be asked to promise the client that the insurance will have certain characteristics: this promise is called a warranty.

5.13. At the same time the insurance broker will make enquiries of the client with a view to providing the insurers with the material facts, taking into account the policyowner's obligations under the IC Act which imposes different duties of disclosure on policyowners in different circumstances, so that the insurers can decide whether to accept the risk and at what price and on what terms.

5.14. An insurance broker also has a heavy onus to make enquiries and to pass information to various parties in the course of placing a policy. As insurance markets become more complex and the need for speed is greater, insurance brokers are offering to perform services for parties whose interests may conflict – insurance brokers are providing more links in more chains of insurance transactions. Where an agent is acting for more than one party, then both as a matter of law and as a matter of commercial observation, it is more likely to be sued by someone when things go wrong.

5.15. The insurance broker will then seek the insurer's agreement to accept the client's business. If the insurance broker is successful in this, the insurer will enter into a contract with the insurance broker's client. This can be done in a variety of different ways depending on the type of business (retail client business or wholesale client business), the nature of the business (new business or renewal) and any special arrangement the insurance broker has in place with the insurer (in some cases acceptance by an insurer within pre-agreed terms on renewal may occur automatically if the client advises the insurance broker they wish to renew).

5.16. The law firmly takes the view that an insurance broker is the agent of the policyowner, certainly for the purposes of completing and lodging the proposal and negotiating the issue of a policy, unless the arrangement is different. It follows from this that misstatements made by the insurance broker without the knowledge or instructions of the policyowner will bind the latter, although such conduct will amount to a breach of duty owed to the policyowner.

**Insurer's agent**

5.17. An insurance agent is differentiated from an insurance broker and is the insurer's representative in relation to a contract of insurance. An insurer's agent is either 'tied' to the one insurer or is the agent of a number of insurers – a multi-agent.

5.18. An insurer may use agents (usually called an authorised representative), but can be called by a number of names, e.g. agent, distributor or intermediary, to market and sell insurance on its behalf. The agent is typically paid a commission or agreed fee for the products sold by the insurer.

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115 Kyles Transport Pty Ltd v Zurich Australian Insurance Ltd (1984) 3 ANZ Insurance Cases 60-600 (SC NSW) at 78,640.

116 Sutton, para. 5.40.

or on some other basis agreed with the insurer. The insurer is responsible for the agent's conduct when performed within their scope of authority and if they act outside their authority in some cases, due to the operation of the Corporations Act, Chapter 7.

Intermediary for policyowner and insurer

5.19. Traditionally and at common law, an insurance agent or intermediary was a broker acting as the agent for the policyowner or an agent acting for the insurer. The position was confused by two features. First, in some matters the intermediary had a role for both the policyowner and the insurer or various other functions for either the policyowner or the insurer. Second, sometimes a broker acted under a binding authority (binder) for the insurer. A binder is an agency arrangement between the insurer and the insurance broker which authorises the insurance broker to 'bind' the insurer and so to effect insurances for it. A binder allows the broker to enter into a policy on behalf of the insurer without prior approval from the insurer if it is within the scope of the binder authority set by the insurer. If it is outside the binder authority the broker must refer it to the insurer for approval. If the risk is approved and all other criteria met and the client wants to buy the policy, the broker can agree, on the insurer's behalf, to enter into cover with the customer without further reference to the insurer.

5.20. Under the Corporations Act, Chapter 7, a binder is an authorisation, given to a person by a financial services licensee who is an insurer, for the person to:
- enter into contracts that are risk insurance products on behalf of the insurer as insurer; or
- deal with and settle, on behalf of the insurer, claims against the insurer as insurer relating to risk insurance products.

5.21. A binder does not include authorisation that is limited to effecting contracts of insurance by way of interim cover only. The authorised representative under a binder acts for all purposes connected with insurance contracts or claims, on behalf of the insurer, but not the policyowner. Under the National Insurance Brokers Association Code of Practice, brokers are required to inform clients clearly if they are acting as agent of the insurer, including under a binder.

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118 Sutton, para. 5.50.
121 See, e.g. Markel International Insurance Co Ltd v Surety Guarantee Consultants Ltd [2009] Lloyd's Rep IR 77; [2008] EWHC 1135 (Comm); Callaghan v Thompson [1999] All ER (D) 1205, QBD.
123 s. 761A; compare the definition of a "binder" in s. 9 of the Insurance (Agents and Brokers) Act 1984 repealed; compare Europ Assistance Insurance Ltd v Temple Legal Protection Ltd [2008] Lloyd's Rep IR 216; [2007] EWHC 1785 (Comm).
124 Contracts that are "risk insurance products" (that is, contracts of insurance, both general and life, described in s. 764A(1)(d) and (e)).
125 Corporations Act, s. 916E(2); Markel International Insurance Co Ltd v Surety Guarantee Consultants Ltd [2009] Lloyd's Rep IR 77; [2008] EWHC 1135 (Comm); compare Callaghan (t/a Stage 3 Discotheque) v Thompson and Anderson Insurance Services Ltd [2000] Lloyd's Rep IR 125.
126 NIBA Insurance Brokers Code of Practice, Service Standard 3.
5.22. The repealed *Insurance (Agents and Brokers) Act 1984*\(^{127}\) generally insisted on a sharp distinction between the role of the policyowner’s broker and the insurer’s agent but it blurred this distinction for an insurance broker with a binder by assuming that there was no other type of agency between an intermediary and an insurer. The Act ignored the more conventional agency between an insurer and the insurer’s agent.

5.23. A broker is also treated by the Corporations Act, Chapter 7, as acting for the insurer in the payment process between the policyowner and the insurer. The Act has condoned the practice of allowing an insurance broker a considerable period of credit before the broker must account to the insurer for premiums paid to them, and in the meantime the insurance broker can invest the funds with any interest or investment income being for the insurance broker’s own benefit. Under the Corporations Act, Chapter 7, the risk of premiums being lost through the insurance broker’s insolvency or otherwise lies on the insurer, by stipulating that payment to an insurance broker of a premium should operate as a discharge of the policyowner’s debt to the insurer. Conversely, payment by an insurer to a broker on behalf of a policyowner of a refund of premium or in settlement of a claim does not operate to discharge the insurer’s liability to the policyowner until the policyowner actually receives the funds.\(^{128}\) Subject to these exceptions, the Corporations Act, Chapter 7, does not distinguish between a broker for the policyowner or an agent of the insurer; all must be the subject of the Corporations Act, Chapter 7, licensing regime.

### 6. Parties – insurance contract

#### Policyowner

6.1. A policyowner can be an individual, a sole trader, a business, a partnership or a company.\(^{129}\)

6.2. An insurance policy will normally name the policyowner as a party to the contract. A person other than the policyowner may be entitled to claim under an insurance policy if:

- a) the person is:
  - i. a party to the contract as an insured or policyowner or referred to by description in the policy and may be a single insured or a co-insured;
  - ii. named, specified or referred to by description in a policy as one who is entitled to benefit, or entitled to claim, under the policy;
- b) a named insured:
  - i. is the agent of the person;
  - ii. is a trustee of the person; or
  - iii. has transferred all, or some only, of the benefits under the policy to the person.\(^{130}\)

#### Third party beneficiary and rights

6.3. A third party beneficiary to a contract of general insurance has the right to recover from the insurer in accordance with the contract the amount of any loss suffered by the third party, even

\(^{127}\) The *Insurance (Agents and Brokers) Act 1984* was superseded by the *Financial Services Reform Act 2001* which came into force on 11 March 2001, although the repealing statute, the Corporations Act, s. 1436A, allowed for a transitional period of 2 years from that date, during which insurance intermediaries could continue to operate under the old regime; *Davis v CGU Insurance Ltd* (2009) 104 SASR 422; 15 ANZ Insurance Cases 61-812; [2009] SASC 220.

\(^{128}\) See Corporations Act, ss. 916E(2), 985B.

\(^{129}\) *Sutton*, paras. 11.20-11.120.

\(^{130}\) *Sutton*, para. 11.10.
though the third party is not a party to the contract. A third party beneficiary is a person who ‘is not a party to the contract but is specified or referred to in the contract, whether by name or otherwise, as a person to whom the insurance cover provided by the contract extends’. The person need not be named, if he or she is sufficiently described or referred to, to be identified.

The IC Act, section 20, emphasises that a claimant does not need to be referred to in the policy by name; an insurer's liability is not relieved by reason only that the name of a person who may benefit under an insurance contract is not specified in the policy document.

6.4. A number of other statutory provisions give a person, who is not a party to the insurance contract, rights against the insurer or in relation to insurance funds.

**Insurer**

**One insurer**

6.5. Often there will be only one insurer as a party to the insurance contract. It is common for an agent to issue the policy on behalf of the insurer, sometimes with all the appearance of the agent itself being the insurer.

6.6. The insurer might have one of a number of business forms: a corporation, a syndicate at Lloyd’s of London (Lloyd’s), a mutual or a captive.

6.7. The regulation of insurers either as insurance companies or as members of Lloyd's is described in Part Six of this Background Paper.

**More than one insurer**

6.8. It is also common in larger wholesale insurances for there to be more than one insurer as a party to any one contract of insurance. There may be a number of policies with different insurers. This can occur in one of two ways: as an excess layer insurer or as an insurer of a proportion of the risk.

6.9. In the first method, each insurer may be wholly liable to the policyowner for claims falling within a particular monetary range or layer and by taking these ‘layers’ together the policyowner will have an indemnity up to the required amount.

6.10. In the second method, each insurer may be liable for a proportion, usually expressed as a percentage, of the maximum amount of the indemnity under the policy. The relationship between

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131 s. 48(1) of the IC Act as amended by the Insurance Contracts Amendment Act 2013; s. 48 when originally enacted included contracts of life insurance but life insurance contracts were deleted from s. 48 and substantially re-enacted in a new provision, s. 48A, by the Life Insurance (Consequential Amendments and Repeals) Act 1995, s. 5(2) and Schedule, 43D with effect from 1 July 1995; Zurich Australian Insurance Ltd v Metals & Minerals Insurance Pty Ltd (2007) 209 FLR 247; [2007] WASC 62 (16 March 2007); ABN AMRO Bank NV v Bathurst Regional Council (2014) 309 ALR 445; 99 ACSR 336; [2014] FCAFC 65 at 1618-1638.

132 IC Act, s. 11(1).


134 ALRC, Report 20.117, 147 and 149. ‘Policy document’ is defined in the 1984 s. 11(1) as a document which is evidence of the contract; Barroora Pty Ltd v Provincial Insurance Ltd (1992) 26 NSWLR 170; 7 ANZ Insurance Cases 61-103; Quinlan v Safe International Forsakrings AB (2006) 14 ANZ Insurance Cases 61-693; [2005] FCA 1362 (FCA). In Pacific Dunlop Ltd v Maxitherm Boilers Pty Ltd (1997) 9 ANZ Insurance Cases 61-357 (SC Vic) at 76,952; revsd in part (1998) 10 ANZ Insurance Cases 61-393 it was suggested that s. 20 abrogated the necessity for a person benefiting under a contract of insurance to be expressly named in the policy.

135 IC Act, s. 51, Property Law Act 1969 (WA), s. 11, Corporations Act, ss. 562 and 601AG; Bankruptcy Act 1966, s. 117; Sutton, Ch 11.

136 Sutton, paras. 11.1010-11.1040.
two or more insurers gives rise to issues about the limits on the amount of cover and claims against the insurers.  

Assignment or delegation by insurer

6.11. An insurer cannot, at common law or in equity, assign its obligation to indemnify the policyowner. It is likely, as a matter of principle, (although there is no authority in point) that because the contract to indemnity is a personal one, the insurer as the provider of those personal services, cannot compel the policyowner to accept performance by an agent or delegate of the insurer. This can arise in a practical way if there is a pool of insurers promoted by an agent or broker and the intermediary controls and manages the pool; a typical problem is that there is a failure to distinguish between the several capacities in which each party may from time to time be called upon to act, with consequent confusion and doubt.

Statutory assignments

6.12. The Insurance Act 1973 for general insurance provides a scheme for statutory assignment by one insurer to another. The law and practice on portfolio transfers are beyond the scope of this Background Paper.

Reinsurer

6.13. The insurer will have a reinsurance contract with a reinsurer. The policyowner is not a party to the reinsurance contract and has no rights under it.

6.14. Reinsurance has been defined as the insurance of insurers. The concept of reinsurance plays an essential role in the insurance industry, is used in every class of insurance business and operates across national boundaries. The notion behind it is the desire of an insurer to lay off part of the risk undertaken, and reinsurance is a means whereby the original (or ‘direct’) insurer can spread that risk amongst other insurers both nationally and internationally, thereby reducing its own exposure and losses on business written. Reinsurance thus allows an insurer to expand its own portfolio of cover and also reduces the risk that the insurer will not be able to meet claims.

6.15. An agreement is made between the direct insurer (sometimes called the ‘ceding company’ or the ‘reinsured’) and the reinsurers whereby the former agrees to cede and the latter to accept a certain

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139 The Insurance Act 1973, s. 3(4), provides that: ‘A reference in this Act to a general insurer having no liabilities in respect of insurance business carried on by it in Australia includes a reference to a general insurer who has assigned, other than by an equitable assignment, all of its interests (including rights and benefits) under all contracts of insurance in respect of insurance business carried on by it in Australia to another general insurer.’
140 But see for example Re Sompo Japan Insurance Inc [2014] FCA 396 (8 April 2014).
141 Sutton, Ch 24.
142 Travellers Casualty & Surety Co of Europe Ltd v Commissioners of Customs and Excise [2006] Lloyd's Rep IR 63. It has also been defined as ‘insurance between consenting adults’: Reinsurance Practice and the Law, Clyde & Co, looseleaf. Other works are: Butler and Merkin's Reinsurance Law, looseleaf; Edelman, The Law of Reinsurance 2005; O'Neill and Wolonecki, The Law of Reinsurance 3rd ed., 2010. In Gater Assets Ltd v Nak Naftogaz Ukrainy [2008] EWHC 237; [2008] 1 Lloyd's Rep 479; [2008] 1 CLC 141 (Comm) a contract described as ‘reinsurance’ was found not to involve any element of transfer of risk whatsoever but merely operated as a device for overcoming a prohibition on a transfer of rights under a contract between the ‘insured’ and a third party. The only question was whether there had been a deliberate attempt to withhold the true nature of the transaction from arbitrators, an allegation which was dismissed on the facts.
143 See R v Insurance Commissioner; Ex parte Saltersgate Insurance Co Ltd (1976) 12 ACTR 1; 28 FLR 407 at 6-8.
share of the direct risk on the terms there set out. Reinsurers may reinsure their own liabilities, such contracts being referred to as retrocessions.\textsuperscript{146} A direct insurer may also be a reinsurer of the risks of other insurers while some companies transact nothing but reinsurance business (‘pure’ reinsurers).\textsuperscript{147}

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\textsuperscript{146} Farmers Mutual Insurance Ltd v QBE Insurance International Ltd, 7 ANZ Insurance Cases 78,069; [1993] 3 NZLR 305 at 308.
\textsuperscript{147} Sutton, para.24.10.
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PART SIX – REGULATION

This introduction to insurance regulation is discussed below under the following headings:

1. Introduction;
2. Prudential regulation;
3. Consumer protection regulation;
4. Self-regulation and the Code;

1. Introduction

Background

1.1. A practical and effective definition of regulation might be along the following lines:

Regulation is the system of laws, practices and controls which are made compulsory or practically necessary by governmental agency and which require the regulated entity to organise its affairs, both internally and externally, in relation to selected stakeholders, in accordance with those requirements.\(^{148}\)

1.2. It is clear that regulation is different from traditional law and practice. Traditional law and practice displays, for the purposes of the contrast with regulation, the following elements:

a) the relative freedom of individuals and entities in their conduct and to enter into contracts;
b) negative sanctions against civil wrongs through the characterisation and consequences of certain civil wrongs, like breach of contract or torts; and
c) statutory or legislative law – which tend to prohibit conduct.\(^{149}\)

1.3. Modern regulation is different from traditional law and practice. It has, for the purposes of the contrast with traditional law and practice, three distinguishing features. First, regulatory standards or rules tend to prescribe particular types of conduct. Second, the conduct prescribed tends to be positive rather than negative. Third, consequences and sanctions arise from regulatory standards or rules and can be civil and criminal.\(^ {150}\)

Types

1.4. There are four main types of regulation in the financial system: regulation to promote financial market integrity; competition regulation – mergers and anti-competitive conduct; prudential regulation; and consumer protection regulation. All of these types have the purpose of ensuring that financial promises are both understood and met. The first two are less directly relevant to insurance than the last two.\(^ {151}\)

1.5. Regulation, in the financial services sector, is generally thought of in a number of facets and each facet has recognised domains for the deployment of regulatory measures.

1.6. Prudential regulation has the following recognised domains: authorisation or licensing requirements – these are the rules which must be complied with for an entity to be authorised to carry on a particular type of business in the financial markets; approval of ownership or control;

\(^{148}\) Sutton, para. 4.10.

\(^{149}\) Sutton, para. 4.10.

\(^{150}\) Sutton, para. 4.10.

\(^{151}\) Sutton, para. 4.40.
restrictions on corporate or entity form; standards for board composition and governance; capital adequacy requirements including minimum capital requirements, minimum solvency ratios of defined assets in relation to liabilities, and risk based capital; supervision of other members of the corporate group in which the regulated entity is structured (group supervision); outsourcing; and risk management frameworks, standards and arrangements.\textsuperscript{152} Systemic risk, when financial distress in one market or institution is communicated to others and engulfs the system, is a heightened concern. The global financial crisis from 2007 raised regulatory and community awareness of financial services entities whose size, networks and position in the system mean that each could be, in itself, a focus for systemic risk: ‘too big to fail’ was the media label. Prudential regulation might therefore be described as giving security to customers.\textsuperscript{153}

1.7. Market conduct or consumer protection regulation applies usually only to retail products and customers, and has the following recognised domains. The first is selling: rules about advertising, marketing, advising on and selling financial products and product disclosure rules. The second is conduct of business rules: minimum terms in contracts between the regulated financial services entity and its customers (and sometimes suppliers). They include specialised requirements for customer relationships; information access, retention and disclosure – privacy, personal information and confidentiality; proper identification of the customer and arrangements to ensure that customers’ funding and money are lawful – compliance with anti-money laundering rules; and particular rules about the assessment of customer risk – including anti-discrimination matters.\textsuperscript{154} It might be described as giving clarity to customers.\textsuperscript{155}

1.8. Dispute resolution and investor compensation regulation has the following recognised domains. First, there are internal and external dispute resolution schemes intended to give customers accessible, low cost, informal and law-free resolution of a complaint or dispute with a financial services entity. Second, there are compensation schemes including: policyowner protection funds; specialist arrangements for insolvency in the event of the collapse of a financial services entity; and professional indemnity insurance for certain entities in the relevant markets.\textsuperscript{156}

1.9. The regulatory methods are applied with varying focus, style and approaches: principles based or rule based; legal principles and rules; actuarial principles and rules; consultation or surveillance and enforcement.

1.10. Enforcement regulation has the following recognised domains: the enforcement regime is buttressed by gatekeepers, their activities and reports. The gatekeepers include directors, officers and senior management, auditors, actuaries and, in a more commercial sense, reinsurers. Regulation requires the compulsory appointment of internal officers and external professionals with mandated qualifications to manage the entity's business and to advise it. There are also compulsory reporting, access and audit requirements in favour of the regulator.\textsuperscript{157}

1.11. All purposes, types and methods of regulation are now supported by regulator surveillance, monitoring and enforcement powers: all types of regulatory intervention. The consequences for a financial services entity of a breach of or failure to comply with regulation can be grave: being the subject of significant operational intervention by the regulator; requiring different types or

\textsuperscript{152} Sutton, para. 4.40.
\textsuperscript{153} Sutton, para. 4.40.
\textsuperscript{154} Sutton, para. 4.50.
\textsuperscript{155} Sutton, para. 4.50.
\textsuperscript{156} Sutton, para. 4.50.
\textsuperscript{157} Sutton, para. 4.50.
increased amounts of capital; ceasing operations altogether because of a revocation of its licence; and loss of reputation through serious regulatory breach.  

1.12. The history of the regulation of insurance in Australia alerts us to a number of features. First, regulation is driven by financial crises (Insurance Act 1973, Occidental, HIH, New Cap Re) or natural disasters (2010–2013 floods and fires). The major regulatory developments have been reactive to a financial crisis; the regulation has been mostly prudential with the purpose of securing systemic stability. Second, the major consumer protection developments have not been reactive, certainly not to financial crisis. There is anecdotal evidence that these consumer protection developments are a result of serial failures, actual or perceived, to meet customer expectations which culminate in a burst of regulatory activity through temporary alliances of consumer advocates, concerned regulators and communal value governments. Third, the greater the crisis or disaster, the more severe the community and political reaction, and the more penetrating and intrusive the regulation and surveillance. Fourth, international events (Enron) and regulatory bodies (Basel Committee and the IAIS) are becoming increasingly influential in Australia. Fifth, regulation is moving increasingly away from self-regulation to government based and controlled regulation. Sixth, the insurance sector, the insurers and their customers, are at a critical point in their shared history. The natural disasters have so scarred the consciousness of our country that in 2013 for the first time, an important part of our consumer protection regulatory framework was being driven by a crisis; not a financial crisis but a crisis of natural disasters. There is a separate Insurance Background Paper: Catastrophes and Natural Disasters. In the life insurance sector the crisis of disability claims is a similar challenge with potentially similar results. There is no prospect that we will ever be free of natural disasters or disability and no prospect of amelioration of natural disasters through mitigation in the near future such is the scale of work required for that purpose.

1.13. General insurers are regulated by Commonwealth, state and territory legislation (some specific to insurers and some of general application) and by:

- a) the prudential regulator – Australian Prudential Regulation Authority (APRA). APRA was established by the Australian Prudential Regulation Authority Act 1998 (APRA Act): sections 7 and 13. It is responsible, amongst other things, for the general administration of the Insurance Act 1973 subject to the Commonwealth Treasurer’s directions: Insurance Act 1973, section 8; and
- b) the corporate and financial services regulator – the Australian Securities and Investments Commission (ASIC). ASIC was established by the Australian Securities and Investments Commission Act 2001 (ASIC Act): section 8. It is responsible, amongst other things, for:
  - i. the general administration of the Insurance Contracts Act 1984 (IC Act) subject to the Commonwealth Treasurer’s directions: IC Act, section 11A;
  - ii. monitoring and promoting market integrity and consumer protection in relation to the Australian financial system: ASIC Act, section 12A(2); and
  - iii. the licensing and conduct of insurers, insurance intermediaries and others in relation to the provision of financial services: Corporations Act 2001 (Corporations Act), Chapter 7 and section 5B.

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158 Sutton, para. 4.50.
159 For a detailed account see Sutton, Ch 4, particularly paras. 4.440-4.460.
160 Sutton, para. 4.620.
161 For a detailed account see Sutton, Ch 4, particularly paras. 4.630-4.1020.
1.14. This Part also discusses the regulation of general insurers by other Commonwealth legislation and by self-regulation, as follows:
   b) Financial Sector (Collection of Data) Act 2001;
   c) Privacy Act 1988; and
   d) Self-regulation and the Code.

1.15. The IC Act regulates insurance contracts – see Part Seven of this Background Paper. Regulation of insurers by the Marine Insurance Act 1909 (MI Act 1909) and the Life Insurance Act 1995 is outside the scope of this Background Paper, as is the regulation of health insurers. State and territory legislation regulating insurers (for example, in their compulsory motor vehicle third party personal injury and workers’ compensation schemes) is not affected by the Insurance Act 1973 and is outside the scope of this Background Paper.

2. Prudential regulation

The Insurance Act 1973 and APRA

The Insurance Act 1973

2.1. The Insurance Act 1973 is concerned with regulating:
   a) insurers that carry on general insurance business; and
   b) entry to the market by those seeking to carry on general insurance business.

2.2. The main object of the Insurance Act 1973 is to protect policyowners and intending policyowners ‘under insurance policies (issued by general insurers and Lloyd’s underwriters) in ways that are consistent with the continued development of a viable, competitive and innovative insurance industry’: section 2A(1).

2.3. Protecting ‘insureds and intending insureds’ is a reference to ensuring that in all reasonably foreseeable circumstances, general insurers and Lloyd’s underwriters operating in Australia will have the financial resources (sufficient capital reserves and levels of solvency) to pay proper claims on their insurance contracts as and when they fall due for payment.

2.4. By section 2A(2), the Act and the prudential standards determined by APRA under the Act, set out to achieve their central objective, mainly by:
   a) restricting who can carry on insurance business in Australia by requiring general insurers, and the directors and senior management of general insurers, to meet certain suitability requirements;
   b) imposing primary responsibility for protecting the interests of policyowners on the directors and senior management of general insurers;
   c) imposing on general insurers requirements to promote prudent management of their insurance business;
   d) providing for the prudential supervision of general insurers by APRA;
   e) providing for judicial management of general insurers whose continuance may be threatened by unsatisfactory management or an unsatisfactory financial position, so as to protect the interests of policyowners and financial system stability in Australia; and

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162 Insurance Act 1973, ss. 99, 100; Palmdale AGCI Ltd v Workers’ Compensation Commission (NSW) [1977] HCA 69; (1977) 140 CLR 236.
163 The regulatory objective is that insurers be financially sound or solid. In Sweden, this notion is termed ‘solidetet’.
f) providing for APRA to pay valid claims on policies issued by certain general insurers that are under judicial management and that APRA believes are insolvent before they would receive payment in a winding up of the general insurers.

2.5. Only a body corporate, a Lloyd’s underwriter or a person with a determination by APRA under section 7(1) can carry on ‘insurance business’ in Australia: section 9.

2.6. Section 3(1) broadly defines ‘insurance business’ and specifically excludes from its ambit life, health and various other insurance business. Workers’ compensation and various other types of insurance business are excluded from the application of the Act: section 5(2)(c) and the Insurance Regulations 2002, regulation 6 and Schedule 2.

2.7. The phrase ‘carry on business’ would usually require ‘the doing of a [series, repetition or] succession of acts designed to advance some enterprise of the company pursued with a view to pecuniary gain’. Nevertheless, an insurer can ‘carry on insurance business’ without ‘a view to pecuniary gain’.

2.8. A body corporate can only carry on ‘insurance business’ in Australia if it is a general insurer or a person with a determination by APRA under section 7(1): section 10(1). A ‘general insurer’ includes a ‘foreign general insurer’ as defined in section 3(1).

2.9. A ‘general insurer’ is a body corporate authorised by APRA under section 12 to carry on insurance business: section 11.

2.10. Unless it has a determination by APRA under section 7(1), a Lloyd’s underwriter can only carry on insurance business in Australia for as long as section 93 has effect in relation to that underwriter: section 10(2).

2.11. The Financial Claims Scheme (FCS) set up by ‘Pt VC – Financial claims scheme for policyholders with Insolvent general insurers’ (section 62ZW) of the Insurance Act 1973 provides that if the relevant Minister makes a declaration about a general insurer that:

a) is under judicial management; and

b) APRA believes is insolvent, then,

i. certain persons who have claims on certain of that insurer’s policies are entitled to be paid certain amounts by APRA before they would receive payment in a winding up of the insurer (the policies covered by the Scheme are listed in Pt 4A of the Insurance Regulations 2002); and

ii. APRA is substituted for those persons as a creditor of the insurer to the extent of the entitlements.

2.12. Insurance policies held by medium and large businesses are covered by the FCS if the claim is under $5,000. In certain circumstances:

a) claims greater than $5,000 will be paid; and

b) a third party’s claim will be paid.

APRA

2.13. APRA is the prudential regulator. Amongst other things, it is responsible for the:

a) prudential regulation of entities that provide services for deposit taking, general insurance, life insurance and superannuation; and

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165 R v Holmes; Ex parte Manchester Unity Independent Order of Oddfellows in Victoria [1980] HCA 46; (1980) 147 CLR 65 at [18] (Mason J); R v Cohen; Ex parte Motor Accidents Insurance Board [1979] HCA 46; (1979) 141 CLR 577 at [24].
b) general administration of the *Insurance Act 1973* subject to the Commonwealth Treasurer’s

2.14. In performing and exercising its functions and powers, APRA is obliged ‘to balance the
objectives of financial safety and efficiency, competition, contestability and competitive neutrality
and, in balancing these objectives, is to promote financial system stability in Australia’: APRA
Act, section 8(2).

2.15. Under the *Insurance Act 1973*, APRA is responsible for granting or refusing applications for a
section 12 authorisation to carry on ‘insurance business’ in Australia and:
   a) can revoke a general insurer’s section 12 authorisation in the circumstances described in
      section 15; and
   b) must revoke a general insurer’s section 12 authorisation in the circumstances described in
      section 16.

2.16. APRA can determine prudential standards relating to prudential matters that some or all general
insurers or non-operating holding companies (NOHCs) or their subsidiaries must comply with:
sections 32 and 35 of the *Insurance Act 1973*. ‘Prudential matters’ are defined in section 3(1) as
matters relating to:
   a) the conduct by the insurer, NOHC or subsidiary of any of its affairs in such a way as:
      i. to keep itself in a sound financial position; or
      ii. not to cause or promote instability in the Australian financial system; or
   b) the conduct by the insurer, NOHC or subsidiary of any of its affairs with integrity, prudence
      and professional skill.

2.17. The following APRA-issued Prudential Standards govern general insurers (GPS are specific to
general insurers; CPS are common to all industry sectors):
   a) GPS 001: Definitions;
   b) GPS 110: Capital Adequacy;
   c) GPS 112: Capital Adequacy: Measurement of Capital;
   d) GPS 113: Capital Adequacy: Internal Model-based Method;
   e) GPS 114: Capital Adequacy: Investment Risk Capital Charge;
   f) GPS 115: Capital Adequacy: Insurance Risk Capital Charge;
   g) GPS 116: Capital Adequacy: Concentration Risk Capital Charge;
   h) GPS 120: Assets in Australia;
   i) GPS 220: Risk Management;
   j) CPS 232: Business Continuity Management;
   k) GPS 222.1: Risk Assessment and Business Continuity Management;
   l) GPS 230: Reinsurance Management;
   m) CPS 231: Outsourcing;
   n) GPS 310: Audit and Actuarial Reporting and Valuation;
   o) GPS 410: Transfer and Amalgamation of Insurance Business for General Insurers;
   p) CPS 510: Governance; and
   q) CPS 520: Fit and Proper.

2.18. Amongst other things, the standards require a Level 1 (individual) general insurer to maintain a
capital base in excess of its Minimum Capital Requirement. 166 In Prudential Practice Guide GPG
110 – Capital Adequacy: Capital Management, section 2, APRA describes ‘capital’ as:

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166 Prudential Standard GPS 110: Capital Adequacy.
... the cornerstone of an insurer’s financial strength. It supports an insurer’s operations by providing a buffer to absorb unanticipated losses from its activities and, in the event of problems, enables the insurer to continue to operate in a sound and viable manner while the problems are addressed or resolved.

2.19. By section 52(1) of the Insurance Act 1973, APRA has the power to investigate a general insurer or authorised NOHC where ‘information in its possession calls for the investigation of the whole or any part of the business of a general insurer or authorised NOHC’ or, more specifically, where it appears to APRA that:

a) a general insurer or authorised NOHC:
   i. is, or is likely to become, unable to meet its liabilities; or
   ii. has not complied with the requirements of the Insurance Act 1973 or the Financial Sector (Collection of Data) Act 2001; or

b) there is, or may be:
   i. a risk to the security of a general insurer’s or authorised NOHC’s assets; or
   ii. a sudden deterioration in a general insurer’s or authorised NOHC’s financial condition.

2.20. APRA also has the power to apply to the Federal Court for an order that a general insurer be placed under judicial management: section 62K. Amongst other things, a general insurer under judicial management cannot issue insurance policies without the leave of the Federal Court: section 62T(2). A judicial manager is subject to the control of the Federal Court: section 62X.


2.21. The Financial Sector (Shareholdings) Act 1998 requires ministerial approval for a proposal to hold a 15 per cent or more stake in an insurer: section 13.

2.22. The Insurance Acquisitions and Takeovers Act 1991 requires ministerial approval for a proposal to:

a) acquire 15 per cent or more of an insurer’s assets: section 36; or

b) link an entity controlling an interest in an insurer of 15 per cent or more with a director of that insurer: section 50.

3. Consumer protection regulation

The Corporations Act, Chapter 7

3.1. Chapter 7 of the Corporations Act regulates financial services and markets. Its main object (section 760A) is to promote:

a) confident and informed decision making by consumers of financial products and services while facilitating efficiency, flexibility and innovation in the provision of those products and services; and

b) fairness, honesty and professionalism by those who provide financial services; and

c) fair, orderly and transparent markets for financial products\(^\text{167}\) and

\(^\text{167}\) In Transmarket Trading Pty Ltd v Sydney Futures Exchange Ltd [2010] FCA 534, Perram J said (at [95]) that ‘the notion of a fair, orderly and transparent market … [has] at least two concepts at its core. One relates to a state of affairs in which all market participants are placed in an equal position such that there is a level playing field. The second, which is encompassed by the word ‘orderly’, is the notion of reliable market operations displaying price continuity and depth and in which unreasonable price variations between sales are avoided. I do not think that the pursuit of orderly markets carries with it the eradication of volatile or unpredictable markets’. 
d) the reduction of systemic risk and the provision of fair and effective services by clearing and settlement facilities.

3.2. A detailed analysis of the Corporations Act, and Chapter 7 in particular, is outside the scope of this Background Paper.

3.3. In broad terms, a general insurer that provides financial services to ‘retail clients’ must hold an Australian Financial Services Licence (AFSL) and must conduct itself and provide product and advice disclosure as required by Chapter 7. Not all of the obligations imposed by Chapter 7 on an AFSL holder are directly linked to the services it provides to ‘retail clients’.

3.4. Amongst other things, Chapter 7 imposes pre-contractual disclosure obligations on a general insurer in its dealings with retail clients. These are discussed in Part Five of this Background Paper.

3.5. The concepts of ‘financial services’, ‘financial product advice’, ‘retail clients’ and ‘wholesale clients’ are central features of Chapter 7. Each of these concepts is discussed below.

3.6. A person provides a ‘financial service’ if, for example, they:
   a) provide ‘financial product’ advice: sections 761A (Definition section) and 766A(1)(a); or
   b) deal in a ‘financial product’: sections 761A (Definition section) and 766A(1)(b).

3.7. A ‘financial product’ includes the general and other insurance contracts described by section 764A(1)(d), (e) and (f) (general insurance product). It does not include the insurance products listed in section 765A(1)(c)–(g), such as reinsurance, health insurance, insurance provided by the Commonwealth, a state or territory, or other insurance described in the Regulations, such as workers’ compensation insurance: regulation 7.6.01(1)(p).

3.8. Section 764A(1A) and (1B) describes the application of section 764A(1)(d) to circumstances in which a general insurance product ‘provides 2 or more kinds of cover’ or ‘provides a kind of cover in relation to 2 or more kinds of asset’.

3.9. A general insurance product includes a contract that:
   a) … would ordinarily be regarded as a contract of insurance even if some of its provisions are not by way of insurance; and
   b) … includes provisions of insurance in so far as those provisions are concerned, even if the contract would not ordinarily be regarded as a contract of insurance.

3.10. ‘Financial product advice’ is defined in section 766B(1) as ‘a recommendation or a statement of opinion, or a report of either of those things’ that is intended to influence, or could reasonably be regarded as being intended to influence, a person in making a decision in relation to a type of financial product.

3.11. ‘Financial product advice’ does not include:
   a) the communication of objectively ascertainable information (information that is not reasonably open to question), unless it is expressed in a way that suggests or implies a recommendation or statement of opinion;
   b) the provision of an exempt document or statement as defined in section 766B(9): section 766B(1A) (if the document or statement contains personal advice relating to a financial product it is probably not exempt); or
   c) the kind of ‘insurance’ advice described in section 766B(6) and (7), such as the inquired-about cost or likely cost of an insurance product.

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168 A person deals in a financial product, amongst other things, if they issue a financial product, whether as principal or agent: s. 766C(1)(b). ‘Issue’ includes ‘circulate, distribute and disseminate’: s. 9.
169 s. 764A(2), an echo of IC Act, s. 10.
3.12.’Financial product advice’ is either ‘personal’ or ‘general’. It is:

a) ‘personal’ if it is given or directed to a person in circumstances where (section 766B(3));
   i. the insurer ‘has considered one or more of the person’s objectives, financial situation and needs’; or
   ii. a reasonable person might expect the insurer to have considered one or more of those matters;

b) ‘general’ if it is not ‘personal advice’: section 766B(4).

3.13.If a general insurer gives ‘personal advice’ to a ‘retail client’, the insurer ‘must act in in the best interests of the client in relation to the advice’: section 961B(1).

3.14.A ‘retail client’ (section 761G(5)) loosely approximates a ‘consumer’ as defined by the ASIC Act and the Competition and Consumer Act 2010 (CCA). A person is a ‘retail client’ in relation to the provision of a financial product or service that relates to a general insurance product only if:

a) the person is an individual or the product is or would be used in connection with a small business171; and

b) the product is a motor vehicle, home building or contents, sickness and accident, consumer credit, travel, personal and domestic property or medical indemnity insurance (added by regulation 7.1.17A) or another kind of general insurance product prescribed by the Regulations: section 761G(5)(b).

3.15.If a client is not a ‘retail client’ it is a ‘wholesale client’: section 761G(4). An underlying theme of Chapter 7 is that ‘wholesale clients’ do not need the same protection as ‘retail clients’.

3.16.Set out below is a brief discussion of the following aspects of Chapter 7:

a) Part 7.6, which requires a general insurer that provides financial services to ‘retail clients’ to hold an AFSL;

b) Part 7.6 Division 3, which imposes obligations on an AFSL holder;

c) Part 7.8, which regulates an AFSL holder’s conduct in relation to financial services other than disclosure;

d) Part 7.10, which prohibits market misconduct in relation to financial services; and

e) Part 7.9 Division 5, which gives a retail client a 14-day cooling-off period after purchasing a financial product.

**Part 7.6: The licensing of providers of financial services**

3.17.Unless exempt, a person who carries on a ‘financial services’ business in ‘this jurisdiction’172 must hold an AFSL covering the provision of the ‘financial services’: section 911A(1). To do so without an AFSL is an offence: section 1311(1).

3.18.A person is exempt from the requirement to hold an AFSL in the circumstances described in section 911A(2), including where that person is:

a) regulated by APRA and its services are regulated by APRA and are only provided to ‘wholesale clients’: section 911A(2)(g);

b) a representative of a person who either has an AFSL or is exempt from the requirement to hold one: section 911B(1); or

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171 A ‘small business’ is a business that employs less than 20 people, or in the case of a business that is or includes the manufacture of goods, 100 people: s. 761G(12).

172 For the purposes of Ch 7 (other than Pts 7.2, 7.5 and 7.11), ‘this jurisdiction’ means the Commonwealth of Australia and the territories of Christmas Island and of Cocos (Keeling) Islands for the purpose of superannuation and RSA (retirement savings account) products and the financial services that relate to them. Otherwise, it only means the Commonwealth of Australia. See ss. 5, 9 and r. 1.0.22 of the Corporation Regulations 2001.
c) appointed by a general insurer to distribute their ‘general insurance products’. 173

3.19. It follows that a general insurer that provides financial services to ‘retail clients’ must hold an AFSL.

3.20. A person does not have to hold an AFSL if they are simply:
   a) advising on the handling or settlement of insurance claims: Corporations Regulations 2002, regulation 7.1.33(1) and (2); or
   b) providing referrals, in particular informing other people that the holder of an AFSL or their representative can give a particular financial service or telling other people how to contact them: Corporations Regulations 2002, regulation 7.6.01(1)(e) and (ea).

**Part 7.6 Division 3: The obligations of an AFSL holder**

3.21. A general insurer that is the holder of an AFSL is obliged to:
   a) do everything necessary to ensure that it provides financial services efficiently, honestly and fairly: section 912A(1)(a);
   b) have adequate arrangements in place for managing conflicts of interest: section 912A(1)(aa);
   c) comply with the conditions of its licence: section 912A(1)(b);
   d) comply with the financial services laws: section 912A(1)(c)174;
   e) take reasonable steps to ensure that its representatives comply with the financial services laws: section 912A(1)(ca);
   f) maintain the competence to provide the financial services: section 912A(1)(e);
   g) ensure that its representatives are properly trained and competent to provide the financial services: section 912A(1)(f); and
   h) have a dispute resolution system for services provided to retail clients: section 912A(1)(g).

3.22. Unlike other holders of an AFSL, a general insurer, because it is regulated by APRA, is not required by Chapter 7 to have adequate:
   a) resources to provide the financial services and carry out supervisory arrangements: section 912A(1)(d); or
   b) risk management systems: section 912A(1)(h).

3.23. Nor is a general insurer required to have professional indemnity insurance (regulation 7.6.02AAA(3)(i)) as protection against any liability it may have for loss or damage suffered by retail clients as a result of breaches of the Chapter-7-imposed obligations: see section 912B and regulations 7.6.02AA and 7.6.02AAA.

**Part 7.8: Provisions relating to conduct connected with financial products and services, other than financial product disclosure**

3.24. Part 7.8 Divisions 2 and 3 relate to dealings by an AFSL holder who is not an insurer with client’s money and client’s property respectively. Division 4 is headed ‘Special provisions relating to insurance’. It deals with the following issues:
   a) the status of amounts paid to an AFSL holder in respect of an insurance contract: section 985B;

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173 A general insurer can appoint an agent to distribute its general insurance products without appointing the agent as an authorised representative: ASIC Class Order 05/1070. The general insurer will be responsible for the acts of the distributors it appoints.

174 The ‘financial services laws’ are the other provisions of the Corporations Act and the ASIC Act ‘which regulate the conduct of providers of financial services businesses’: *Sovereign Capital Ltd and Australian Securities and Investments Commission* [2008] AATA 901 at [14].
b) the requirements that an AFSL holder must comply with in relation to the money situations described in section 985C(2); and
c) the requirement that an AFSL holder or an authorised representative of an AFSL holder not deal in a general insurance product in the circumstances described in section 985D.

3.25. Division 7 is headed ‘Other rules of conduct’. It prohibits an AFSL holder from:

a) engaging in conduct in relation to the provision of a financial service ‘that is, in all the circumstances, unconscionable’: section 991A. A person who suffers loss or damage because an AFSL holder engages in unconscionable conduct ‘may recover the amount of the loss or damage’ from the holder. There is a six-year limitation period; and
b) offering to issue or sell to a retail client, or inviting a retail client to apply for or offer to buy, a financial product ‘in the course of, or because of (section 992A(3), (3A) and (5)):
   i. an unsolicited telephone call to another person; or
   ii. an unsolicited contact with another person in another way that is prescribed by the regulations for the purposes of this paragraph …’ except in the circumstances described in section 992A(3)(a)–(e) (which includes the client being given a Product Disclosure Statement before becoming bound to buy a financial product). A failure to comply with section 992A(3) gives the client a limited amount of time to return the product and obtain a refund: section 992A(5).

3.26. ASIC can exempt a financial product from the provisions of section 992A(1) or (3).

Part 7.10: Market misconduct and other prohibited conduct relating to financial products and financial services

3.27. Division 2 prohibits a person from:

a) making a materially misleading statement or disseminating misleading information that is likely to induce someone to apply for a financial product if they do not care whether the statement or information is true or they know, or ought reasonably to have known, that the statement or information was materially misleading: section 1041E (to do so is an offence);
b) engaging ‘in dishonest conduct in relation to a financial product or financial service … in the course of carrying on a financial services business in this jurisdiction’: section 1041G. To do so is an offence; and
c) engaging in misleading or deceptive conduct in this jurisdiction ‘in relation to a financial product or a financial service’: section 1041H. It is not an offence to do so.

3.28. A contravention of section 1041E, 1041G or 1041H may give rise to civil liability under section 1041I to anyone who suffers loss or damage by the contravention. In the case of section 1041H, Division 4 might provide relief against the liability. There is a six-year limitation period for commencing such an action.

3.29. Division 2A sets out the circumstances of proportionate liability for a contravention of section 1041H.

Part 7.9 Division 5: Cooling-off period

3.30. A client has the right to return a risk insurance product (in broad terms, a general insurance contract as defined by sections 761A and 764A(1)(d)) to a general insurer and to have their money returned if, within the 14-day period described in section 1019A, they comply with the requirements of that section.

The Australian Securities and Investments Commission Act 2001
3.31. Part 2 of the ASIC Act deals with ‘consumer protection in relation to financial services’ in the following Subdivisions:
   a) C: Unconscionable conduct;
   b) D: Consumer protection;
   c) E: Conditions and warranties in consumer transactions;
   d) G: Enforcement and remedies; and
   e) GA: Proportionate liability for misleading and deceptive conduct.

3.32. Subdivision BA Unfair contract terms does not apply to insurance contracts subject to the IC Act.

3.33. The ‘consumer protection’ provisions of the CCA (Pt XI Division 2 and Schedule 2) do not apply to financial services (CCA, section 131A) because they are dealt with by the ASIC Act.

4. Self-regulation and the Code

Background

4.1. The Banking Industry Ombudsman scheme was initiated in 1989 and its Code of Practice, (recommended by the Martin Committee in 1991), was released in 1993.

4.2. The insurance industry established its ombudsman scheme, the descriptively named General Insurance Enquiries and Complaints Scheme (IEC) and the Life Insurance Complaints Service, both in 1991. The Superannuation Complaints Tribunal commenced in 1994. The original life insurance Code of Practice was launched in 1995 – the same year as the Life Insurance Act 1995.

4.3. The first General Insurance Code of Practice (the Code) came into effect in 1994. It was one of the first codes. The Code was developed by the Insurance Council of Australia (ICA) and aimed to raise the standards of practice and service in the insurance industry. It was developed in anticipation that the Insurance Act 1973 would be amended to require each authorised insurer to adopt the Code approved by the Insurance and Superannuation Commission (the precursor to the Australian Prudential Regulation Authority).

4.4. The emphasis in the 1994 Code was on policy documentation, the work of agents and employees, claims handling, dispute resolution and sanctions. The insurers and their agents should make information about the Code and its operation available for customers. The ICA – with the assistance of the IEC – was responsible for the continuing development of the Code. The Code covered retail business and other business determined by the individual insurer. The Code is a part of the regulatory framework for general insurance. The Code has always been voluntary.

4.5. The period 1989 to 1995 had seen the advent of codes and ombudsman schemes for the insurance industry as a whole. The Wallis Inquiry, a year later, considered the role of codes: ‘a regime of co-regulation where statutory provisions provide the enforcement and broad principles for regulation, but the details are left to more flexible industry-based Codes and dispute resolution arrangements’. It also considered amending the provisions in existing laws to ‘make penalties proportionate to losses incurred through Code breaches’.

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175 See for a more detailed analysis, Sutton, paras. 4.1040-4.1260
176 Sutton, paras. 4.1180.
177 The Code of Banking Practice was released in 1993.
178 First page.
179 s. 1.8.
180 s. 1.6.1.
181 Definition of ‘insurance business’.
Principles

4.6. There are principles for a code self-regulation framework and principles for code content.

4.7. The code framework principles are:

a) The regulated entity community adopts voluntarily a code of practice that contains standards for the conduct of their businesses with the community and retail customers. The adoption of the code by a regulated entity should be through a contract directly with the code governance body.

b) The code governance body should be well credentialed and expert and have a sufficiently balanced representation of stakeholder interests and independent representation to give authority to its work and decisions. It should have the information and resources necessary to do its work. The governance framework, its process and conduct should be visible and accountable.

c) All stakeholders should participate in the development of the standards in the code and its governance. The regulated entities should have an influential but not decisive involvement in the development of the standards in the code and its governance. The views of the regulated entities should be given weight as a factor in these aspects. The code governance body should have ultimate responsibility for the development and setting of the standards.

d) The regulated entities should fund and resource the self-regulation model to a level necessary for it to work effectively.

e) The self-regulation model should be properly integrated into the overall regulatory framework; it should dovetail with the law and government agency regulation.

f) The best place for a code to work is to link legislation to market practice. Its standards link the law that affects the customer's relationship with the regulated entity and endorses, enhances and improves the industry's best practice.

g) The framework and code should enhance stakeholder trust and confidence in each other and enhance the esteem of each individual involved in it.

4.8. The code content principles, based on the account and analysis above, are:

a) The code content should address all stakeholder relevant issues.

b) The code should be adequately promoted.

c) The code objectives and scope should be clear. The standards should cover the full range and all relevant phases of the regulated entity's interactions with its customers.

d) The standards in the code should promote good business practices, set a high standard of service and have legal minimums. The standards should be supported by education and training. The standards should contribute to the regulated entity's risk management.

e) The standards in the code should contain ethical statements, principles, rules and guidelines. The standards should be enforceable.

184 Sutton, paras. 4.1190.
185 Compare ASIC RG 183.18, 22(c), 28–30 and 37.
186 Compare ASIC RG 183.66.
187 ASIC RG 183.13(c); ASIC RG 183.15; 27; ASIC 183.73–RG 183.75.
189 See also ASIC RG 183.17, 18, 22(b), (c), 28–30, 37 and 62–66.
192 ASIC RG 183.44(b) and 56.
193 ASIC RG 183.13 and ASIC RG 183.23, 56(c) and 59.
f) The code should be in plain language and accessible.\(^{197}\)

g) The standards which are rules should be expressed as rules which are measurable and can clearly be complied with or breached to enable the regulated entity to assess what conduct is needed to comply with the standard.\(^{198}\)

h) Compliance with the code should be monitored, audited and enforced by the code governance body.\(^{199}\)

i. The consequences for the breach or non-compliance with a standard, the remedies and sanctions, should have regard to the principles of procedural fairness\(^{200}\) and be:

a) sufficient to deter breach or non-compliance and consistent with the code objectives\(^{201}\); and

b) clear, fair and reasonable in order to promote the spirit and effect of the code.\(^{202}\)

i) A customer should have the right to complain about a regulated entity's conduct under the code and be informed about that right.\(^{203}\)

j) A customer should have the right to refer a dispute about a regulated entity's conduct under the code to an external dispute resolution scheme and be informed about that right.\(^{204}\)

k) The code standards and its operation should be reviewed periodically by the code governance body and reviewed from time to time by an independent reviewer.\(^{205}\)

5. The 2014 Code

**Code standards**

5.1. The Code is a self-regulatory code that binds all general insurers who are signatories to it.

5.2. The Code covers all general insurance (not reinsurance) products except workers’ compensation, marine insurance, medical indemnity insurance and compulsory third party insurance: para 3.5.

5.3. It does not apply to life and health insurance products issued by life or registered health insurers: para 3.6.

5.4. The Code is voluntary. By adopting the Code, an insurer:

a) enters into a contract with the ICA to abide by the Code: para 1.5. Accordingly, contractual remedies are available for a breach of the Code or non-compliance with a sanction imposed for breach of the Code;

b) commits to upholding minimum standards when providing services covered by the Code: para 1.1;

c) acknowledges that its customers and its relationships with them are the foundations of the insurer’s business: para 1.2; and

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\(^{195}\) Compare ASIC RG 183.18, 22(c), 28–30, 37, 56(c) and 59.

\(^{196}\) ASIC RG 183.13–15; ASIC RG 183.56; see also ASIC RG 183.17, 22(a), (e), 24, 25, 39, 40 and 44(c).

\(^{197}\) ASIC RG 183.99 and ASIC RG 183.44(b) and 56; Hockey Hon J, MP, *Taskforce on Industry Self-Regulation – Final Report* (2000), Executive Summary, para 19 and p 65, Ch 7.

\(^{198}\) See also ASIC RG 183.17, 22(a), (d), (e), 24, 25, 31, 39, 40, 44(c) and (d), 56(c) and 59.

\(^{199}\) ASIC RG 183.13(c); ASIC RG 183.15; ASIC RG 183.69–71; ASIC RG 183.76–RG 183.78.

\(^{200}\) ASIC RG 183.69.

\(^{201}\) See also ASIC RG 183.17, 22(a), (d), (e), 24, 25, 31, 39, 40 and 44(c) and (d); Hockey Hon J, MP, *Taskforce on Industry Self-Regulation – Final Report* (2000), Executive Summary, para 20 and p 66; paras 25–28 and pp 71–77.

\(^{202}\) See also ASIC RG 183.13(c), 15, 17, 22(a), (d), (e), 24, 25, 31, 39, 40 and 44(c) and (d); ASIC RG 183.67–RG 183.72.


\(^{205}\) ASIC RG 183.8, 44(e) and 79–81; Hockey Hon J, MP, *Taskforce on Industry Self-Regulation – Final Report* (2000), Executive Summary, para 29 and p 78.
d) agrees to be open, fair and honest in its dealings with its policyowners and third party beneficiaries: para 1.3.

5.5. The objectives of the Code (para 2.1) are to:

a) commit insurers to high standards of service;

b) promote better, more informed relations between insurers and policyowners and third party beneficiaries;

c) maintain and promote trust and confidence in the general insurance industry;

d) provide fair and effective mechanisms for the resolution of complaints and disputes between insurers and policyowners and third party beneficiaries; and

e) promote continuous improvement of the general insurance industry through education and training.

5.6. The Code requires an insurer that has adopted it to:

a) conduct the process of selling insurance efficiently, honestly, fairly and transparently: para 4.4\textsuperscript{206};

b) provide its employees and authorised representatives ‘with, or require them to receive, appropriate education and training to provide their services competently and to deal with [the policyowner and third party beneficiaries] professionally …’: para 5.1;

c) ensure that its service suppliers provide their services in an honest, efficient, fair and transparent manner: para 6.2;

d) handle claims in an honest, fair, transparent and timely manner (paras 7.2) and in accordance with the timetable set out in paras 7.3–7.18 and 7.21 and 7.22;

e) respond to an event the ICA declares to be a catastrophe ‘in an efficient, professional and practical way, and in a compassionate manner’: para 9.2. A ‘catastrophe’ includes a fire, flood or earthquake which results in a large number of claims involving a number of insurers; and

f) handle complaints about its products or services (including its complaints handling service) in a fair, transparent and timely manner: para 10.4.

5.7. If an insurer denies an insurance claim, it must give written reasons for its decision and inform the person claiming of their right to have the decision reviewed by one of the insurer’s employees (other than the person that made the original decision to deny the claim), in accordance with the insurer’s internal complaints process: para 10.13. If the person claiming is unhappy with the outcome of the review, they can take their complaint to the Financial Ombudsman Service (FOS) within a certain timeframe and subject to the FOS having jurisdiction to deal with the complaint.

5.8. The Code Governance Committee (CGC) is an ‘independent body responsible for monitoring and enforcing compliance with [the] Code’: paras 12.1, 12.3 and 13.7.

5.9. An insurer that has adopted the Code is obliged to report a significant breach to the CGC within 10 days of becoming aware of the breach: para 13.3.

5.10. FOS may report possible Code breaches to the CGC: para 13.17.

5.11. If an insurer breaches the Code, the CGC can, pursuant to para 13.15:

a) require the insurer to take particular steps to rectify the breach within a specified period of time;

b) require the insurer to undertake a compliance audit;

c) require the insurer to undertake corrective advertising; and

d) arrange publication of the insurer’s non-compliance.

\textsuperscript{206} The Code also refers to the utmost good faith duty: s. 2.2.
5.12. Insurers stand or fall on their reputation, so publication of an insurer’s noncompliance is a strong deterrent. The Australian Productivity Commission Submission to the Hockey Taskforce on Industry Self-Regulation in Consumer Markets in 2000 said, ‘public shaming is like being “dumped into custard — it is a soft landing, but it sticks”’.

5.13. The Code, like other ASIC-approved codes, does not include amongst its sanctions financial penalties. Financial penalties would only deter if the amounts of the penalties were significant. And if that were the case, the Code would need to ensure natural justice for those facing penalties.

5.14. A court may have regard to the Code in determining whether a supplier’s conduct is unconscionable: section 12CC(1)(h) and (3) of the ASIC Act and section 51ACA(1) of the CCA.

5.15. The prohibition on a corporation in trade or commerce contravening an applicable industry code is limited to a prescribed code: CCA, sections 51ACA(1), 51AB and 51AE. The General Insurance Code of Practice is not a prescribed or declared code.

**ASIC approval**

5.16. A code may be submitted to ASIC for approval in accordance with section 1101A of the Corporations Act and ASIC Regulatory Guide 183: *Approval of financial services sector codes of conduct* (ASIC RG 183). ASIC has power under the Corporations Act to approve a code. ASIC Regulatory Guide 183 is a guideline for the process and its minimum content. However, ASIC approval has no statutory or regulatory effect beyond the ASIC Act. ASIC approval of a Code seems to have two effects, namely, it will be a signal to consumers that it is a code they can have confidence in. An approved code would also respond to identified and emerging consumer issues and would deliver substantial benefits to consumers and heighten the possibility of misrepresentations about the nature of the code and any approval. The legal effect of a code in itself is a complex question.

5.17. ASIC’s code approval power is limited to entities that are regulated by ASIC. Relevantly for the Code, these entities include AFSL holders. However, ASIC is prepared to consider the approval of a code that covers bodies which it does not regulate. This raises the question about general insurers who are not AFSL holders for any reason including because they are wholesale only or carrying on business offshore. ASIC encourages codes to extend beyond retail clients where appropriate.

5.18. Codes of Practice occupy a fragile place in the matrix of insurance regulation. The prohibition on a corporation in trade or commerce contravening an applicable industry code is limited to a code that is prescribed. The ASIC Act provides that a Court may have regard to an applicable industry code in determining whether the conduct of a financial services supplier is unconscionable. The reference includes both mandatory and voluntary codes, but only if they are in the Regulations. The reference also includes any industry code but only if the service

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207 *Sutton*, para. 4.1220.
208 See also ss. 761E and 761G, 1017G, 912A and 916B.
209 s. 1101A, ASIC RG183.
210 ASIC RG, para. 183.6.
211 ASIC RG, paras. 183.107, 108.
212 *Sutton*, para. 4.1260.
213 Corporations Act, s. 1101A; ASIC RG 183.10.
214 Corporations Act, s. 1101A; ASIC RG 183.10.
215 ASIC RG 183, para. 183.20; compare para 183.42.
216 ASIC RG 183, paras. 183.18, 183.56–61.
217 *Australian Competition and Consumer Act 2010*, Part IVB, s. 51ACA(1) and 51AE.
218 s. 12CC(1)(g) and (3).
219 s. 12CC(1) (3); *Australian Competition and Consumer Act 2010*, s. 51ACA(1).
recipient acted on the reasonable belief that the supplier would comply with that code. On this basis the Code is a benchmark for unconscionable conduct.

220 s. 12CC(1)(h) and (3).
PART SEVEN – INTRODUCTION TO THE INSURANCE CONTRACTS ACT 1984

This introduction to the Insurance Contracts Act 1984 (IC Act) is discussed below under the following headings:

1. Background;
2. Application of the IC Act: Sections 8 and 9;
3. IC Act, section 9A;
4. Extended application of the IC Act: Section 10;
5. Limited relief elsewhere: Section 15;
6. Overview of the IC Act;
7. Balancing the interests of insurer and policyowner.

1. Background

1.1. In the eighteenth and nineteenth centuries (insurance’s formative legal years), Britannia ruled the waves, the Industrial Revolution unfolded, and the prevailing economic philosophy was free market and laissez faire. Insurance fitted neatly into the picture as an important encouragement to business to create, invent and innovate without fear of some of the insurable risks of business. Against this backdrop, legislators sought to protect the insurance market, and the judiciary allowed insurers to allocate risk in their insurance contracts as they pleased.

1.2. The shift in political and economic focus in the last 30 years or so — from business promotion to consumer protection — is reflected by the IC Act, the world’s first comprehensive consumer-oriented insurance contract legislation.

1.3. The IC Act came into effect on 1 January 1986. It was enacted pursuant to the Commonwealth Government’s power under section 51(xiv) of the Australian Constitution to make laws with respect to ‘insurance, other than State insurance; also State insurance extending beyond the limits of the State concerned’.

1.4. The limit on the Commonwealth’s power to legislate for state insurance explains why section 9(2) of the IC Act excludes from the IC Act’s application: ‘… contracts and proposed contracts of insurance entered into, or proposed to be entered into, in the course of State insurance or Northern Territory insurance …’

1.5. Although the IC Act does not extend to state insurance, some state insurers expressly make their insurance arrangements subject to the IC Act. For example, in New South Wales, state insurance is made subject to the IC Act by section 5(1) of the Insurance (Application of Laws) Act 1986.

1.6. The IC Act is almost identical to the Bill recommended by the Australian Law Reform Commission in its Report No 20, Insurance Contracts (1982). As explained in its Long Title, the IC Act was enacted to:

... reform and modernise the law relating to certain contracts of insurance so that a fair balance is struck between the interests of insurers, insureds and other members of the public and so that the provisions included in such contracts, and the practices of insurers in relation to such contracts operate fairly ...

221 Articulated by Adam Smith in the Wealth of Nations (published 1776) and other writings.
222 See, for example, the preamble to 43 Eliz c 12 enacted in 1601.
1.7. The IC Act is not a complete code of insurance contract law. It does not:

'affect the operation of any other law of the Commonwealth, the operation of law of a
state or territory or the operation of any principle or rule of the common law
(including the law merchant) or of equity', except to the extent that it does so
'expressly or by necessary intendment': section 7.

1.8. The IC Act is expressly a code in respect of:

a) insurers’ remedies for policyowners’ precontractual non-disclosure and misrepresentations: section 33;
b) acts or omissions the subject of section 54: section 55;
c) the circumstances in which insurers can cancel general insurance contracts: section 63(1).

1.9. As it is not a complete code, any aspect of insurance law not covered by the IC Act ‘expressly or
by necessary intendment’ is to be found in other Commonwealth legislation and in:

a) state or territory legislation; and
b) the common law of Australia.

1.10. The parties to an insurance contract cannot contract out of the IC Act where this would prejudice
someone other than the insurer: section 52.

2. Application of the IC Act: Sections 8 and 9

2.1. Subject to section 9, the IC Act applies to:

contracts of insurance ... the proper law of which is or would be the law of [an
Australian] State or ... Territory ...: section 8(1).

2.2. The ‘proper law’ of a contract is the legal system with which the contract has its closest and most
real connection. In determining the proper law of an insurance contract, the court will:

a) consider a number of factors, including ‘the places of residence or business of the parties, the
place of contracting, the place of performance, and the nature and subject matter of the
contract [including the location of the risk]’, and
b) ignore an express provision in the contract nominating the law of another country as the law
of the contract: section 8(2).

2.3. Section 8(2) is intended to prevent the parties to an insurance contract, the proper law of which is
Australian law, avoiding the application of the IC Act by selecting a foreign law or the law of a
territory in which it does not apply, that is, by way of a choice of law clause.

2.4. Section 8(2) only applies if the parties have expressly chosen the law of another country to govern
the contract. They will have done so if:

... upon the proper construction of the contract (which may include an expression of
choice in direct language) ... the parties exercised liberty given by the common law to
choose a governing law for their contract.

2.5. In Akai Pty Ltd v The Peoples Insurance Company Ltd, the majority in the High Court said that
in determining the application of the IC Act to a credit insurance policy issued by The Peoples
Insurance to Akai, section 8(2) required the court to ascertain the proper law of the contract

223 See Part Twelve.
225 Akai Pty Ltd v The People’s Insurance Company Ltd [1996] HCA 39; (1996) 188 CLR 418 at 437 (Toohey, Gaudron and
Gummow JJ).
226 Akai Pty Ltd v The People’s Insurance Company Ltd [1996] HCA 39; (1996) 188 CLR 418 at 437 (Toohey, Gaudron and
Gummow JJ).
without reference to a ‘choice of law and forum’ clause (which chose English law as the governing law of the contract and England as the forum for any dispute arising out of the contract).

2.6. A ‘choice of foreign forum’ clause in an insurance contract will not exclude the operation of the IC Act, but will leave an Australian court with a discretion whether to stay Australian proceedings. A court will decline a stay if a stay would deprive the plaintiff of the IC Act’s protection (if a court of the foreign country would not apply the IC Act to the dispute).228 In the absence of that consideration, a stay would be granted in the absence of strong countervailing reasons.229

2.7. Although the High Court in Akai rejected The People’s Insurance Company Ltd’s application to stay the Australian proceedings on the basis that a stay would deprive Akai of the protective benefit of section 54 of the IC Act, the English High Court subsequently concluded that the IC Act did not apply to the insurance contract because the contract was governed by English law pursuant to the ‘choice of law and forum’ clause.230

2.8. Section 9(1) states that except as otherwise provided by the IC Act, the IC Act does not apply to, or in relation to, contracts or proposed contracts:

a) of reinsurance; or
b) and (ba) of insurance entered into, or proposed to be entered into, by a private health insurer ... in respect of its health insurance [or health-related] business ...; or ...
c) of insurance entered into, or proposed to be entered into, by a friendly society; or
d) of insurance entered into, or proposed to be entered into, by the Export Finance and Insurance Corporation, other than short term insurance contracts ...; or
e) to or in relation to which the Marine Insurance Act 1909 applies; or
f) entered into or proposed to be entered into for the purposes of a law (including a law of a State or Territory) that relates to:
   i. workers’ compensation; or
   ii. compensation for the death of a person, or for injury to a person, arising out of the use of a motor vehicle.
g) entered into or proposed to be entered into:
   i. for the purposes of a law (including a law of a State or Territory) that relates to workers’ compensation; and
   ii. to provide insurance cover in respect of an employer’s liability under a rule of the common law that requires payment of damages to a person for employment-related personal injury.

2.9. (1A) and (1B) address the application of the IC Act to a ‘bundled’ contract of insurance. That is, a contract of insurance that includes different types of cover some of which, if contained in separate insurance contracts would be subject to the IC Act and some of which would not.

2.10. Section 9(2) states that except as otherwise provided by the IC Act, the IC Act does not apply to, or in relation to, contracts or proposed contracts:

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... entered into, or proposed to be entered into, in the course of State insurance or Northern Territory insurance, including contracts and proposed contracts entered into, or proposed to be entered into, by:

a) a State or the Northern Territory; and
b) some other insurer;
c) as joint insurers.

2.11. By section 9(1)(d), the IC Act does not apply to or in relation to insurance contracts to which the Marine Insurance Act 1909 (MI Act 1909) applies.

2.12. Apart from the exclusion of ‘pleasure craft’ from the application of the MI Act 1909 (section 9A IC Act), there is a question as to whether a particular insurance contract is subject to the MI Act 1909.

3. IC Act, section 9A

3.1. The IC Act, not the MI Act 1909, applies to a marine insurance contract made in respect of a ‘pleasure craft’: section 9A(1). By section 9A(2), a ship is a ‘pleasure craft’ if it is:

a) owned legally and beneficially by one or more individuals; and
b) used or intended to be used wholly for recreational or sporting activities and not for reward.

3.2. Minor, irregular and infrequent use of a ship for recreational or sporting activities will not prevent a ship from being regarded as a ‘pleasure craft’: section 9A(3).

3.3. The MI Act 1909, not the IC Act, applies to a marine insurance contract made in respect of a ‘pleasure craft’ if it is made in connection with the ‘pleasure craft’s’ capacity as cargo: section 9A(1).

4. Extended application of the IC Act: Section 10

4.1. The IC Act applies to insurance contracts and to the ‘provisions of insurance’ in a contract that would not ordinarily be regarded as an insurance contract: section 10(2).

4.2. An indemnity clause in a non-insurance arrangement, such as a lease or a sale of goods or supply of services agreement, is a ‘provision of insurance’ because the indemnity promise in such a clause is an essential characteristic of an insurance arrangement.

4.3. In Bayswater Car Rental Pty Ltd v Hannell, the Full Court of the Supreme Court of Western Australia concluded that an indemnity clause in a car hire agreement was a ‘provision of insurance’ for the purposes of section 10(2) of the IC Act. Accordingly if, as required by the terms of the hiring agreement, the person whose car was damaged by the hirer’s negligent driving of the hire car had obtained a judgment against the hirer, he could have sued the car rental company direct pursuant to section 51 of the IC Act (the hirer could not be found after reasonable enquiry).

4.4. If nothing else, this means the overarching duty of utmost good faith (sections 13 and 14 of the IC Act) applies to the operation of an indemnity clause in a non-insurance contract and perhaps to other provisions of such a contract.

5. Limited relief elsewhere: Section 15

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231 See Part Two, paras. 2.13-2.17.
5.1. Section 15 prevents an IC Act-governed insurance contract from being made the subject of the following relief (not including compensatory damages) under any other Australian legislation (Commonwealth, state or territory):

a) the judicial review of a contract on the ground that it is harsh, oppressive, unconscionable, unjust, unfair or inequitable; or

b) relief for policyowners from the consequences in law of making a misrepresentation.

5.2. Any common law (including equitable) principles of relief from unconscionable contracts or from the consequences of making a misrepresentation continue to apply as section 15 refers only to the exclusion of relief provided by legislation.

5.3. Amongst other things, section 15 prevents a policyowner from seeking the above relief under the Australian Securities and Investments Commission Act 2001 (ASIC Act) Part 2 Division 2, in particular, Subdivision:

a) BA, unfair contract terms (s 12BF renders a term of a standard form consumer contract void if the term is unfair).

b) The Australian Consumer Law contains similar unfair contract terms provisions: section 23;

c) C, unconscionable conduct (sections 12CA and 12CB); and

d) D, consumer protection (sections 12DA and 12DB, misleading or deceptive conduct or false or misleading representations).

5.4. The ASIC Act itself specifically excludes insurance contracts from the application of Subdivision E – Conditions and warranties in consumer transactions (section 12ED): section 12ED(3).

5.5. In Swann Insurance (Aust) Pty Ltd v Fraillon, the Full Court of the Supreme Court of Victoria held that section 15 of the IC Act prevented relief being granted under the Credit Act 1984 (Vic).

5.6. The Insurance Contracts Amendment (Unfair Terms) Bill 2013 was prepared to amend section 15 to introduce an unfair contracts terms scheme for standard form consumer general insurance contracts similar to that in Part 2 Division 2 Subdivision BA of the ASIC Act. The Labor Party introduced the Bill into the Commonwealth Parliament on 26 June 2013. The Bill lapsed when Parliament was prorogued for the 2013 federal election.

6. Overview of the IC Act

6.1. The IC Act has four main purposes. The first purpose is captured in sections that deal with pre-contract issues: insurable interest and conduct. A fundamental feature of these provisions is the limitation of an insurer's remedies for a policyowner's conduct. Importantly, the effect of a misrepresentation or non-disclosure must be proportionate to the prejudice to the insurer, not the loss of the whole contract, no matter how minor the wrong nor how disconnected from the loss. Second, the IC Act sets out standard terms of cover, which could be derogated from by the insurer by giving notice of the difference to the customer. The third purpose is captured in provisions that explicitly or implicitly add or subtract terms in the insurance contract, or give them limited effect, in certain circumstances. There are some limitations and prohibitions on the legal effect of certain common terms of the insurance contract. Some modify the general law so that the insurance contract

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234 Proceedings contrary to s. 15 are liable to be struck out as soon as they are commenced: Australian Competition and Consumer Commission v IMB Group Pty Ltd [2002] FCA 402; (2003) 12 ANZ Ins Cas 61-545 at [105] (Drummond J).
235 The s. 15 exemption applies where a contract contains provisions that operate unconscionably on a party to a contract or where the contract was concluded in circumstances involving unconscionable conduct by a party to the contract: Australian Competition and Consumer Commission v IMB Group Pty Ltd [2002] FCA 402; (2003) 12 ANZ Ins Cas 61-545, at [110] (Drummond J).
237 Pt III.
238 Pt IV.
contract operates differently. Some require notification of a term for it to be effective under the IC Act.239 Importantly, the effect of a breach of the contract must also be proportionate to the prejudice to the insurer, not the loss of the whole benefit and contract, no matter how major the wrong nor how disconnected from the loss. The fourth purpose is captured in provisions that require the insurer to give information, notices or reasons on a subject.240

7. Balancing the interests of insurer and policyowner

7.1. For hundreds of years, insurers developed their policy wordings with one eye on profit and the other on the competition. The policyowner was simply the person that funded that venture. This led to a seriously skewed, and common law supported, allocation of rights and obligations in insurance contracts in favour of insurers, who were allowed to indulge their interest by drafting almost incomprehensible policy wordings with a view to keeping claim payouts to a minimum. The outcome was chaotic and unfair.241

7.2. The IC Act was introduced to try and achieve a fairer balancing of the interests of:
   a) the policyowner, who, for the lowest possible premium, would like to be indemnified for every financial loss suffered as a result of a fortuitous event; and
   b) the insurer, who, year in and year out, seek to collect sufficient premium to pay all claims and make a good profit for its shareholders.

7.3. The IC Act made radical changes to the common law for the purpose of achieving that balance. Proposed changes to the IC Act should bear in mind the need to preserve or achieve that balance, having regard to everyone’s interest in seeing insurers stay profitable and in business.

239 They are found in Pts V – VIII.
240 Pts IX and X and sprinkled in Pts V – VIII.
PART EIGHT – PRE-CONTRACT DISCLOSURE AND REPRESENTATIONS

This introduction to pre-contract disclosure and representations is discussed below under the following headings:

1. Introduction;
2. Brief history;
3. Part IV of the IC Act – disclosure and representations;
4. Non-disclosure.

1. Introduction

1.1. A contract of general insurance is entered into when an insurer accepts an offer, also called a proposal, made by a prospective policyowner, known as a ‘proponent’ (but referred to in this chapter as the ‘policyowner’). In proposing and presenting the insurance risk to the insurer the policyowner is required to make disclosure (limited in the case of eligible contracts explained below). Also commonly the policyowner makes representations to the insurer whether in answer to questions posed or otherwise. For instance, the policyowner may be required to answer questions in a proposal form. The policyowner has both a duty of disclosure and a duty not to misrepresent to the insurer prior to the contract of insurance being entered into. These two duties have been collectively referred to as the policyowner’s duty of fair presentation.

1.2. The duty of disclosure generally requires the policyowner, and those who can give disclosure on behalf of the policyowner, to disclose to the insurer every matter known to the policyowner that the policyowner knows to be relevant, or that a reasonable person in the circumstances could be expected to know is relevant, to the insurer’s decision to accept the risk and the terms of the acceptance. The duty not to misrepresent generally requires the policyowner not to make untrue or incorrect statements unless they are made on the basis of a belief that a reasonable person in the circumstances would have held. Both duties are subject to exceptions.

2. Brief history

2.1. The Australian common law of disclosure was ostensibly the same as the English common law prior to the enactment of the Insurance Contracts Act 1984 (IC Act) which commenced on 1 January 1986. The Australian Law Reform Commission (ALRC) in its Report No. 20, Insurance Contracts (1982) (ALRC 20) recommended reform of the laws of pre-contractual disclosure and misrepresentation. Two of the main changes concerned the common law test of materiality which requires the policyowner to disclose all facts which the policyowner knew and which would...
reasonably affect the mind of a prudent insurer246 and an insurer’s right to avoid a contract from its inception for innocent non-disclosure.

2.2. The ALRC recommended in ALRC 20 that the duty of disclosure be retained in a modified form. The ALRC recommended, amongst other changes, the adoption of a modified test of materiality and that an insurer’s remedy for innocent conduct be based upon the amount that would place the insurer in the position in which it would have been if the conduct had not occurred. The IC Act, as first enacted was almost identical to the Bill appended to ALRC 20. The duties of disclosure and not to misrepresent and the available remedies are found in Part IV of the IC Act which spans sections 21 to 33D.

2.3. Whilst most policies of insurance are subject to the IC Act, the common law pre-contractual disclosure regime still applies to contracts excluded from the application of the Act by section 9. Contracts still subject to the pre-IC-Act common law regime include statutory insurances (workers compensation and motor vehicle CTP), marine insurance (other than pleasure craft) and reinsurance.

2.4. Since the IC Act was first enacted there have been a number of significant amendments to Part IV. One major change was the restriction of the duty of disclosure in respect of ‘eligible contracts of insurance’ to answering specific questions asked by an insurer (the addition of sections 21A and 21B and subsequent amendments). Another was the introduction of Key Facts Sheets (KFS), a reform which arose from the perceived confusion as to policy terms, particularly flood exclusions, following the floods in Queensland, NSW and Victoria in 2010-11 (the addition of division 4 spanning sections 33A, 33B, 33C, and 33D).

3. Part IV of the IC Act – disclosure and representations

3.1. Part IV of the IC Act is divided into four Divisions. Division 1 concerns the duty of disclosure (sections 21, 21A, 21B and 22); Division 2 misrepresentations (sections 23 to 27); Division 3 the remedies for non-disclosure and misrepresentation (sections 27A to 33); Division 4 KFS (33A, 33B, 33C and 33D).

3.2. Part IV is a statutory code which replaced the common law.247 The circumstances in which it is legitimate to resort to the antecedent common law for the purpose of interpreting Part IV are extremely limited.248 This codification is supported by section 33 which states that an insurer cannot, by contract, have a greater range of remedies in relation to non-disclosure than those conferred by Division 3.

3.3. The duty of utmost good faith (Part II IC Act) does not place a higher duty on a policyowner than is otherwise required under Part IV.249

3.4. Focussing upon general insurance, putting life insurance to one side, it can be said that there are two pre-contractual disclosure regimes for contracts subject to the IC Act: first, contracts of insurance (other than eligible contracts of insurance) governed by section 21 of the IC Act; and second, eligible contracts of insurance governed by sections 21A and 21B of the IC Act. The remedies under division 3 are the same for both.

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246 See Mayne Nickless v Pegler [1974] 1 NSWLR 228 at 239 where Samuels J (as he then was) considered what a prudent insurer would want to know as part of the common law test of materiality.

247 Advance (NSW) Insurance Agencies Pty Ltd v Matthews (1989) 166 CLR 606; 5 ANZ Ins Cas 60-910 per High Court.

248 Advance (NSW) Insurance Agencies Pty Ltd v Matthews (1989) 166 CLR 606 per High Court majority at 615.

249 s. 12 and CIC Insurance Ltd v Barwon Region Water Authority (1998) 147 FLR 353; 10 ANZ Ins Cas 61-425; [1998] VSCA 77 per Ormiston JA at [40].
4. Non-disclosure

4.1. Section 21 deals with the duty of disclosure in two parts. Section 21(1) deals with the matters to be disclosed by a policyowner. Sub-sections 21(2) and (3) deal with those matters which a policyowner is not required to disclose.

4.2. Disclosure is required pre-contractually, that is before the insurance contract being ‘entered into’. This includes a renewal, extension or variation of an existing insurance contract or a reinstatement of a contract.250

Knowledge

4.3. Knowledge of a matter for disclosure and disclosure of that matter are two separate things. Knowledge of both the policyowner and the insurer is crucial to the question as to whether a matter needs, or is required by the insurer, to be disclosed.

Policyowner’s knowledge of the matter for disclosure

4.4. A matter for disclosure can be a fact, intention or an opinion.251

4.5. A policyowner can only disclose a matter that is known to the policyowner. This follows the common law. A question arises as to whether the policyowner has requisite knowledge.

4.6. The policyowner’s knowledge includes actual252 and imputed (attributed from an agent or within a corporation)253 knowledge. It probably includes constructive knowledge. Although this remains uncertain. The High Court majority and minority judgments in Permanent Trustee Australia Ltd v FAI General Insurance Co Ltd (in liq)254 appear to contain different views on whether relevant knowledge of an agent, in this case an insurance broker, can properly be imputed to the policyowner. It has been accepted in a number of cases since that pending further clarification by the High Court, the wider view that a policyowner can know a matter for disclosure by an agent should be the view taken.255

Subjective and objective knowledge of relevance to insurer

4.7. Importantly, if an insurer proves a particular matter is known to the policyowner, it must also prove that the policyowner had subjective knowledge or that there was objective knowledge that the matter was relevant to the decision of the insurer whether to accept the risk and, if so, on what terms. Subjectively, that the policyowner knows it to be a matter so relevant.256 Or, objectively that a reasonable person in the circumstances could be expected to know of its relevance to the insurer.257

4.8. Whether or not a policyowner knows a matter is relevant to the insurer is a question of fact. The knowledge of the policyowner is actual knowledge – suspicion or belief are not knowledge.258

4.9. The knowledge of a reasonable person in the circumstances is an objective test. It is now clear that the intrinsic circumstances of the subject policyowner are not relevant. The extrinsic

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250 IC Act, s. 10(9), (10), (10A) and (11).
251 Sutton, 7.130; Pynt, Ch 7; Mann [21.10 .5].
252 s. 21(1); Sutton, 7.150; Pynt, Ch 7; Mann [21.10 .5].
253 s. 21(1); Sutton, 7.160-7.190; Pynt, Ch 7; Mann [21.10 .5].
256 IC Act, s. 21(1)(a).
257 IC Act, s. 21(1)(b).
258 s. 21(1); Sutton, 7.240; Pynt, Ch 7; Mann [21.10.5]
circumstances are relevant and two extrinsic factors were added to section 21(1) in 2013 and commenced on 28 December 2105. The two factors are:

a) the nature and extent of the insurance cover to be provided under the relevant contract of insurance; and 

b) the class of persons who would ordinarily be expected to apply for insurance cover of that kind.

4.10. The questions an insurer asks a policyowner prior to entering into a contract of insurance contract are important in determining what ‘a reasonable person in the circumstances could be expected to know to be a matter so relevant’. 

Knowledge of the insurer

4.11. A policyowner need not disclose matters that are of common knowledge or that an insurer knows, in the ordinary course of its business as an insurer ought to know.

4.12. A policyowner need not disclose matters that diminish the risk.

4.13. Additionally, a policyowner need not disclose a matter as to which compliance with the duty of disclosure is waived by the insurer. Apart from this general waiver there is a specific waiver that concerns answers to questions in a proposal form. An insurer waives disclosure in relation to a particular matter if a policyowner does not answer, or gives an obviously incomplete or irrelevant answer to, a question in a proposal form about the matter.

Duty of disclosure and eligible contracts

4.14. A different disclosure regime applies to ‘eligible contracts’: as defined and specified in the Insurance Contracts Regulations 2017. There are six specified eligible contracts; motor vehicle insurance; home buildings insurance; home contents insurance; sickness and accident insurance; consumer credit insurance; and travel insurance. All other contracts are not eligible contracts unless adopted by the insurer as an eligible contract by giving notice.

4.15. In broad terms there is no general duty of disclosure for eligible contracts of insurance. The duty of disclosure is restricted to specific questions asked prior to an ‘eligible’ contract of insurance being originally entered into. Prior to the renewal of an eligible contract, the insurer may ask the policyowner either specific questions or for disclosure by way of an update of any changes to matters previously disclosed by the policyowner, a copy of which is to be provided to the policyowner. If an insurer does neither of these things, the insurer is taken to have waived compliance with the duty of disclosure on renewal.

259 Amended by the Insurance Contracts Amendment Act 2013.

260 An insured’s knowledge of relevance to an insurer will be guided by the questions asked. It will be apparent to an insured, in many if not most cases, that a matter which is the subject of questions is relevant to the decision making of the insurer. The reverse is also true. Two recent cases in which lack of questions by an insurer was taken into account in determining a lack of knowledge under s. 21(1)(b) are Stealth Enterprises Pty Ltd t/as The Gentlemen’s Club v Callden Insurance Limited [2017] NSWCA 71 per NSW Court of Appeal (see Meagher JA at [53] and Sackville AJA at [82] and Marketform Managing Agency Ltd v Amashaw Pty Ltd [2018] NSWCA 70 per NSW Court of Appeal (see Meagher JA referring to the reasons of the primary judge).

261 IC Act, s. 21(2)(a).

262 IC Act, s. 21(2)(d).

263 IC Act, s. 21(3).

264 Insurance Contracts Regulations 2017 commenced on 1 April 2018.

265 Insurance Contract Regulations 2017: s. 6(3).

266 IC Act, s. 21A, as amended to apply to apply to eligible contracts of insurance entered into after 28 December 2015.

267 IC Act, s. 21B.
matters in addition to specific questions or an update of previous disclosures will result in a waiver of compliance with the duty of disclosure with respect to those other matters.  

**Duty of disclosure notices**

4.16. An insurer cannot rely on an innocent pre-contractual non-disclosure and exercise any otherwise available remedy unless the insurer, before the contract of insurance is entered into, ‘clearly informs’\(^{269}\) the policyowner in writing of: the general nature and effect of the duty of disclosure; that the duty of disclosure applies until the contract is entered into; and if the contract is an eligible contract, the general nature and effect of sections 21A and 21B of the IC Act.\(^{270}\) This is called a duty of disclosure notice. There are prescribed forms in the regulations.\(^{271}\) An insurer can give the information orally if it is not ‘reasonably practicable’ for it to be given in writing before the contract is made, as long as the information is given in writing within 14 days of the making of the contract.\(^{272}\)

4.17. If an insurer accepts a policyowner’s offer to insure or makes a counter offer to insure more than two months after the policyowner’s most recent disclosure, the insurer will not be able to rely on any non-disclosure after the last disclosure unless it reminds the policyowner at the time of the acceptance or counter offer that the policyowner’s duty of disclosure applies until the insured contract is entered into.\(^{273}\)

4.18. There is no requirement for an insurer to inform the policyowner of the duty of disclosure if the contract of insurance is arranged by an insurance broker, as ‘agent of the insured’ (that is, not under a binder).\(^{274}\) If an insurer fails to inform a policyowner of the duty of disclosure as required it is limited to remedies based on a fraudulent conduct.\(^{275}\)

**Duty not to misrepresent**

4.19. Division 2 of Part IV of the IC Act contains a scheme in relation to misrepresentations. The IC Act is silent on the meaning of ‘misrepresentation’ which remains based in the common law.\(^{276}\)

4.20. A misrepresentation is a statement, usually positive but sometimes constituted by silence\(^{277}\), which is untrue and which is intended to affect the other party – not a ‘mere puff’.\(^{278}\) The statement might be one of fact, intention or opinion.\(^{279}\) A representation ‘with respect to the existence of a state of affairs’ cannot be turned into a contract term or warranty by a ‘basis clause’.\(^{280}\)

4.21. The IC Act exempts, or modifies the effect of, some representations from its application.

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\(^{268}\) Overall ss. 21A and 21B of the IC Act are not simply expressed with s. 21B being particularly complex. Whether this causes problems in practice is a question worth posing.

\(^{269}\) The meaning of ‘clearly inform’ has been considered in several cases. Most notably by the NSW Court of Appeal in *Suncorp General Insurance Ltd v Cheihk* [1999] NSWCA 238; (1999) 10 ANZ Ins Cas 61-442. The Court of Appeal noted that clarity was required not only in the contents of documents provided by the insurer but also in the manner in which the contents of the documents were made known. The Court said that a notice in the documents, ‘without attention appropriately drawn to it would not suffice, even if the contents of the note were adequate to state the general nature and effect of the duty of disclosure’ (at [38]).

\(^{270}\) IC Act, s. 22(1).

\(^{271}\) Insurance Contracts Regulations 2017.

\(^{272}\) IC Act, s. 69.

\(^{273}\) IC Act, s. 22(3).

\(^{274}\) IC Act, s. 71.

\(^{275}\) s. 22(5).

\(^{276}\) Sutton, 7.580; Pynt, Ch 7.

\(^{277}\) Sutton, 7.620; Pynt, Ch 7; Mann [26.25].

\(^{278}\) Sutton, 7.600, Pynt, Ch 7.

\(^{279}\) s. 26(1); Sutton, 7.650-680; Pynt, Ch 7; Mann [26.30].

\(^{280}\) IC Act, s. 24; Sutton, 7.630; Pynt, Ch 7; Mann [24.10] and [24.20].
4.22. First, a question – described in the section heading as ambiguous - in relation to a proposed insurance contract will be interpreted in the way the policyowner understood the question if a reasonable person in the circumstances would have understood the question in the same way.  

4.23. Second, a statement is not a misrepresentation if the policyowner fails to answer a question in a proposal form at all or gives an obviously incomplete or irrelevant answer to a question.  

4.24. Third, a statement is not a misrepresentation if it is an untrue statement based on its maker’s belief, but the belief was one which a reasonable person in the circumstances would have held. The effect is that a statement of an honest and reasonable belief is not a misrepresentation.  

4.25. Fourth, a statement is not a misrepresentation unless either: its maker knew that it would have been relevant to the insurer’s decision to accept the risk and, if so, on what terms; or a reasonable person in the circumstances could be expected to have known that it would have been relevant to the insurer’s decision to accept the risk and, if so, on what terms.

**Remedies**

4.26. Division 3 of Part IV of the IC Act specifies an insurer’s remedies in the event of a non-disclosure or a misrepresentation.  

4.27. An insurer has no remedy for a policyowner’s non-disclosure or misrepresentation (innocent or fraudulent) under a general insurance contract if the insurer would have entered into the contract for the same premium and on the same terms and conditions even if the non-disclosure had not occurred or the misrepresentation had not been made. This is a threshold question.  

4.28. Subject to satisfying the threshold question, the available remedies depend on whether the policyowner’s non-disclosure was innocent or fraudulent.  

4.29. If the non-disclosure or the misrepresentation was fraudulent the insurer may avoid the contract of insurance. An insurer cannot avoid a contract for a policyowner’s innocent non-disclosure or misrepresentation.  

4.30. The IC Act does not define fraudulent non-disclosure or fraudulent misrepresentation. Accordingly, their meaning is derived from the common law. It appears that fraud in relation to misrepresentation has been more clearly judicially defined than fraud in relation to non-disclosure. A statement may be made fraudulently if it is made recklessly. However, carelessness, even gross carelessness, does not satisfy the degree of recklessness required to constitute a fraudulent misrepresentation.  

4.31. If the insurer is not entitled to avoid the contract or is entitled to do so but has not done so, the insurer’s liability for a claim is reduced to an amount that would put the insurer in the position it

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281 IC Act, s. 23.
282 IC Act, s. 27.
283 IC Act, s. 26(1).
284 s. 26(2) which applies to misrepresentations the s. 21(a) and (b) requirements for non-disclosure.
285 IC Act, s. 28(1).
286 IC Act, s. 28(2).
287 A statement is made fraudulently if it is made with knowledge of its falsity or without belief in its truth or recklessly, not caring whether it is true or false. In other words, it is made deliberately or recklessly. This well settled formulation, which dates back to the House of Lords decision in *Derry v Peek* (1889) 14 App Cas 337. Reckless disregard has also been described as conscious indifference. The NSW Court of Appeal described reckless disregard in terms of ‘conscious indifference’ in *Prepaid Services Pty Ltd v Atradius Credit Insurance NV* (2013) 302 ALR 732; 17 ANZ Ins Cas 61-981; [2013] NSWCA 252 per Meagher JA at [39] and [40].
288 The NSW Court of Appeal distinguished ‘conscious indifference’ from ‘mere, or even gross, carelessness’ in the context of answering questions in a proposal form in *Prepaid Services Pty Ltd v Atradius Credit Insurance NV* (2013) 302 ALR 732; 17 ANZ Ins Cas 61-981; [2013] NSWCA 252 per Meagher JA at [46].
would have been in if the non-disclosure had not occurred or the misrepresentation had not been made.289

4.32. The insurer has the onus of proving the position it would have been in if the non-disclosure had not occurred or the misrepresentation had not been made.290 An insurer might prove that it would have charged a higher premium if non-disclosure had not occurred or might prove that a higher excess would have been applied. The insurer’s liability will be reduced by the amount of the proved notional increase in premium or excess, respectively.

4.33. Another more contentious example is where the insurer can demonstrate that if the misrepresentation or non-disclosure had not been made it would have declined to enter into the contract of insurance. If demonstrated the insurer can escape liability altogether. This reduction of liability has been referred to as ‘reduced to nil’.291

4.34. A court can disregard an insurer’s decision to avoid for fraudulent non-disclosure if avoidance would be harsh and unfair.292 A court will only do so if the non-disclosure has not prejudiced the insurer or if it has, the prejudice ‘is minimal or insignificant’.293 If the avoidance is disregarded, the court will allow the policyowner ‘to recover the whole, or such part as the court thinks just and equitable in the circumstances, of the amount that would have been payable if the contract had not been avoided’.294 In determining how much a policyowner can recover, the court, amongst other things, will have regard to the need to deter fraudulent conduct in relation to insurance and will weigh the extent of the culpability of the policyowner in the fraudulent conduct against the magnitude of the loss that would be suffered by the policyowner if the avoidance were not disregarded.295

Key Facts Sheets

4.35. Following extensive flooding in Queensland (but also NSW and Victoria) in 2010 and 2011, the IC Act was amended to require insurers to provide a Key Facts Sheet (KFS) in respect of all home building and contents insurance products.296 A KFS is a prescribed or potential prescribed contract and is a document that complies with the regulations.297 A KFS is intended to make key information about an insurance policy more accessible and more readily permit comparison of products. An insurer commits an offence if it does not provide a KFS.298

289 IC Act, s. 28(3).
290 An insurer seeking to reduce its liability to nil under s. 28(3) needs to adduce underwriting evidence to the effect that it would not have entered into the contract of insurance were it not for the misrepresentation or non-disclosure. Likewise an insurer seeking to reduce its liability must adduce evidence as to any additional amounts that would have been borne by the insured had there not been a misrepresentation or non-disclosure. For instance, evidence as to additional premium or any excess that may have been imposed. In Fruehauf Finance Corp Pty Ltd v Zurich Australian Insurance Ltd (1990) 6 ANZ Ins Cas 61-014 Brownie J (NSW Sup Ct) referred to the necessity for an insurer who invokes s. 28(3) to put before the court evidence from which the court can calculate the amount of the reduction contended for.
291 Reduction to nil is more contentious because it can produce the same consequence as avoidance without the ability of the insured to seek relief under s. 31 of the IC Act, which only concerns fraudulent conduct.
292 s. 31. It should also be noted that this only applies to the loss and that the disregard of the avoidance does not reinstate the contract: s. 31(4).
293 s. 31(2). A s. 31(2) example was where the insurer had misrepresented the purchase price of a motor vehicle on an insurance proposal and where the prejudice, being the difference between the previous insurer’s agreed value of $60,000 compared with the insurer’s agreed value of $65,000, was considered minimal: Von Braun v Australian Associated Motor Insurers Ltd (1998) 135 ACTR 1; 10 ANZ Ins Cas 61-419 per Higgins J.
294 s. 31(1).
295 s. 31(3).
296 IC Act, ss. 33A, 33B, 33C and 33D, which were added by way of the Insurance Contracts Amendment Act 2012. The KFS regime commenced in September 2014.
297 s. 33B. The prescription is under Insurance Contracts Regulations 2017 (which commenced on 1 January 2018) which contains KFS amendments to the previous regulations and scheduled forms (Schedule 5).
298 s. 33C(5).
PART NINE – UTMOST GOOD FAITH

This introduction to the duty of utmost good faith is discussed below under the following headings:

1. Introduction;
2. Brief history;
3. IC Act duty of utmost good faith;
4. Duty of utmost good faith: Informing principle and implied term;
5. Third party beneficiaries and utmost good faith;
6. Reliance on a provision as a breach of the duty;
7. Regulatory supervision of utmost good faith;
8. Utmost good faith: Content of duty;
9. Utmost good faith: Remedies and consequences.

1. Introduction

1.1. Utmost good faith is the most applied concept of insurance law in Australia. The duty of utmost good faith applies to all aspects of the relationship between insurer and policyowner and between insurer and third party beneficiary post-contractually, including the settlement of claims. It is an informing principle. The duty is an implied term in every contract of insurance subject to the Insurance Contracts Act 1984 (IC Act). Breach of the duty is therefore a breach of contract and can give rise to a liability for contractual damages. A breach of the duty of utmost good faith is also a breach of the IC Act. One particular application of the duty of utmost good faith provides that a party may not rely on a provision of a contract of insurance when to do so would be a breach of the duty.

1.2. Utmost good faith as a concept is not defined under the IC Act. What it means and what it requires of the parties to a contract of insurance have been the subject of formulations at common law. The most authoritative formulations come from the judgments of the High Court in CGU Insurance Ltd v AMP Financial Planning Pty Ltd (CGU v AMP). Two words commonly appearing in judicial formulations of the duty are the requirement to act with ‘fairness’ and ‘reasonableness’. Whist one word cannot describe the duty, if one word had to be chosen to describe utmost good faith, arguably the word would be ‘fairness’.

1.3. Just how important utmost good faith has become under the IC Act is apparent when the historical development at common law is considered.

2. Brief history

2.1. The principle of utmost good faith originated in and was settled by the well-known 1766 judgment of Lord Mansfield in Carter v Boehm. Carter v Boehm is widely regarded as the most important case in the history of English and Australian insurance law. Lord Mansfield’s expression of good faith subsequently became known as utmost good faith.

299 CGU v. AMP (2007) 235 CLR 1; 14 ANZ Ins Cas 61-739.
300 Carter v Boehm (1766) 3 Burr 1905; 97 ER 1162.
2.2. Utmost good faith at common law was limited in that:
   a) the common law duty of utmost good faith was linked with the common law duty of
disclosure; it was most commonly involved an insurer alleging that a policyowner had
committed a pre-contractual breach of the duty of disclosure301;
   b) a significant restriction on the application of the common law duty of utmost good faith was
its remedy of avoidance of the contract of insurance.302 This is obviously an inappropriate
remedy for a policyowner seeking performance of contractual obligations by the insurer under
a contract of insurance; and
   c) there was uncertainty as to whether the common law duty was a contractual implied duty, on
the one hand, or an extra-contractual principle of law or bundle of principles of law, on the
other. The balance of authority weighed in favour of the duty not being a contractual implied
duty meaning that a breach of the duty did not give rise to contractual damages, only the
remedy of avoidance.303

2.3. The Australian Law Reform Commission (ALRC) in Report No 20 (ALRC 20) which led to the
IC Act sought to address these problems amongst others. The ALRC appears to have been
primarily concerned to ensure that the duty operated post-contractually (and particularly in respect
of the settlement of claims). The ALRC noted that, at the time of reporting, there was no reported
decision in Australia applying the duty to the payment of claims304. The ALRC also expressed a
concern in ALRC 20 that the common law requirement of utmost good faith had usually been
recognised in connection with the duty of disclosure. The ALRC was of the view that, in
principle, the duty should apply equally to other aspects of the insurance relationship.

2.4. Accordingly, the ALRC recommended that the proposed IC Act should make it clear that the duty
of utmost good faith applies to all aspects of the relationship between insurer and policyowner,
including the settlement of claims. Also that a policyowner should be entitled to recover damages
for loss suffered as a result of the insurer’s breach of the duty of utmost good faith in relation to
the settlement of a claim with an assessment of damages for a breach based on ordinary
contractual principles.305 These recommendations were enshrined in section 13 of the IC Act as
first enacted and at commencement on 1 January 1986.

2.5. The ALRC also noted in ALRC 20 that neither party should be entitled to rely on a contractual
provision when to do so would involve a breach of the duty of utmost good faith.306 This
recommendation was enshrined in section 14 of the IC Act as first enacted.

2.6. A Review Panel comprising Mr A. Cameron and Ms N. Milne commissioned by the Australian
Government in September 2003 reviewed the IC Act and made recommendations for reform in
their Final Report dated June 2004. The Review Panel recommended that a breach of the duty of

301 The development of the duty of utmost good faith at common law appears to have been constrained by the facts of Carter
v Boehm (1766) 3 Burr 1905; (1766) 97 ER 1162 which was a disclosure case. This history is described in Sutton at [6.10];
302 Avoidance is no longer a remedy for a breach of utmost good faith in the UK by virtue of the Insurance Act 2015 (UK)
which removed the remedial expression of avoidance from the Marine Insurance Act 1906 (UK).
303 The common law duty of utmost good faith was described by Young J in GIO Insurance Ltd v Leighton Contractors Pty
Ltd (1995) 8 ANZ Ins Cas 61-293 as ‘not one legal principle [but]… a general norm from which many principles have
sprung’ (at 76,309). Young J considered the various alternatives posited by English judges (at 76,309 and 76,310). Some
judges had said that the duty is a principle of law applied equally to pre-contractual and post-contractual disclosure. Others
had drawn a distinction between the duty requiring pre-contractual disclosure and the post contractual duties. The former
being a duty implied by law and the latter being a matter of implied terms. Rogers J in NSW Medical Defence Union Ltd v
Transport Industries Insurance Co Ltd (1985) 4 NSWLR 107 differentiated between a pre-contractual duty to disclose
matters relevant to the risk and a post-contractual implied term that operated in connection with promises made under the
policy.
304 ALRC 20 at [328].
305 ALRC 20 at [328].
306 ALRC 20 at [51].
utmost good faith should be a breach of the IC Act, although any such breach would not be an
offence and would attract no penalty. 307

2.7. The Review Panel also recommended that third party beneficiaries should have access to the
utmost good faith provisions under the IC Act, but not pre-contractually. 308

2.8. Sections 13(2), (3) and (4) and 14A were added to the IC Act to effect the changes recommended
by the Review Panel.

3. IC Act duty of utmost good faith

3.1. The duty of utmost good faith is found in Part II of the IC Act, which spans sections 12 to 15.
Certain contracts of insurance 309, including contracts of reinsurance, fall outside the IC Act 310 and
remain subject to the duty of utmost good faith at common law.

Duty of utmost good faith and duty of disclosure

3.2. The IC Act bifurcates the duties of utmost good faith, on the one hand, and of disclosure and not
to misrepresent, on the other hand. This differs from the common law.

3.3. The duty of utmost good faith in Part II of the IC Act is not limited or restricted in any way by
any other law. 311 This includes the subsequent provisions of the IC Act. In other words, the duty
of utmost good faith is paramount. It is not displaced or read down by any other duties imposed
by the IC Act.

3.4. The duty of utmost good faith in Part II does not have the effect of imposing on a policyowner, in
relation to the disclosure of a matter to the insurer, a duty other than the duty of disclosure. 312 The
interaction between the duty of utmost good faith and the duty of disclosure pursuant to the
second limb of section 12 is an exception to the general principle of paramountcy. In practice, the
duty of disclosure exception to the paramountcy of the duty of utmost good faith means that in
circumstances of a failure to disclose, insurers tend to rely upon the duty of disclosure, or both
duties rather than the duty of utmost good faith in isolation. A failure to make proper disclosure
may be seen for certain purposes, at least, as a breach of the duty of utmost good faith, even if that
might have the effect of providing an alternative remedy for a failure to make disclosure to those
remedies which appear in Part IV of the IC Act. 313

Other legislation providing certain relief has no application

3.5. Commonwealth, State or Territory legislation providing relief for harsh, oppressive,
unconscionable, unjust, unfair or inequitable contracts does not apply to contracts of insurance
subject to the IC Act. 314 Further, relief from the consequences of misrepresentation does not apply
to contracts of insurance subject to the IC Act. 315

307 Final Report (June 2004), at [1.2]–[1.8].
308 Final Report (June 2004), at [10.1]–[10.6].
309 References to contracts of insurance under the IC Act include contracts of general insurance and contracts of life
insurance.
310 IC Act, s. 9.
311 The first limb of s. 12 of the IC Act.
312 The second limb of s. 12 of the IC Act.
313 CIC Insurance Ltd v Barwon Region Water Authority (1998) 147 FLR 353; 10 ANZ Ins Cas 61-425; [1998] VSCA 77
per Ormiston JA at [40].
314 IC Act, s. 15(1) and (2)(a).
315 IC Act, s. 15(1) and (2)(b).
3.6. This means that contracts of insurance subject to the IC Act are not subject to Unfair Contracts Terms (UCT) regimes in other legislation.\textsuperscript{316} However, whether an UCT regime should be enacted for contracts of insurance is a matter under review.\textsuperscript{317}

**No tort of bad faith**

3.7. The tort of bad faith which has arisen in the United States was specifically considered by the ALRC. The ALRC concluded that the introduction of a tort of bad faith would not add substantially to the remedies available to a policyowner and therefore rejected the introduction of a tort of bad faith in Australia.

4. **Duty of utmost good faith: Informing principle and implied term**

4.1. The duty of utmost good faith as an informing principle and an implied term finds expression in section 13(1)\textsuperscript{318} of the IC Act which reads:

**13 The Duty of the Utmost Good Faith**

(1) A contract of insurance is a contract based on the utmost good faith and there is implied in such a contract a provision requiring each party to it to act towards the other party, in respect of any matter arising under or in relation to it, with the utmost good faith.

4.2. Under the first limb of section 13(1), ‘a contract of insurance is a contract based on the utmost good faith’.\textsuperscript{319} The second limb of section 13(1) provides that a contract of insurance contains an implied provision requiring each party to act towards the other with utmost good faith. The duty of utmost good faith is therefore a contractual duty under the IC Act. Under the IC Act, a breach of the duty of utmost good faith by an insurer is a breach of an implied term in a contract of insurance and can give rise to a claim for damages to be assessed according to ordinary contractual principles.

4.3. The implied term is that each party to the contract is to act towards the other party, in respect of any matter arising under or in relation to it, with the utmost good faith. This is a wide expression of the duty which encompasses all parties in respect any matter arising under or in relation to the contract of insurance. That is both pre-contractual matters and post-contractual matters.

5. **Third party beneficiaries and utmost good faith**

5.1. The duty of utmost good faith under the IC Act extends post-contractually to third party beneficiaries of cover. A reference in section 13 to a 'party to a contract of insurance’ includes a reference to a third party beneficiary under the contract.\textsuperscript{320} Section 13 applies in relation to a third

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\textsuperscript{316} One UCT regime is in the *Australian Consumer Law (Competition and Consumer Act) 2010* (sch 2 ss. 23 - 28). Another UCT regime is in the *Australian Securities and Investments Commission Act 2001* (ASIC Act) (Part 2, Division 2, Sub-Division BA ss12BF to 12BM).

\textsuperscript{317} In 2013 the then Assistant Treasurer exposed for public consultation draft legislation, the *(Insurance Contracts Amendment (Unfair Terms) Bill 2013)* amending the IC Act to potentially give consumers protection against unfair contract terms in general insurance contracts. Since then the debate has widened to include life insurance. At the time of publication of this paper a consultation package has been promised.

\textsuperscript{318} s. 13(1) was a renumbering of s. 13 which was amended by the *Insurance Contracts Amendment Act 2013* to renumber the section as s. 13(1) and to add subsections. The amendment commenced on 28 June 2013 and applies to contracts of insurance entered into or renewed after this date (which is the day the *Insurance Contracts Amendment Act 2013* received Royal Assent).

\textsuperscript{319} The first limb of s. 13(1) is substantially the same as the first limb of s. 23 of the *Marine Insurance Act 1909*, ‘a contract of marine insurance is a contract based upon the utmost good faith’.

\textsuperscript{320} IC Act, s. 13(3).
party beneficiary under a contract of insurance only after the contract is entered into.\textsuperscript{321} A post-contractual duty of utmost good faith is imposed on both insurer and third party beneficiary.

5.2. A third party beneficiary is defined to mean a person who is not a party to the contract but is specified or referred to in the contract, whether by name or otherwise, as a person to whom the benefit of the insurance cover provided by the contract extends.\textsuperscript{322}

6. Reliance on a provision as a breach of the duty

6.1. Section 14 sets out a very important, even remarkable, application of the duty of utmost good faith whereby reliance on a provision in a contract of insurance may be to fail to act with utmost good faith. If the reliance is a failure to act with utmost good faith then the party may not rely on the provision. Section 14(1) reads:

\textit{14 Parties not to Rely on Provisions except in the Utmost Good Faith}

\begin{itemize}
  \item[(1)] If reliance by a party to a contract of insurance on a provision of the contract would be to fail to act with the utmost good faith, the party may not rely on the provision.
\end{itemize}

6.2. The ALRC intended that section 14, in combination with section 13, would ensure that insurers apply the terms of contracts of insurance fairly.\textsuperscript{323} Expressed differently, the ALRC intended, and section 14 provides, what can be termed an unfair reliance contract term regime (URCT regime). Arguably this URCT regime is much wider in scope than an UCT regime.\textsuperscript{324}

6.3. In deciding whether reliance by an insurer on a provision of the contract of insurance would be a breach of the duty of utmost good faith, the court shall have regard to any notification of the subject provision that was given to the policyowner, whether a notification under section 37 of the IC Act or otherwise.\textsuperscript{325}

6.4. Section 14 appears to have been underutilised.\textsuperscript{326}

6.5. Section 14 does not extend to third party beneficiaries. On balance it seems logical that the section should extend to third party beneficiaries based on a construction of sections 13 and 14, read together. Section 14 is but one application of the duty of utmost good faith. It follows from the general expansion of the duty post-contractually to third party beneficiaries that a specific post-contractual application of the duty would be similarly expanded to provide relief to third party beneficiaries. Being remedial of nature, these sections should be given a liberal construction.\textsuperscript{327}

7. Regulatory supervision of utmost good faith

\begin{itemize}
  \item\textsuperscript{321} IC Act, s. 13(4).
  \item\textsuperscript{322} IC Act, s. 11(1). The definition was inserted in s. 11(1) by the Insurance Contracts Amendment Act 2013.
  \item\textsuperscript{323} ALRC 20 at [51].
  \item\textsuperscript{324} The URCT regime in s. 14 applies when a term is operating unfairly in breach of the duty of utmost good faith. The breach may be situational and in other circumstances reliance on the provision may not be a breach. However, a UCT regime, only operates if a term is inherently unfair, which terms of insurance contracts seldom are. It is tolerably clear that an insurer’s reliance on a term that is inherently unfair would most likely be considered to be a breach of the insurer’s duty of utmost good faith under s. 14.
  \item\textsuperscript{325} IC Act, s. 14(3). s. 37 provides than an insurer may not rely on an unusual term unless it clearly informed the insured of its effect before the contract was entered into.
  \item\textsuperscript{326} There have been surprisingly few reported cases on s. 14. Surprising because of the frequency of criticisms reported in the media of allegedly unfair insurance provisions and the UCT debate which has thrown up complaints about allegedly unfair provisions all of which could potentially be addressed by s. 14.
  \item\textsuperscript{327} There do not appear to be any reported cases in which a third party beneficiary has sought to invoke s. 14.
\end{itemize}
7.1. Regulatory supervision of utmost good faith was achieved through the enactment of section 13(2) and section 14A of the IC Act. The rationale for the changes was the limitation under the pre-existing law that parties to a contract of insurance could enforce compliance with the implied duty of utmost good faith through private legal action. This presented too great an expense for some parties and did not provide long-term solutions to systemic breaches of utmost good faith committed over time. The answer was perceived to be greater regulatory supervision in the area of utmost good faith.

7.2. Under section 13(2) a breach of the duty of utmost good faith is a breach of the requirements of the IC Act. A breach of the IC Act for failure to comply with the duty of utmost good faith is not an offence against the IC Act, nor does it attract any penalty under the IC Act.

7.3. To avoid any doubt about applicable remedies, section 14A was also inserted into the IC Act to clarify the powers of the Australian Securities and Investments Commission (ASIC) under the Corporations Act 2001 (Corporations Act) in respect of an insurer's breach of the duty of utmost good faith in claims handling or the settlement of a potential claim. Section 14A applies if an insurer under a contract of insurance has failed to comply with the duty of the utmost good faith in the handling or settlement of a claim or potential claim under the contract. ASIC may exercise its powers under Subdivision C of Division 4 of Part 7.6 of the Corporations Act or Subdivision A of Division 8 of that Part as if the insurer's failure to comply with the duty of the utmost good faith were a failure by the insurer to comply with a financial services law.

7.4. The remedies available to ASIC include the issue of a banning order under section 920A of the Corporations Act, the suspension or cancellation of the insurer's financial services licence, the imposition of conditions on the licence or the acceptance of an enforceable undertaking not to act in a particular manner.

7.5. It is said that an example of the type of conduct leading to a permanent banning order is a pattern of persistent contraventions that indicates systemic failures or a general lack of understanding of, and regard for, compliance. Isolated breaches of the duty would not be expected to result in ASIC pursuing a banning order.

8. Utmost good faith: Content of duty

8.1. ‘Utmost good faith’ is not defined in the IC Act. The High Court in CGU v AMP did not attempt a comprehensive definition of the duty. However, the judicial formulations of the duty in CGU v AMP are arguably definitional and have provided subsequent judicial guidance.

8.2. The appeal was from the Full Court of the Federal Court (Moore and Emmett JJ): AMP Financial Planning Pty Ltd v CGU Insurance Ltd. Emmett J said:

The precise content of the concept of utmost good faith depends on the legal context in which it is used. In the context of insurance, the phrase encompasses notions of

328 The amendment by the addition of ss. 13(2) and s. 14A of the IC Act was by the Insurance Contracts Amendment Act 2013; ss. 13(2) and 14A commenced on 28 June 2013.
329 Explanatory Memorandum to Insurance Contracts Amendment Bill 2013 (ICAB 2013) at [1.6].
330 IC Act, s. 14A (1).
331 IC Act, s. 14A (2). A financial services law has the meaning given by s. 761A of the Corporations Act.
332 Searches have not revealed any publicly available evidence as to the application by ASIC of s. 14A since it commenced.
333 Explanatory Memorandum to ICAB 2013 at [1.14].
334 CGU v AMP; per Callinan and Heydon J at [257].
fairness, reasonableness and community standards of decency and fair dealing. While an essential element of honesty may be at the head of the concept of utmost good faith, dishonesty is not a prerequisite for a breach of the duty.\footnote{AMP Financial Planning Pty Ltd \textit{v} CGU Insurance Ltd (2005) 146 FCR 447; 13 ANZ Ins Cas 61-658; [2005] FCAFC 185 at [89].}

8.3. The High Court in three separate judgments in \textit{CGU v AMP} agreed with the majority of the Full Court that dishonesty is not a prerequisite for a breach of the duty of utmost good faith. The formulations of the duty of utmost good faith in the three separate judgments of the High Court provide valuable guidance on the meaning of utmost good faith generally and specifically applied to an insurer's delay in making a decision on indemnity.

8.4. Gleeson CJ and Crennan J said:

\begin{quote}
\ldots an insurer's statutory obligation to act with utmost good faith may require an insurer to act, consistently with commercial standards of decency and fairness, with due regard to the interests of the insured.\footnote{FN 11; at [15].}
\end{quote}

8.5. Kirby J (in dissent on the appeal) said:

\begin{quote}
In my view, the criteria of dishonesty, caprice and unreasonableness more accurately express the ambit of what constitutes a breach of s 13 of the Act.\footnote{Ibid at [131].}
\end{quote}

8.6. Callinan and Heydon JJ, in agreeing with Gleeson CJ and Crennan J, used an analogy of the equitable doctrine of clean hands in describing aspects of the duty of utmost good faith.

8.7. They said:

\begin{quote}
The analogy may not be taken too far, but the sort of conduct that might constitute an absence of utmost good faith may have elements in common with an absence of clean hands according to equitable doctrine which requires that a plaintiff seeking relief not himself be guilty of tainted relevant conduct. \ldots That is not to say that conduct falling short of actual impropriety might not constitute an absence of utmost good faith of the kind which the Insurance Act [sic] demands. Something less than that might well do so. Utmost good faith will usually require something more than passivity: it will usually require affirmative or positive action on the part of a person owing a duty of it.\footnote{Ibid at [257].}
\end{quote}

8.8. There is a consistency in the judicial formulations of the High Court in \textit{CGU v AMP} and of the Full Court of the Federal Court below:

1. There is no essential element of honesty. However, dishonest conduct would likely be a breach of the duty of utmost good faith;

2. The standards are community (Full Court) and commercial (High Court) standards; and

3. ‘Fairness’, ‘decency’ and ‘reasonableness’ are relatively similar terms and arguably essential elements of the duty of utmost good faith. But the meaning of the duty goes beyond these subjective terms.

\section*{Nature of respective interests – not a fiduciary duty}

8.9. The duty of utmost good faith between the parties to a contract of insurance is not a fiduciary duty. A fiduciary duty requires a party to put the other party’s interests above its own and the duty of utmost good faith does not require this. The duty of utmost good faith does not require an insurer to put the interests of its policyowner above its own. The duty may require an insurer to
have regard to the interests of the policyowner as well as its own interests. However, unlike a fiduciary duty, the duty of utmost good faith does not require an insurer to surrender or subjugate its own interests in favour of the interests of its policyowner.\(^{341}\)

9. **Utmost good faith: Remedies and consequences**

9.1. A policyowner or third party may seek to have the insurer held liable in damages for the loss suffered as a result of a breach of the implied term of the duty of utmost good faith under section 13. The ALRC said that assessment of damages for a breach of the duty should be based on ordinary contractual principles.\(^{342}\)

9.2. A breach by an insurer of its duty of utmost good faith which entitles a policyowner (or third party beneficiary) to damages does not automatically equate with the insurer being liable to indemnify the policyowner under the contract of insurance.

9.3. Gleeson CJ and Crennan J in *CGU v AMP* said:

> However, the Act does not empower a court to make a finding of liability against an insurer as a punitive sanction for not acting in good faith. If there is found to be a breach of the requirements of s 13 of the Act, there remains the question how that is to form part of some principled process of reasoning leading to a conclusion that the insurer is liable to indemnify the insured under the contract of insurance into which the parties have entered.

> ... Between a premise that [the insurer’s] delay constituted a failure to act with the utmost good faith, and a conclusion that [the insurer] is liable to indemnify [the insured] ..., there must be at least one other premise.\(^{343}\)

9.4. The need for a conclusion that an insurer is otherwise liable to indemnify a policyowner under a contract of insurance means that it is questionable whether a breach of the duty of utmost good faith would ever add anything to damages flowing ordinarily from a contractual breach. Therefore, in most, if not all cases, in which a policyowner or third party beneficiary claims damages for a breach of a contract of insurance by an insurer in failing to indemnify or provide a benefit, an additional breach of the duty of utmost good faith will not add to the quantum of damages claimed.


\(^{342}\) ALRC 20 at [328].

\(^{343}\) FN 11 at [16].
PART TEN – COVER AND INDEMNITY

The cover and the nature of an insurer’s promise to indemnify are discussed below under the following headings:

1. Cover – main terms;
2. Indemnity;
3. Debt, liquidated sum and damages;
4. Indemnity – first party insurance;
5. Indemnity – third party liability insurance.

1. Cover – main terms

Introduction

1.1. An agreement must have terms that are certain. This means that a contract must contain all the material or main terms of the agreement between the parties. The parties must have agreed on every material term of the contract they wish to make, and in the case of a contract of insurance the material terms (apart from the identity of the parties) are the definition of the risk to be covered, the duration of the cover, the amount and mode of payment of the premium, and the amount of the insurance payable in the event of the occurrence of the risk insured against. These must be certain and not so incomplete or vague that there is no binding contract.

1.2. If there is agreement on all the substantial terms, but some essential matters have been left for future decision between the parties, the transaction has not got beyond the stage of negotiations. An agreement may leave a sufficient number of necessary or important issues unsettled to raise the inference that the parties have not yet concluded an agreement and that they do not intend to be bound immediately. In these circumstances, there will not be a binding contract. An agreement may, however, be binding even though it is not worked out in meticulous detail.

Further, as is the case with vague agreements, the courts will be more ready to hold that there is a binding agreement if the arrangement is commercial or partially executed.

Material or main terms

1.3. An acceptance will be of no effect in law to conclude an agreement unless the parties have agreed on every material term of the contract. The Courts say that all of the terms should be agreed or

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344 Sutton, para. 9.450.
345 Rankin v Mutual Life & Citizens' Assurance Co Ltd (1991) 6 ANZ Insurance Cases 61-034 (SC WA) where in the circumstances the proposal was regarded as no more than an invitation to treat by the proponent. As to the effect of lack of agreement about relatively minor terms, see Alice Springs Meatworks Pty Ltd v Aviation Management Services Ltd (1992) 7 ANZ Insurance Cases 61-112 (SC NSW) at 77,530-77,531 and the cases there cited; see, for an application of the principles in the statutory insurance context: Canberra Pools Pty Ltd v MMI General Insurance Ltd (2000) 98 FCR 296; 11 ANZ Insurance Cases 61-471; (2000) 174 ALR 755; [2000] FCA 751.
347 Assicurazioni Generali SpA v Arab Insurance Group (BSC) [2003] 1 Lloyd's Rep IR 131; 1 WLR 577; 1 All ER (Comm) 140; [2002] EWCA Civ 1642 at 143, paras 28-51 and 209 (Lloyd's Rep IR); compare American International Marine Agency of New York Inc v Dandridge [2005] Lloyd's Rep IR 643; 2 All ER (Comm) 496; EWHC 829 (Comm) at 651, para 21 and 655 at paras 47 and 48 (Lloyd's Rep IR).
348 See, e.g. First Energy (UK) Ltd v Hungarian International Bank Ltd [1993] 2 Lloyd's Rep 194 at 200, 201, 205.
349 Carter J, Contract Law in Australia (6th ed, LexisNexis Butterworths, 2012) at [4-02] and [4-12].
350 Sutton, para. 9.460.
there should be an agreement to use the insurer’s usual form. The Courts have described the ‘policy’ as including the four essential features of insurance:

a) the perils insured against;
b) the measure of indemnity;
c) the duration of the cover; and
d) the premium.

1.4. To these four essential features must be added an obvious fifth, namely, there must be certainty about the parties: the entities constituting the policyowner and the insurer.

Duration of the insurance cover

1.5. The duration of the insurance contract, or the policy period, is an essential term.

1.6. It is important to distinguish between:

a) conditions precedent to the contract: if these are not fulfilled there will be no contract; and
b) conditions precedent to the commencement of the risk: if these are not fulfilled there will still be a contract but the insurer will not be ‘on risk’.

1.7. The effective difference is that in the first case the policyowner will not be liable to the insurer for the premium, but in the second it is not necessary for the premium to be paid by the policyowner for there to be a binding contract of insurance; this will depend on the terms of the contract.

1.8. A schedule or certificate to the policy, rather than the form of wording or the special clauses, will specify the duration of the risk. It is important to distinguish the date on which a binding contract of insurance is concluded from the date on which the risk commences; the latter is sometimes called the inception date. Once a contract is formed, the parties may have agreed in it to delay the commencement of the risk by providing that the insurer may only be on risk once certain warranties have been satisfied. These ‘pre-conditions’ may be that the insurer receives the premium or the policy issues, but in the absence of any such ‘pre-conditions’ the insurer will be on risk on the date specified in the policy.

1.9. The nature of the risk described in the policy will affect the duration of the risk. In particular, if the policy is on a ‘losses occurring’ basis then the insurer will be liable for any losses that occur during the period of the policy, whether or not the insurer is notified within that period of a circumstance which might give rise to a loss or claims which are submitted. On the other hand, a ‘claims made’ policy will provide that the insurer is liable for valid claims that are submitted in accordance with the policy terms during the period of the policy. So, the insurer will not be liable for claims made after the end of the policy year unless the period of the policy is in some way extended for certain purposes. For example, the policy may provide that the insurer will pay on a claim even if the claim is submitted after the end of the policy, only if the insurer has received a notification of the claim.

351 Allis-Chalmers Co v Fidelity and Deposit Co of Maryland (1916) 114 LT 433
352 Allis-Chalmers Co v Fidelity and Deposit Co of Maryland.
354 Charter Reinsurance Co Ltd v Fagan.
355 Assicurazioni Generali SpA v Arab Insurance Group (BSC) [2003] 1 Lloyd's Rep IR 131; 1 WLR 577; 1 All ER (Comm) 140; [2002] EWCA Civ 1642 at 143, paras 28-51 (Lloyd's Rep IR).
356 Sutton, para 4.470.
357 Wooding v Monmouthshire & South Wales Mutual Indemnity Society Ltd [1939] 4 All ER 570 at 581; Adie v Insurance Corp Ltd (1898) 108 LT 38 at 43, 44, 45.
358 The insurance law equivalent of conditions in general law, see Part Eleven.
359 See Taylor v Dexta Corporation Ltd [2005] NSWSC 974 (29 September 2005) where the policyowner was not entitled to an indemnity for loss arising from a contract entered into before the commencement of the contract of insurance, but occurring within the duration of the cover.
Rate of premium

1.10. The premium may be the consideration for the insurer's promise or it may be a benefit payable to the insurer under the contract of insurance. The amount of premium to be paid by the policyowner to the insurer must be agreed, although a particular sum need not be specified.

The subject matter of the insurance and the amount covered

1.11. The subject matter of an insurance policy for a first party insurance is the insured event or condition. For a third party liability insurance it is the liability of the policyowner to others arising out of the activities, conduct or business of the policyowner. This may be on a ‘losses occurring’ or ‘claims made’ basis. In third party liability policies, the indemnity will be for any sums of money that the policyowner is obliged to pay resulting from claims or settlements of them, arbitration awards or court judgments against the policyowner in the relevant insured capacity. An insurance contract therefore defines the risks to be covered or the subject matter of the insurance using one or more of the following elements: activities or conduct of the policyowner and the insured event or condition. These elements were described by Meagher JA as follows:

*The respects in which the insured's claim does not have the characteristics of the event of the kind insured are referred to by the plurality in Australian Hospital Care as “restrictions or limitations” inherent in that claim... [the court] describe that event as “the event insured against” and as “an event of the type contemplated by the contract” and note that it will vary according to “the type of insurance in issue”. That event may be an accident which results in personal injury or property damage; or the happening of that injury or damage; or the making of a demand against the insured by a third party; or the happening of an occurrence or circumstance which may give rise to such a demand; or the insured's becoming aware of such an occurrence or circumstance. These descriptions of themselves are not sufficiently specific to define the event covered by a particular type of policy. The accident will have to be of a particular kind, or arise out of or in the course of a specified activity. The injury or damage will usually have to happen in the course of or in connection with a particular activity. The third party demand is usually described as arising out of or in connection with the conduct of a particular business or professional activity. The same may be said of an occurrence or circumstance which may give rise to a claim. The way in which the provisions of the policy describe and define that event or risk will vary between different types of policy, and sometimes between policies which provide the same type of cover. It is here that matters of form are not to dictate the outcome when considering the effect of the contract: East End at 403-404. It nevertheless remains necessary, in addressing that effect, to have regard to the nature of the risk and subject matter insured as well as the commercial or other*

539 Sutton, para. 9.480.
540 See Canberra Pools Pty Ltd v MMI General Insurance Ltd (2000) 98 FCR 296; 11 ANZ Insurance Cases 61-471; (2000) 174 ALR 755; [2000] FCA 751 where there was held to be a binding contract even though the amount of the premium had not been agreed. The Court held, for a statutory workers' compensation policy that there was an implied term that a reasonable premium would be paid. The court must have been influenced by the compulsory status of the insurance, the provisions of the statute on the payment of a ‘minimum and deposit premium’, the calculus for premium on the basis of a wages declaration and the inability of the insurer, without Ministerial consent, of refusing to issue a policy.
541 Allis-Chalmers Co v Fidelity and Deposit Co of Maryland (1916) 114 LT 433; Christie v North British Insurance Co (1825) 3 Sh & D (Ct of Sess) 350.Although in Glicksten & Son Ltd v State Assurance Co (1922) 10 Ll L Rep 604 the premium was to be arranged, this issue was not in dispute: at 615. Compare Marine Insurance Act 1906 s. 31(2); American Airlines Inc v Hope [1973] 1 Lloyd's Rep 233; affd [1974] 2 Lloyd's Rep 301; (premium and geographical area to be agreed); Phoenix General Insurance Co of Greece SA v Halvanon Insurance Co Ltd (1985) 4 ANZ Insurance Cases 60-724; [1986] 1 All ER 908; [1987] 2 WLR 512; [1985] 2 Lloyd's Rep 599 at 610-612 (All ER) (Lloyd's Rep); Kirby v Consindit Societa Per Azioni [1969] 1 Lloyd's Rep 75.
542 Sutton, para. 9.490.
context in which the insurance is written, to the extent that evidence of that kind is admissible on that question of construction. 363

1.12. Either the schedule to the policy or the certificate will identify the maximum amount which can be claimed under the policy and this will usually be referred to as ‘the policy limit’; 364 there will also be a minimum claim and this is described as the ‘excess’ or ‘deductible’.

1.13. The amount 365 and subject of the cover are essential terms in the proof of an insurance contract. 366 The courts have said ‘Where the extent of cover is defined by a maximum amount it may be said that cover is limited to that amount but that is not to categorise that amount as an exception to, condition of or limitation to cover. It is an essential part of the primary obligation to insure.’ 367

2. Indemnity

2.1. The policyowner's right to an indemnity is fundamental to any insurance. 368 When the insured event (whether an occurrence, contingency or claim) or condition occurs in relation to an insurance contract, the policyowner will lodge a claim with the insurer. The claim is for the indemnity that the policyowner contracted to receive and that the insurer contracted to give under the insurance contract and subject to its terms. The ordinary usage speaks of claiming or asking for indemnity and being either granted or denied indemnity; if indemnity is granted, the insurer and the policyowner may disagree about how the indemnity is to be granted or about the amount or value involved. Allsop JA described the notion of grant of indemnity as follows:

Insurers ... often speak of a “grant of indemnity” as a way of stating an acceptance of the response of their policy. It is of course important to recall that an insurer has entered a policy under which it is either legally liable to indemnify or not ... In one sense, there is nothing to “grant”. The expression “grant indemnity” in these circumstances at least contains the recognition or admission, in perhaps customary language, of liability under the policy.... [T]he character of the communication – a recognition of liability (that is an admission) under the terms of the policy and on the basis of what was known. 369

2.2. This commonplace of experience and language is part demonstration that while indemnity is most often described and considered in the context of a measure of damages, neither the measure nor the damages aspect is a complete analysis. The concept of an indemnity is inherently ambiguous and elusive. 370

2.3. The common meaning of indemnity is the measure of the amount one person must pay to another, in a variety of circumstances. For insurance this meaning is classically expressed in Castellian v

368 For life insurance the indemnity right is a right to a sum insured or benefit.
370 In Penrith City Council v Government Insurance Office (NSW) (1991) 24 NSWR 564; 6 ANZ Insurance Cases 61-070, Giles J asked what the insurer was required to do in performance of its promise and thought that the answer that the obligation was to indemnify took the matter no further.
Preston (1883) 11 QBD 380\textsuperscript{371} that the policyowner is entitled, on the principle of indemnity, to recover no more and no less than the loss. Much of the law on the nature of an indemnity involves an elaboration of this rendition of the concept.

2.4. An indemnity is first and foremost its own right and obligation, a promise resulting in a particular type of obligation which one person has to another: in the language of Photo Production Ltd v Securicor Transport Ltd\textsuperscript{372}, a ‘primary obligation’. The measure comes later when value and amounts are considered. The right to damages and the insurer's obligation to pay damages, a secondary obligation, is not at this stage yet a part of the analysis. When the insured event or condition occurs neither party has breached the contract. If the insurer grants indemnity in accordance with the contract and, particularly for current purposes, within the time permitted expressly or impliedly under the contract, the insurer has not breached the contract. If there is no breach, then the question of damages does not arise.\textsuperscript{373}

2.5. The main insuring clause for a first party insurance will usually provide that the insurer agrees to indemnify the policyowner against a defined loss. The definition of loss will cover various forms of property (goods, assets or money), person (limb, facility or ability) or pure economic loss (e.g. income). The loss will be structured in the main insuring clause as one which is caused by or has a causal relationship with an event, occurrence or contingency. The indemnity here is usually against the policyowner or a third party beneficiary's own loss.

2.6. The main insuring clause for a third party liability insurance will usually provide that the insurer agrees to indemnify the policyowner against a series of connected things: the third party's claim against the policyowner; the cause of action or remedy pursued by the third party against the policyowner; the liability of the policyowner to the third party; or the amount (whether defined as damages, compensation, settlement or sum) paid or payable by the policyowner to the third party. The indemnity here can be against any of these five things. The common law trends towards the view that the indemnity is against the policyowner's liability ascertained by verdict, judgment or settlement but this must be confined to an indemnity against an amount paid or payable by the policyowner to the third party. This common law trend is otherwise doubtful in Australia and always subject to the terms of the insurance and any relevant statute.

3. Debt, liquidated sum and damages

3.1. The law distinguishes between a claim in debt, a claim for an unliquidated sum, a claim for liquidated damages and a claim for unliquidated damages.\textsuperscript{374} A claim:

a) in debt is not a claim for damages.\textsuperscript{375} It is a claim for a liquidated sum that ‘can be ascertained by calculation or fixed by any scale of charges or other positive data’: Spain v Union Steamship Co of New Zealand Ltd.\textsuperscript{376} In that case, the High Court concluded that an employee’s claim for reimbursement of reasonable expenses was a claim in debt, even though

\textsuperscript{371} Castellian v Preston (1883) 11 QBD 380. See, e.g. Darrell v Tibbits (1880) 5 QBD 560; Weld-Blundell v Stephens [1919] 1 KB 520 at 529; Meacock v Bryant & Co [[1942] 2 All ER 661; (1942) 59 TLR 51 at 663Y; British Traders' Insurance Co Ltd v Monson (1964) 111 CLR 86; 38 ALJR 20; [1964] ALR 245 at 92, 93 (CLR); Transport Accident Commission v CMT Construction of Metropolitan Tunnels (1988) 165 CLR 436; 80 ALR 545, 548; [1988] HCA 46 at 442 (CLR), 547 (ALR).

\textsuperscript{372} Photo Production Ltd v Securicor Transport Ltd [1980] AC 827; [1980] 2 WLR 283; [1980] 1 All ER 556.

\textsuperscript{373} See \textsuperscript{[3.320]} see also McArthur v Mercantile Mutual Life Insurance Co Ltd [2002] 2 Qd R 197; 11 ANZ Insurance Cases 61-501; [2001] QCA 317 at [4], [58]-[61], to the effect that a life benefit may be a debt.


\textsuperscript{375} Rothenberger Australia Pty Ltd v Lumley General Insurance Ltd [2003] NSWSC 788 at [26]-[27] (Barrett J).

\textsuperscript{376} (1923) 32 CLR 138 (Knox CJ and Starke J).
the court would need to decide on the reasonableness of the expenses before the claim could succeed;

b) for an unliquidated sum is a claim which:
   i. accrues under a contract, but not because the contract has been breached; and
   ii. cannot ‘be ascertained by calculation or fixed by any scale of charges or other positive data’;

c) for liquidated damages is a claim for damages ‘recoverable in satisfaction of a right of recovery created by the contract itself and accruing by reason of breach’;\(^{377}\)

d) for unliquidated damages is a claim for ‘compensation as assessed by the court for loss occasioned by breach’.\(^{378}\) It is an uncertain amount requiring the court to make evaluative decisions before the amount payable is ascertained.

3.2. Sometimes, it is important to make these or similar distinctions. For example:

   a) in ascertaining when a cause of action accrues; or
   b) on an application for a default judgment.

c) In Western Australia, for example, a plaintiff who indorses a Writ with a claim for a liquidated sum is entitled to final judgment against a defendant who fails to enter an appearance to the Writ within time.\(^{379}\) On the other hand, a plaintiff who indorses a Writ with a claim for an unliquidated sum or unliquidated damages is entitled to interlocutory judgment on liability against a defendant who fails to enter an appearance to the Writ within time, with the unliquidated sum or unliquidated damages to be assessed by the court\(^{380}\);

d) in determining whether:
   i. a court should order a company to be wound up on the ground of insolvency;
   ii. there is a liability on the part of the directors of a company because the company traded whilst insolvent;
   iii. a creditor is entitled to serve a statutory demand; or
   iv. payment of an insurance claim is a voidable transaction because the claim was paid when the company was insolvent.

3.3. At common law, a promise to indemnify is a promise to save and keep an indemnified person harmless from loss.\(^{381}\)

3.4. In Scotland, an insurance claim for indemnity is a claim for the amount of the policyowner’s loss or for the provision of money’s worth.\(^{382}\)

3.5. In England, an insurance claim for indemnity is a claim for unliquidated damages for breach of contract.\(^{383}\) This is because, by the common law of England:
   a) an indemnifier is liable for unliquidated damages for breach of contract for failing to prevent an indemnified person from suffering a loss;\(^{384}\)
   b) an insurer’s primary contractual obligation is to hold an insured harmless by preventing them from suffering a loss.\(^{385}\)

\(^{377}\) *Rothenberger Australia Pty Ltd v Lumley General Insurance Ltd* [2003] NSWSC 788 at [26]–[27] (Barrett J).

\(^{378}\) *Alexander v Ajax Insurance Co Ltd* [1956] VLR 436 at 444.

\(^{379}\) Order 13 Rule 2(1) of the Rules of the Supreme Court.

\(^{380}\) Order 13 Rule 7(1) of the Rules of the Supreme Court.


\(^{383}\) *Edmunds v Lloyd Italico e L’Ancora Cia Di Assicurazioni e Riassicurazioni Spa* (1986) 2 ALL ER 249 at 250 (Sir John Donaldson).

\(^{384}\) *Firma C-Trade SA v Newcastle Protection and Indemnity Association* [1991] 2 AC 1 at 35 (Lord Goff of Chieveley).
an insurer is in breach of its primary obligation the moment a loss occurs because it did not prevent the loss;\(^{386}\) and

breach of an insurer’s primary obligation gives rise to the insurer’s secondary obligation to pay damages.\(^{387}\) The idea that the claim is for damages is unusual because there is no suggestion that the claim arises out of the insurer doing anything other than what the policyowner expected it to do.\(^{388}\)

3.6. For the following reasons, it is hard to understand why an insurer should be regarded as being in breach of its primary obligation the moment a loss occurs.

3.7. In the case of first party insurance, an insured usually suffers a loss the moment an insured event occurs, for example when a fire starts burning down an insured home or an insured car is stolen. Even if some time elapses between the happening of an insured event and a loss, it is unlikely that space in time will be sufficient to enable an insurer to prevent the loss. Amongst other things, this is because insurers usually find out about a loss after it has happened. In the circumstances, why would an insurer promise to prevent a loss, and why would a policyowner believe that is what the insurer promised?

3.8. In the case of liability insurance, an insurer promises to indemnify an insured for their legal liability to a third party. An insurer only becomes bound to deliver on its promise when, for the purpose of the contract, the insured suffers a loss. The insured suffers a loss when its liability to a third party is established by a court judgment, an arbitration award or a binding settlement, even though the event that triggered the policy response occurred at an earlier point in time.\(^{389}\)

3.9. There is nothing a liability insurer can do to prevent an insured from incurring a liability to a third party. So, why would an insurer promise to do that, and why would a policyowner believe that is what the insurer promised?

3.10. In Australia, an insurer’s promise to indemnify is regarded as a promise to make good a loss suffered by an insured as a result of an insured event occurring, by indemnifying the insured, paying the amount of their loss or providing money’s worth ‘in accordance with’ the terms of the contract.\(^{390}\) Paying the amount of the loss saves and keeps the insured harmless in a practical way, and accords with what insurers intend by their promise to indemnify and how they deliver on that promise every day of the week.

4. Indemnity – first party insurance

4.1. A claim for loss of, or damage to, property under a first party insurance contract is a claim for an indemnity or an unliquidated sum.\(^{391}\) It is not a claim:

a) in debt or for damages for breach of contract;

b) for a liquidated sum, even though it is similar to a liquidated claim for goods sold and delivered or work and labour done.\(^{392}\)


\(^{386}\) Ventouris v Trevor Rex Mountain (The Italia Express (No 2)) [1992] 2 Lloyd’s Rep 281 (Hirst J).

\(^{387}\) Photo Production Ltd v Securicor Transport Ltd [1980] UKHL 2; AC 827 at 849 (Lord Diplock).

\(^{388}\) Jabbour v Custodian of Absentee Property for the State of Israel [1954] 1 WLR 139 at 143 (Pearson J).


5. Indemnity – third party liability insurance

5.1. The main purpose of liability insurance is to protect the insured against ‘certain types of tortious liability’.393 Broadly stated, it is insurance of the risk that a insured might be held legally liable to pay compensation to a third party for personal injury, property damage or financial loss suffered by the third party.

5.2. Upon suffering a loss, an insured is entitled to a court order that the insurer specifically perform its promise to indemnify by paying:
   a) its policyowner the amount of its liability to the third party; or
   b) to the third party, on its policyowner’s behalf, the amount of the policyowner’s liability to the third party.394

5.3. The insured suffers a loss when its liability to pay compensation to a third party is crystallised by a court judgment, an arbitration award or a binding settlement.395 If an insured does not incur a legal liability to a third party, it suffers no loss and there is nothing for the insurance to respond to.396

5.4. In summary, if an insured:
   a) has paid to the third party the amount of its liability to the third party, its claim against its liability insurer is in debt for the amount of that liability;397
   b) has not paid to the third party the amount of its liability to the third party, its claim against its liability insurer is for:
      i. an order that the insurer pay it or the third party, on its behalf, the amount of its liability to the third party; or
      ii. damages for the insurer’s breach of contract in failing to indemnify it against its liability to the third party.398

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393 Bartoline Ltd v Royal Sun Alliance Insurance Plc [2006] EWHC 3598 (QB); [2008] Env LR 1 at [110] (Hegarty J).
396 West Wake Price & Co v Ching [1957] 1 WLR 45 at 49 (Devlin J).
397 New Cap Reinsurance Corporation Ltd (in liq) v AE Grant, 27 at [87] (White J).
398 Carillion Construction Ltd v AIG Australasia Ltd [2016] NSWSC 495 at [156] and [194] (Stevenson J).
This introduction to the formation and layout of insurance policies is discussed below under the following headings:

1. Insurance contract formation;
2. Anatomy of an insurance policy;
3. Disclosure of policy terms;

1. Insurance contract formation
1.1. The process of, and the elements in, marketing, negotiation and entering into an insurance contract are described in Part Four.
1.2. The process and elements must satisfy certain legal rules before there is a valid and enforceable insurance contract. The parties must intend to enter into a legal relationship. A party must make and offer which is accepted by the other party. The proponent or policyowner must provide consideration for the insurer’s promise of cover under the insurance contract.399
1.3. These issues rarely cause difficulty for retail insurances because the insurer’s usual processes would normally ensure that the necessary elements are satisfied. There can be issues for wholesale insurances and large commercial and financial types of insurance contracts.

2. Anatomy of an insurance policy400

Sources of policy terms
2.1. The purpose of an insurance policy document is to assemble, set out and record the intentions of the parties for their relationship in relation to the subject-matter of the insurance. The subject matter of a general insurance policy is an event which causes loss of or damage to an asset, goods, property or income (together Insured Event). For modern insurance contracts, most of the terms will be in writing and express.
2.2. There will be some matters which have been expressed orally during negotiations between the parties. There may be issues about the extent to which these oral matters, and terms in the preliminary record, govern or influence the anatomy and interpretation of the final policy documents. There will often be implied terms, a number of which arise from the Insurance Contracts Act 1984 (IC Act).
2.3. Some of the terms of the insurance policy may be in the insurance policy, through the incorporation of other documents by reference to those other documents.
2.4. When a court is asked to interpret an insurance contract it will begin with the written express terms including those incorporated by reference. There may be evidence to show that oral matters or other written provisions are properly a part of the policy. If the policy documents do not correctly record the arrangements between the parties, the relevant party may have an action for

399 Sutton, paras.9.10-9.170; Pynt, Ch 9.
400 Sutton, paras. 10.10-10.70; Pynt, Ch 12, particularly paras. 12.1-12.4.
rectification so that the content of the insurance policy reflects the true arrangements between the parties.

2.5. The question of what risk is covered, and on what terms, can be answered only by a careful reading of the policy and other contract documents to ascertain what Insured Event is covered and what amount or benefit the insurer must pay or grant to the policyowner.402

**Proposal**

2.6. There is a proposal form or application for general insurance; it contains various particulars and questions for the policyowner to answer. The policyowner completes and signs it.

2.7. The statements of fact in a proposal are no longer, because of the IC Act section 24, permitted to be incorporated into the insurance policy.403

**Documents**

2.8. An insurance policy usually comprises two documents, one known as the policy wording, and the other described as a ‘schedule’ or ‘certificate’.

2.9. The policy wording usually begins with a preamble or recital and then contains a main insuring clause. It will also contain definitions and terms described as ‘conditions’. There will also be exclusions and extensions.Clauses on the risk will appear under each of these headings in the policy, but the main insuring clause is the key to the risk that the underwriter accepts. Terms described as definitions, conditions, exclusions and extensions are also dealt with throughout this Background Paper, but the categories described below provide a guide to their nomenclature in the insurance policy.

2.10. The policy wording is often in a Product Disclosure Statement (PDS). It can be difficult to discern what parts of the PDS are policy terms and what are not.

2.11. The schedule or certificate contains the specifics of the cover: policyowner, type of policy, duration, premium and a note or labels for the risks covered.

**Main insuring or operative clause**

**General**

2.12. It is essential in any issue involving a general insurance policy, particularly a claim or dispute, to begin with the main insuring clause. It can be difficult to find and it is usually scattered across a number of different clauses. The search is for the terms in the contract which when all put together would read something like this:

*The insurer agrees, in consideration of the premium, to indemnify [or pay] the Policyowner if the [specified Insured Event] causes loss of or damage to the [specified Insured Property] during the period of this policy.*

2.13. The main insuring clause contains the main terms of the policy. First, it specifies the relevant parties and their roles. It is the insurer which must make the payment or grant the indemnity. It is the policyowner who is entitled to receive the amount or benefit. Second, it specifies the insured event, in relation to the insured property, which entitles the claimant to the relevant and specified amount or benefit. Third, it specifies the duration of the policy. It is axiomatic that the specified insured event which triggers the insurer’s liability for the amount or benefit must occur during the period of the policy. It is always very difficult to analyse and decide what the trigger is in a

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401 See Part Fourteen – Claims.
402 *Sutton*, paras. 10.10-10.70.
403 *Sutton*, para. 10.20.
policy. If the trigger occurs before the risk commencement date for the policy or after its expiry, termination or cancellation, the claimant has no entitlement to the amount or benefit. Fourth, it states the obligation to pay the premium.

Steps
2.14. Once the main insuring clause is identified, it is necessary to consider three matters.
2.15. First, it is necessary to identify any definitions in the policy that are definitions of, or related to, the terms of the main insuring clause and to incorporate them into the interpretation of the main insuring clause. The insured event and the insured property is almost always defined.
2.16. Second, it is necessary to consider whether the main insuring clause and the definitions are affected in any way by legislation, particularly the IC Act and the Life Insurance Act 1995.
2.17. Third, it is necessary to consider whether the main insuring clause and the definitions are affected in any way (after the effect of legislation, particularly the IC Act) by decided cases.
2.18. Once this process is finished it is then possible to analyse and decide what are the elements of the insured event the occurrence of which in relation to the insured property, means that the claimant is entitled to the amount or benefit. The elements are each and every thing which the claimant must prove for the entitlement to be established and demonstrated. But only one or two of these elements will be the trigger for the insurer’s liability. The trigger is the thing which must occur during the period of the policy for the insurer to be obliged as a matter of law, to pay the amount or benefit when the other elements are satisfied but no matter when they are satisfied. It can take a period of time for a claim to be finalised but the insurer is not relieved of liability if the trigger has occurred during the period of the policy.

Definitions and conditions
2.19. Some of the expressions in the main insuring clause and other terms of the policy may be defined by terms in the policy, for example the ‘insured’. The definitions sometimes refer to further details contained in a schedule or certificate to the policy. Definitions are a common source of dispute, in that the term defined may be used in different senses throughout the policy but the definition may relate to only one of those uses.
2.20. An insurance policy will usually also contain a series of terms under the heading ‘conditions’. Terms under this heading often, and largely, deal with making claims. Sometimes the conditions can be expressed to be conditions precedent to a claim, but in other policies the conditions are additional obligations placed on the policyowner. The conditions can occasionally contain definitions and exclusions.

Extensions or additional benefits
2.21. Even though there will be a core or main type of insured event, which is the main cover under the insurance policy, the insurer may offer cover against a wider range of events or conditions, causes of action or types of loss and remedy. Provisions for this additional cover can be called ‘options’ or ‘extensions’. A policy wording will often list various extensions and options for the main cover which the policyowner can have for the payment of an additional premium. There may be other extensions or options which are commonly available from insurers which do not always appear as options in the policy wording.

Exclusions
2.22. An insurer will always restrict or limit the cover provided for under the insurance by different types of exclusions. Some of these are described as exclusions but others appear as limitations in
provisions which set out the cover. There is almost always a set of provisions in a policy which are described as exclusions.

Other terms

2.23. The following list may be a useful guide to other common terms of insurance policies:
   a) effect of a misrepresentation, non-disclosure or breach of utmost good faith;
   b) fraud and dishonesty;
   c) formation and terms of contract, particularly incorporation of other documents and the certificate or schedule;
   d) parties covered by the insurance and the type of activities or business covered;
   e) duration of cover;
   f) limits on the amounts payable by the insurer;
   g) making claims;
   h) defences to claims.

3. Disclosure of policy terms

3.1. It is increasingly difficult to find the policy terms. There are a lot of documents and emails that are sent by the insurer and by the policyowner or intermediary.

3.2. The policy wording is often in a PDS. It can be difficult to discern what parts of the PDS are policy terms and what parts are not. The PDS is usually many pages. There is advertising material, guidance, information, options and advice about what to do with a complaint or claim.

3.3. An insurer is obliged by law to bring the terms of the policy, to the mind of the policyowner. There are many sources of the legal obligation of the insurer to disclose fairly the policy terms to the policyowner.

3.4. First, the Corporations Act 2001 (Corporations Act), section 1013C(3), provides that: ‘The information included in the Product Disclosure Statement must be worded and presented in a clear, concise and effective manner.’

3.5. Second, the IC Act section 13(1) provides that an insurance contract is ‘based on the utmost good faith’ (emphasis added) and that the good faith duty is an implied term of the contract. The first limb, the basis concept, imports and confirms the common law on the insurer’s duty of utmost good faith into the IC Act. The effect is that the insurer has a pre-contract duty of utmost good faith to the policyowner and that duty includes a disclosure duty.

3.6. Third, the insurer must deal with the policyowner ‘openly, honestly and fairly’. The High Court in CGU v. AMP said:

   we accept that utmost good faith may require an insurer to act with due regard to the legitimate interests of an insured, as well as to its own interests. The classic example of an insured's obligation of utmost good faith is a requirement of full disclosure to an insurer, that is to say, a requirement to pay regard to the legitimate interests of the insurer. Conversely, an insurer's statutory obligation to act with utmost good faith may require an insurer to act, consistently with commercial standards of decency and fairness, with due regard to the interests of the insured.

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404 Compare Pynt, para. 8.59-8.60.
406 Pynt, para. 7.8.
3.7. Fourth, the mere supply of a policy is not sufficient disclosure of a term with a serious adverse effect on the policyowner. For example, the IC Act sections 33A-D provide, in relation to Key Facts Sheets (KFS) in relation to flood cover, for the supply of a key facts sheet to a policyowner before the contract is entered into. But the supply of the KFS does not of itself constitute ‘clearly informing’ the person of the contents of the KFS.\textsuperscript{408}

3.8. Fifth, for eligible contracts, the IC Act section 37 applies the same precepts. An insurer must clearly inform the policyowner in writing of the effect of any provision ‘of a kind that is not usually included in contracts of insurance that provide similar insurance cover’ failing which the insurer may not rely on that provision. There is a view that a failure of an insurer to give the IC Act section 37 notice does not breach the insurer's statutory duty of utmost good faith under the IC Act section 14 because section 37, qualified by section 71, provides a legislative scheme with its own consequences or remedy.

3.9. Sixth, the risk an insurer has is that the mere supply of the policy document may not amount to informing the policyowner clearly of the effect of the unusual provisions. The procedure for the giving of the document is set out in section 77(1). The combined effect of IC Act sections 11(9) and (10) on renewal is that, although such renewal is the entry into a fresh contract of insurance, information is required to be given only as to provisions which are varied or proposed to be varied, if section 37 has been complied with previously, as, for example, when the insurance was originally taken out or when there had been a prior renewal.\textsuperscript{409}

3.10. Seventh, the common law supports this position. In \textit{Australian Associated Motor Insurers Ltd v Ellis}\textsuperscript{410}, the insurer was held to be unable to rely on the breach of condition because it had failed in its duty to act in the utmost good faith towards the policyowner. Cox J said that there seemed to be no good reason for not regarding the insurer's obligation under section 13 as including, at least in certain circumstances, an obligation to bring to a policyowner's notice the consequences of any breach of a condition of the policy. That view was in his opinion supported by section 14(3). The general policy of the IC Act and the protection given to the policyowner as to the duty of disclosure in the pre-contractual situation by section 22, meant that section 13 should be interpreted so as to require the insurer to give the policyowner adequate warning of the general nature and effect of the clause requiring the policyowner to obtain consent before making any modification to the vehicle. That obligation was not sufficiently discharged by printing an injunction on the proposal form or the bare supply of a copy of the policy or the terms of the renewal notice. The insurer's neglect in this respect was a failure to act with the utmost good faith and as a result reliance could not be placed on the breach of condition.\textsuperscript{411} Sutton concludes:

\begin{quote}
The section is aimed primarily at the insurer, and the intention of the framers of the Act is to ensure that in future an insurer will exercise care in drafting policy documents so as to make certain that it is not guilty of unfair practice.\textsuperscript{412}
\end{quote}

3.11. Eighth, an insurer must comply with the General Insurance Code of Practice standards in relation to the sale of the policy and disclosure of its terms.

3.12. Financial Ombudsman Service (FOS) considers that the test for the quality of a policyowner’s disclosure to the insurer in order to satisfy the policyowner’s duty of disclosure under the IC Act is that the disclosure must actually ‘come to the mind of the insurer’.\textsuperscript{413} FOS considers that it is

\textsuperscript{408} s. 33D.
\textsuperscript{409} Sutton, para.9.200.
\textsuperscript{410} (1990) 54 SASR 61; 10 MVR 143; 6 ANZ Insurance Cases 60-957.
\textsuperscript{411} Sutton, para. 6.250.
\textsuperscript{412} Sutton, para. 6.250.
\textsuperscript{413} Sutton, para. 7.130.
fair to treat that level of quality of disclosure as the test for the insurer’s disclosure to the policyowner for the purposes of the insurer’s duty of utmost good faith and disclosure of the policy terms. The disclosure by the insurer to a policyowner must ‘come to the mind of the person.'

3.13 FOS therefore considers that an insurer would not discharge its duty of utmost good faith under the IC Act, section 13, and under the law above in its disclosure of the policy terms unless the insurer clearly informs the policyowner by bringing the policy terms to the mind of the policyowner. FOS is entitled, under the IC Act, section 14(3), to have regard to the disclosure of the policy terms by the insurer to the policyowner. Where the disclosure of a policy term is a breach of the insurer’s duty of utmost good faith, the insurer is not entitled under the IC Act, section 14(1), to rely on the policy term which is not adequately disclosed.

4. Categories of terms
4.1. The terms of a general contract can be divided into three categories:
   a) Essential terms (sometimes known as ‘conditions’), breach of which will give an innocent party a right to terminate the contract. The test of essentiality:
      ... is whether it appears from the general nature of the contract considered as a whole, or from some particular term or terms, that the promise is of such importance to the promisee that he would not have entered into the contract unless he had been assured of a strict or a substantial performance of the promise, as the case may be, and that this ought to have been apparent to the promisor. If the innocent party would not have entered into the contract unless assured of a strict and literal performance of the promise, he may in general treat himself as discharged upon any breach of the promise, however slight. If he contracted in reliance upon a substantial performance of the promise, any substantial breach will ordinarily justify a discharge. In some cases it is expressly provided that a particular promise is essential to the contract, eg, by a stipulation that it is the basis or of the essence of the contract; but in the absence of express provision the question is one of construction for the Court, when once the terms of contract have been ascertained;
   b) Inessential terms (sometimes known as ‘warranties’), breach of which will give an innocent party a right to damages only;
   c) Intermediate or innominate terms, breach of which will give an innocent party a right to damages and a right to terminate the contract if the breach is sufficiently serious.

4.2. An innocent party will also have a right to terminate a contract if another party, by its conduct, repudiates the contract by evincing an unwillingness or inability to be bound by, or to render substantial performance of, the contract.

4.3. The terms of an insurance contract can also be divided into three categories:
   a) warranties, which unlike their namesake in the general law of contract, are essential terms of the contract;
   b) terms descriptive of the risk; and
   c) conditions, which unlike their namesake in the general law of contract, are inessential terms of the contract.

4.4. If there is a separate category of innominate terms in insurance law (terms that hover between a warranty and a condition), an insurer will not be entitled to repudiate the contract in reliance on a

414 FOS, Terms of Reference, para. 8.2.
415 Mann, paras. 33A.10-33.D10.
417 Tramways Advertising Pty Ltd v Luna Park (NSW) Ltd (1938) 38 SR (NSW) 632 at 641–2 (Jordan CJ).
policyowner’s breach of or non-compliance with such a term, no matter how serious the breach or non-compliance.\textsuperscript{418} An insurer should only be able to repudiate for breach of or non-compliance with such a term if it has clearly reserved to itself the right to do so.

4.5. How a term of an insurance contract is characterised is a matter of construction.\textsuperscript{419} How the parties themselves characterise a term is indicative but not conclusive.\textsuperscript{420} The more drastic the consequences of a breach or non-compliance, the clearer the intention of the parties needs to be in order to categorise the term as one attracting those consequences.

4.6. For contracts not subject to the IC Act, characterisation of a term of an insurance contract is important for the:
   a) procedural purpose of identifying the party who bears the onus of proving breach of, or non-compliance with, the term; and
   b) substantive purpose of ascertaining the remedy if the term is breached or not complied with.

4.7. For contracts subject to the IC Act, characterisation is important for determining who bears the onus of proof and an insurer’s remedy subject to the application of sections 13 and 14 (duty of utmost good faith) and section 54 of the IC Act.\textsuperscript{421}

4.8. Although section 54 has significantly blunted an insurer’s weaponry in the face of a policyowner’s breach of, or non-compliance with, a term of an insurance contract, section 54 will not apply to the breach or non-compliance unless:
   a) the insurer discharges the burden of proving breach or non-compliance or the operation of an exclusion (to the extent that it bears the onus of proof); or
   b) the policyowner fails to discharge the onus of proving it did not breach or fail to comply with the relevant term or that an exclusion does not operate (to the extent that it bears the onus of proof).

**Interpretation\textsuperscript{422}**

4.9. An insurance contract or policy is interpreted or construed according to the following principles.

4.10. The contract is read as a harmonious and consistent whole and in the context of other contracts and arrangements between the parties about the insurance.

4.11. The contract is interpreted objectively and in the context of the facts known to the parties, the background to the arrangement and the commercial and social purpose of the arrangement. The intentions of a party and the negotiations before the contract are irrelevant.

4.12. The words and phrases in the contract have their ordinary meaning or their technical meaning. The meaning is affected by definitions in the contract, legislation and case law. A word or phrase should not be ignored: an interpretation which gives a word or phrase no work to do should be avoided.

4.13. The contract is interpreted in a fair, reasonable and business-like way taking into account the variety of persons entering an insurance contract and the entitlement of such persons to know the bargain which they have secured.

\begin{itemize}
    \item \textsuperscript{418} Friends Provident Life & Pensions Ltd v Sirius International Insurance [2005] EWCA Civ 601 at [29]–[33] (Mance J); Ronson International Ltd v Patrick [2005] EWHC 1767 (QB) at [41] (Seymour QC).
    \item \textsuperscript{419} Kodak (Australasia) Pty Ltd v Retail Traders Mutual Indemnity Insurance Association (1942) 42 SR (NSW) 231 at 234 (Jordan CJ).
    \item \textsuperscript{420} HIH Casualty and General Insurance Ltd v New Hampshire Insurance Co [2001] EWCA Civ 735; 2 Lloyd’s Rep 161 at [101] (Rix LJ).
    \item \textsuperscript{421} See Pynt, Ch 7, for the application of ss. 13 and 14 and Pynt, Ch 22, for the application of s. 54.
    \item \textsuperscript{422} Sutton, Ch 10.
\end{itemize}
4.14. The contract is not interpreted to give an absurd (irrational or meaningless) result or to deny any cover. It cannot be rewritten to make more commercial sense.

4.15. A word or phrase which has two meanings will be interpreted in favour of the policyowner. It is not enough that there is a second arguable meaning.

4.16. The High Court in Wallaby Grip Ltd v QBE (Australia) Limited⁴²³ has clarified that at least in indemnity policies, if a policy is lost the onus of proving the existence of particular policy exclusions and limitations including the limit of indemnity rests on the insurer.

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PART TWELVE – INSURANCE CONTRACTS ACT 1984: SECTION 54

This introduction to the Insurance Contracts Act 1984 (IC Act) section 54 – the section is set out in the Appendix – is discussed below under the following headings:

1. Introduction;
2. Brief history;
3. Gateway requirements;
4. Casual connection test;
5. Proportionality test – no causal connection;
6. Causal connection and its consequences;
7. Scope of cover;
8. Protection of safety and property and impossibility;
9. Act and omission defined;
10. Exclusivity;
11. Common Exclusions and Conditions Table.

1. Introduction

1.1. Very commonly, terms in contracts of insurance, in particular but not exclusively exclusions and conditions, provide that the insurer may refuse to pay a claim because of conduct by the policyowner or some other person such as a third party beneficiary. In simple terms, section 54 of the IC Act can provide proportional relief when an insurer refuses to pay an insurance claim because of the conduct of a policyowner or some other person.

1.2. But in achieving proportional relief section 54 has a number of ‘working parts’.

1.3. Section 54 can provide relief where the effect of a contract of insurance is that an insurer may refuse to pay an insurance claim because of an act or omission of a policyowner or some other person that occurred after the contract was entered into.\(^\text{424}\) The applicable relief depends on the application of a causal connection test as to whether the act or omission could reasonably be regarded as being capable of causing or contributing to a covered loss.\(^\text{425}\) If the causal connection test is not satisfied then the insurer’s liability may be proportionally reduced according to the prejudice suffered by the insurer.\(^\text{426}\) If the causal connection test is satisfied then the insurer may refuse to pay the claim.\(^\text{427}\)

1.4. An ‘act’ in section 54 includes a reference to an act or omission.\(^\text{428}\)

1.5. Section 54 is exclusive of any right that an insurer has otherwise than under the IC Act in respect of an act or omission.\(^\text{429}\)

\(^{424}\) s. 54(1) first limb.
\(^{425}\) s. 54(2).
\(^{426}\) s. 54(1) second limb.
\(^{427}\) s. 54(2).
\(^{428}\) s. 54(6)(b).
2. Brief history

2.1. The Australian Law Reform Commission (ALRC) in its Report No. 20, Insurance Contracts (1982) (‘ALRC 20’) recommended reform of the laws concerning the application of insurance terms that protected the interests of insurers. The ALRC examined the operation of warranties, conditions and temporal exclusions. It was noted that the precise remedy available to an insurer depended on matters of form rather than substance. The wording of the particular term was crucial. Including whether the term took the form of a warranty, condition or temporal exclusion. A matter beyond the understanding of most policyowners. The ALRC also noted that when applying certain terms, the legal effect of the policyowner’s conduct could be out of proportion to the prejudice suffered by the insurer. By way of example a breach of a warranty could result in the termination of the contract of insurance. The ALRC concluded that the rights of the parties should depend on matters of substance, not on subtle differences in form.

2.2. The ALRC considered the adoption of various tests including those adopted by way of legislative intervention in various jurisdictions including NSW. One test considered was a causal connection test whereby an insurer’s rights are limited to cases where the policyowner’s conduct caused or contributed to the particular loss. A causal connection test had been adopted in New Zealand. The ALRC also considered the substitution of damages. Either by way of the principle of proportionality or contribution to loss.

2.3. The ALRC recommended the adoption of a combination of two tests, namely, a combination of causal connection and proportionality tests.

2.4. A causal connection test involves a determination of damages by reference to whether the policyowner’s conduct, either actually or in principle, could have caused or contributed to a loss. The principle of proportionality requires that the policyowner should suffer penalties only in proportion to the harm caused by the policyowner's conduct. The tests combine in section 54.

3. Gateway requirements

3.1. Section 54 operates where the effect of a contract of insurance is that an insurer may refuse to pay a claim, by reason of some act or omission of the policyowner or some other person that occurred after the contract was entered into. For section 54 to apply there are various gateway requirements in the first limb of section 54(1).

Post-contractual

3.2. Importantly, section 54 governs post-contractual conduct as opposed to pre-contractual conduct. It is important to understand when the relevant act or omission has taken place to ensure that section 54 as opposed to part IV of the IC Act applies to the conduct.

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429 Division 3 of Part V of the IC Act contains three sections, namely ss. 54, 55 and 55A. s. 55 is headed ‘no other remedies’ and provides that the provisions of Division 3 are exclusive of any right that an insurer has otherwise than under the IC Act in respect of an act or omission. s. 55A concerns representative actions by ASIC, as opposed to any right that an insurer may have. Therefore, in effect, s. 54 is exclusive of any right that an insurer has otherwise than under the IC Act in respect of an act or omission.
430 Insurance Act 1902 (NSW) s. 18.
431 Insurance Law Reform Act 1977 (NZ) s. 11.
432 ALRC 20 at [228].
‘Effect’ of a contract of insurance

3.3. There must be a requisite effect of the contract for section 54 to apply. That is, that the insurer may refuse to pay the claim pursuant to the contract of insurance by reason of the act or omission. This ‘effect’ must come from the contract of insurance. The question as to whether a contract of insurance has the requisite effect does not depend upon matters of form. If the contract of insurance does not have the requisite effect, then section 54 is not enlivened.

3.4. Deeming clauses in claims made and notified policies, such as professional indemnity covers, have been considered a problem by many insurers. Deeming clauses provide for the notification of circumstances that may give rise to a claim. Any subsequent claim in accordance with the notification is deemed to be made within the period of insurance of the notification. A failure to give notice of circumstances that might give rise to a claim in accordance with a contractual requirement to do so is an omission within the meaning of section 54 because the ‘effect’ of the contract is that the insurer can refuse to pay the claim.

Act or omission

3.5. There must be an act or omission. There may be an effect of the contract of insurance whereby the insurer has refused to pay a claim that is not by reason of some act or omission. An act or omission can be contrasted with a state of affairs. An example of a state of affairs is a person ‘normally living’ with a policyowner in accordance with the meaning of that term in an exclusion to liability cover. The policy excluded injury to any person who normally lives with the policyowner. This was not an act under section 54 but rather a state of affairs, a description of a relationship or the character of the relationship between the injured person and the policyowner.

The policyowner or ‘some other person’

3.6. The act or omission is that of the policyowner or some other person. Some other person may be a third party beneficiary. It refers to a person interested in the contract of insurance and doesn’t encompass a third party claimant.

4. Causal connection test

4.1. Section 54(2) contains the causal connection test and is the fulcrum around which other subsections of section 54 turn. The causal connection test requires a determination as to whether an act or omission could reasonably be regarded as being capable of causing or contributing to a loss for which cover is provided. If it can, then the act or omission is treated according to section 54(2), (3) and (4). If it cannot, then section 54(1) applies.

433 The NSW Court of Appeal held in East End Real Estate Pty Ltd v CE Heath Casualty & General Insurance Ltd (1991) 25 NSWLR 400; 7 ANZ Ins Cas 61-092 that it does not matter whether the effect arises from, for example, an insuring clause or an exclusion.

434 In Lipari v Union des Assurances de Paris IARD [1998] NSWSC 606; (1998) 44 NSWLR 652; 10 ANZ Ins Cas 61-415, the NSW Court of Appeal came to the conclusion that there was no requisite ‘effect’ when considering a general condition in a policy which contained no promise or obligation upon the part of the insured. The consequence of a breach of the condition was that the insurer could elect to avoid the policy. In the absence of the exercise of an election by the insurer (and in the absence of an entitlement to refuse to pay the claim), s. 54 did not arise for consideration.

435 Australian Hospital Care.

436 Allianz Australia Insurance Ltd v Inglis [2016] WASCA 25 per WA Court of Appeal.


438 Seery v John R Carr and Associates Pty Ltd (unreported, NSW Sup Ct, Giles CJ Comm D, 3 November 1995).
4.2. The determination as to whether an act or omission could reasonably be regarded as being capable of causing or contributing to a loss for which cover is provided may be difficult in some cases. Subject to exceptions it is possible to make some generalisations.

4.3. For instance, a failure by the policyowner to notify the insurer of a requisite matter is likely to be an ‘act’ that could not reasonably be regarded as being capable of causing or contributing to a loss in respect of which insurance cover is provided. If the failure to notify is not capable of causing or contributing to a loss, then section 54(1) applies.439

4.4. Another generalisation is that if the act or omission is the material change to the risk itself, rather than the notification of the material change, then it is more likely that the act or omission could reasonably be regarded as being capable of causing or contributing to a loss.440

4.5. A number of causal connection cases and the common terms which have given rise to them can be found in the Common Exclusions and Conditions Table below.441

5. Proportionality test – no causal connection

5.1. If an act or omission could not reasonably be regarded as being capable of causing or contributing to a loss, then the proportionality test in the second limb of section 54(1) potentially applies. The onus is on an insurer to prove its prejudice. Quantification of the insurer’s prejudice requires identification of the amount of damage which the insurer suffered as a result of the relevant act or omission. That damage is the actual financial damage, expressed in monetary terms, that either has been or will be suffered by the insurer.

5.2. If the insurer would have gone off risk entirely, had the relevant act or omission not occurred, the amount of the prejudice is the whole of the amount claimed. If the insurer would not have gone off risk, the prejudice is to be measured by reference to what would have happened (as distinct from what could or might have happened) if the act or omission had not occurred.

5.3. The High Court explained the application of the second limb of section 54(1) and the determination of prejudice, whether or not the insurer has lost an opportunity to go off risk, in two cases.

5.4. In Ferrcom Pty Ltd v Commercial Union Assurance Co of Australia Ltd442 the High Court explained the application of the second limb of section 54(1) where there is a loss of opportunity to go off risk. It also gave its unequivocal imprimatur to an insurer’s ability to reduce to nil under the second limb of section 54(1). The High Court held that in the circumstances of that case the insurer had lost its opportunity to ‘go off risk’ and that this lost opportunity was equal to the prima facie liability imposed by section 54(1) which was thereby ‘reduced to nil’.

439 An example of a failure to notify an insurer is found in Ferrcom Pty Ltd v Commercial Union Assurance Co of Australia Ltd (1993) 176 CLR 332; 67 ALJR 264; 7 ANZ Ins Cas 61-156 which concerned a failure by the insured to notify the insurer that it had registered a mobile crane for road use. The High Court noted that it was common ground that this act or omission was not capable of causing or contributing to a loss.

440 In Austcan Investments Pty Ltd v Sun Alliance Insurance Ltd (1992) 7 ANZ Ins Cas 61-116 the insured changed the use of its premises to include a manufacturing process which necessitated keeping larger quantities of flammable liquid on site than had been the case, which increased the risk of fire. This change was an alteration of manufacture which increased the risk of destruction or damage in breach of a policy condition. The Full Court of the SA Supreme Court held that the act of changing the manufacture could reasonably be regarded as being capable of causing or contributing to the fire that occurred, within s. 54(2).

441 This table has been extracted from a prospective publication.

442 Ferrcom Pty Ltd v Commercial Union Assurance Co of Australia Ltd (1993) 176 CLR 332; 67 ALJR 264; 7 ANZ Ins Cas 61-156.
5.5. In Moltoni Corporation Pty Ltd v QBE Insurance Ltd\textsuperscript{443} the High Court extended its reasoning in Ferrcom and explained the application of the second limb of section 54(1) where the insurer would not have gone off risk. The High Court noted that the expression in section 54(1) ‘the insurer’s liability in respect of the claim is reduced by the amount that fairly represents the extent’ of prejudice to the insurer assumes that the consequences of the act or omission can be expressed in a monetary sum. The High Court also noted that the reference to ‘the extent to which the insurer’s interests were prejudiced’ invites attention to, and requires identification of, the amount of damage suffered by the insurer as a result of the relevant act or omission. The act or omission may not always constitute a breach of the contract of insurance. For instance, it may have been by ‘some other person’. Therefore, the amount of damage suffered by the insurer will not always be identifiable as an amount for compensatory damages for breach of contract. Nevertheless, the High Court said that like compensatory damages ‘the amount of which section 54(1) speaks, as fairly representing the extent to which the insurer’s interests were prejudiced, will be the actual financial damage that has been or will be sustained as a result of the relevant act or omission’.\textsuperscript{444}

5.6. The High Court in Moltoni noted that if, as in Ferrcom, it can be shown that the insurer would have gone off risk, then the prejudice is the whole of the amount claimed. In respect of not going off risk, the High Court said that ‘if the insurer would not have gone off risk…the relevant prejudice suffered is to be measured by reference to what would have happened (as distinct from what could or might have happened) if the act or omission had not occurred’.\textsuperscript{445}

6. Causal connection and consequences

6.1. Under the second limb of section 54(2) an insurer may refuse to pay a claim where an act or omission could reasonably be regarded as being capable of causing or contributing to a loss in respect of which insurance cover is provided by the contract. It then becomes a matter for the policyowner to apply section 54(3) and prove that no part of the loss that gave rise to the claim was caused by the act or omission. If the policyowner proves this, then the insurer may not refuse to pay the claim by reason only of the act or omission. Alternatively, the policyowner may apply section 54(4) and prove that some part of the loss that gave rise to the claim was not caused by the act or omission. If the policyowner proves this, then the insurer may not refuse to pay the claim, so far as it concerns that part of the loss, by reason only of the act or omission.

6.2. Subsections 54(3) and (4) are expressed to apply ‘where the insured proves’ the relevant facts. The expression ‘the insured’ in section 54(3) and (4) can be interpreted as referring to an insured person which would include a third party beneficiary of cover and third party claimant seeking direct access. It is consistent with the object of section 54(1) to interpret the expression ‘the insured’ in section 54(3) and section 54(4) as referring to an insured person, thus including a third party claimant seeking direct access.\textsuperscript{446}

7. Scope of cover

7.1. Section 54 may not be engaged if an insurance claim or a potential insurance claim is not payable because of a restriction or limitation on the scope of cover that is provided under a contract of

\textsuperscript{443} Moltoni Corporation Pty Ltd v QBE Insurance Ltd (2001) 205 CLR 149; 76 ALJR 337; 11 ANZ Ins Cas 61-512; [2001] HCA 73.
\textsuperscript{444} Moltoni at [16].
\textsuperscript{445} Moltoni at [18].
\textsuperscript{446} Gorczynski v W & FT Osmo Pty Ltd (2010) 77 NSWLR 62; 241 FLR 242; 16 ANZ Ins Cas 61-852; [2010] NSWCA 163 per NSW Court of Appeal.
insurance. The question as to whether or not section 54 is engaged if there is a scope of cover declinature, has received a great deal of judicial consideration. The High Court explained in *FAI General Insurance Co Ltd v Australian Hospital Care Pty Ltd*447 and again in *Maxwell v Highway Hauliers Pty Ltd*448 that section 54 does not operate to relieve the insured of restrictions or limitations that are inherent in the claim in fact made and which must be acknowledged in the making of the actual claim. Section 54 does not permit or require the reformulation of the claim that has been made.

7.2. The restriction or limitation formulation does not, without more, provide a simple answer to the question as to which inherent restrictions and limitations in actual claims must necessarily be acknowledged in the making of claims. In most cases it will be obvious whether or not the claim has an inherent restriction or limitation that must be acknowledged when the claim is made. The restriction or limitation may be, to mention a few examples; quantitative (e.g. public liability cover for construction work where the contract price exceeds a dollar amount ceiling); temporal (e.g. an event occurs outside the period of insurance); or geographical (e.g. insured event within the US which is not covered).

7.3. The formulation is informed by examples. Examples are:

a) Under an ‘occurrence’ based contract, no claim can be made under the contract unless the event insured against takes place during the period of cover.449

b) Under a ‘claims made and notified’ policy, if no demand is made by a third party upon the insured during the period of insurance, any claim that may subsequently be made by the insured on the insurer would necessarily acknowledge that indemnity is sought in relation to a demand not of a type covered by the policy.450

c) Under a trade credit policy the claim for indemnity was for losses which were not losses in respect of a third party’s failure to meet payment obligations arising in relation to each of the insured, under a contract identified in Declarations. The insurer’s refusal to pay was because the claim was in respect of a payment default which was not covered by the policy.451

d) Under a boat insurance policy cover under the policy was geographically limited to within 250 nautical miles of Australia. The contract of insurance only applied if that were the case. That was the restriction or limitation that must inhere in the claim.452

8. Protection of safety and property and impossibility

8.1. Where an act or omission is either necessary to protect personal safety or preserve property or was not reasonably possible for the insured or other person not to do it, the insurer may not refuse to pay the claim under section 54(5). There is little case law on section 54(5)453 and it is seldom referred to in practice.

9. Act and omission defined

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447 *FAI General Insurance Co Ltd v Australian Hospital Care Pty Ltd* (2001) 204 CLR 641; 11 ANZ Ins Cas 61-497; [2001] HCA 38 per McHugh, Gummow and Hayne JJ at [41].

448 *Maxwell v Highway Hauliers Pty Ltd* (2014) 88 ALJR 841; 18 ANZ Ins Cas 62-035; [2014] HCA 33 per the plurality at [23].

449 *Australian Hospital Care and Maxwell.*

450 *Australian Hospital Care and Maxwell.*

451 *Prepaid Services Pty Ltd v Atradius Credit Insurance NV* (2013) 302 ALR 732; 17 ANZ Ins Cas 61-981; [2013] NSWCA 252 per NSW Court of Appeal.

452 *Watkins Syndicate 0457 at Lloyd’s v Pantaenius Australia Pty Ltd* [2016] FCAFC 150 per Full Court of Federal Court at [47].

453 See Pynt at [22.45].
9.1. A reference in section 54 to an act includes a reference to an omission under section 54(6)(a). A reference in section 54 to an act also includes an act or omission that has the effect of altering the state or condition of the subject-matter of the contract or of allowing the state or condition of that subject-matter to alter under section 54(6)(b).

10. Exclusivity

10.1. The provisions of Division 3 of Part V of the IC Act, which are relevantly section 54 and section 55 (section 55A concerns representative actions by the Australian Securities and Investments Commission (ASIC)) with respect to an act or omission are exclusive of any right that the insurer has otherwise than under the IC Act in respect of the act or omission. Section 55 does not, however, affect an insurer's right to cancel a contract of insurance under Part VII of the IC Act.

10.2. The High Court in Antico v Heath Fielding Australia Pty Ltd noted that section 55 evinces a legislative intention to establish a regime to overcome the perceived inequities to the insured in the operation of the common law remedies available to the insurer. Those remedies depended upon form rather than substance.

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454 (1997) 188 CLR 652; 71 ALJR 1210; 9 ANZ Ins Cas 61-371.
### 11. Common Exclusions and Conditions Table

<table>
<thead>
<tr>
<th>Case name and facts</th>
<th>Common exclusion or condition</th>
<th>Application of section 54</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ferrcom Pty Ltd v Commercial Union Assurance Co of Australia Ltd (1993) 176 CLR 332</td>
<td>Clause 1(a): Material change condition</td>
<td>High Court noted: The act or omission was the failure to notify a material change to the insurer. It was common ground that the act or omission by the insured, in failing to notify the registration for road use of a mobile crane, could not ‘reasonably be regarded as being capable of causing or contributing to [the] loss’ and was therefore an ‘act’ falling within section 54(1).</td>
</tr>
<tr>
<td>The insured Ferrcom registered a mobile crane for road use and failed to notify the insurer that it had done so. This was a failure to notify a material change of the circumstances existing at policy commencement to the insurer.</td>
<td>The extent of the liability of the Company is conditional upon - (a) The notification as soon as possible by the Insured to the Company of any change materially varying any of the facts or circumstances existing at the commencement of this Policy.</td>
<td></td>
</tr>
<tr>
<td>Gibbs Holdings Pty Ltd v Mercantile Mutual Insurance (Australia) Ltd [2002] 1 Qd R 17; [2000] QCA 524</td>
<td>Material change general condition and exclusion (2): If there is any change or alteration after the commencement of [this Policy] which will or might increase the risk of any claim being made, and in particular relating to: 2.1 the nature of the Business carried on; 2.2 the nature of the occupation of or other circumstances affecting the buildings insured; then no benefits will be payable… unless you have advised us in writing as to any such changes and we have agreed to them.</td>
<td>Qld Sup Ct CA held (by majority): The ‘act’ was the failure to notify the insurer of the change which was not reasonably to be regarded as being capable of causing or contributing to a loss and therefore fell within section 54(1). In finding that the ‘act’ was the failure to notify (rather than granting possession to a tenant which manufactured plastics) the majority applied Ferrcom. The relevant act could not be confined to the acceptance of the plastics manufacturer as a tenant or to the insured permitting the use of its premises by a plastics manufacturer.</td>
</tr>
<tr>
<td>The insured failed to notify the insurer that there had been a material alteration of a risk arising from a plastics manufacturer going into occupation of part of the insured premises. There had been a material change and subsequent failure to notify.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mercantile Mutual Insurance (Aust) Ltd v Schigulski [1993] SASC 4137</td>
<td>Clause 2: Unoccupancy clause UNOCCUPANCY</td>
<td>SA Sup Ct noted: It was difficult to perceive why a breach of an unoccupancy clause in a contract of insurance for premises at the particular location of the subject premises could not reasonably be regarded as capable of causing or contributing to a loss caused by</td>
</tr>
<tr>
<td><strong>unoccupied in breach of the unoccupancy clause in the policy.</strong></td>
<td><strong>days during which the Buildings have been left uninhabited, unless You have notified Us in writing beforehand and obtained Our written consent for cover to continue.</strong></td>
<td><strong>vandals.</strong></td>
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**Bunting v Australian Associated Motor Insurers Ltd [1994] TASSC 9**

A person driving the insured’s motor vehicle had an accident because he failed to apply the brakes. He was driving under the influence of alcohol. Evidence from pathologists that the probabilities were that a person who had his concentration of alcohol in the blood is between .1 and .15 of a gram per 100 millilitres would have impaired driving skills.

**Exclusion 4: alcohol and drugs exclusion**

You will not be entitled to claim under this policy if, at the time of the accident or event which results in the loss, damage or liability your car was:

4.1.1 being driven by a person who was under the influence of intoxicating liquor or of a drug or whose blood alcohol level was in excess of the legal limit prescribed in the State or Territory where the accident or event took place …

**Tas Sup Ct held:**

Driving a motor vehicle with that particular blood alcohol concentration was an act that could reasonably be regarded as being capable of causing or contributing to a loss within section 54(2).

**Allianz Australia Insurance Ltd v Inglis [2016] WASCA 25**

A liability claim under a home insurance policy was refused because the 10 year old injured claimant normally lived with the insured which was an excluded risk under the policy.

The WA Ct of Appeal found that the claimant normally living with the insured did not constitute an ‘act’ within section 54. It followed that the appeal was allowed. However, McLure P considered and dismissed a further ground of appeal based on causal connection.

**Clause 14: Person living with you exclusion (see Standard Cover)**

What you are not covered for:

1. We will not cover your legal liability for:
   a. Injury to any person who normally lives with you, or damage to their property;
   i. Injury to your employees, or damages to their property.

**WA Sup Ct CA McLure P**

If the claimant normally living with the insured was an act, then the risk of financial loss for liability in respect of an accident injuring that person was not an act which could reasonably be regarded as being capable of causing or contributing to a loss in respect of the insurance cover provided. To satisfy section 54(2), the act must be reasonably regarded as legally capable of satisfying the requirement that the act could potentially cause or contribute to an accident and any consequential harm and loss. It must satisfy the causation requirements for liability.
PART THIRTEEN – CAUSATION

Causation is a complex, contextually variable concept, in law as in life.\(^{455}\)

Causation is discussed below under the following headings:

1. The causation inquiry in the insurance context;
2. Proximate cause of an insured loss;
3. Cover – competing proximate causes;
4. Intervening cause;
5. Deliberate cause.

1. The causation inquiry in the insurance context

1.1. In most insurances, the insurer promises to cover loss or damage caused by an insured event. The connection between ‘cause’ and ‘effect’ is essentially a question of fact. It is to be resolved simply, practically and as a matter of common sense.\(^{456}\)

1.2. The inquiry ‘is to be understood as the man in the street ... would understand it’.\(^{457}\) It is ‘not a scientific inquest into a mixed sequence of phenomena or an historical investigation of the chapter of events’.\(^{458}\)

1.3. The ‘common sense’ approach to causation is not a legal test. Common sense defines the approach to evaluating the evidence, not a test to be applied to it.\(^{459}\)

1.4. How the inquiry into ‘What caused an effect?’ is conducted and resolved will depend on the purpose of the inquiry, for example whether it is to decide:

a) someone’s guilt in criminal proceedings; or

b) whether a plaintiff should succeed in a claim for damages for breach of contract or for negligence, and if so, how much they should be awarded.

1.5. Lord Hoffmann illustrated the relevance of the purpose of the inquiry when he said that causation questions:

repeatarise for the purpose of attributing responsibility to someone, for example, so as to blame him for something which has happened or to make him guilty of an offence or liable in damages. In such cases, the answer will depend upon the rule by which responsibility is being attributed. Take, for example, the case of the man who forgets to take the radio out of his car and during the night someone breaks the quarterlight, enters the car and steals it. What caused the damage? If the thief is on trial, so that the question is whether he is criminally responsible, then obviously the answer is that he caused the damage. It is no answer for him to say that it was caused by the owner carelessly leaving the radio inside. On the other hand, the owner’s wife, irritated at the third such occurrence in a year, might well say that it was his fault. In the context of an inquiry into the owner’s blameworthiness under a non-legal, common sense

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\(^{455}\) United States v Oberhellmann 946 F 2d 50, at 53 (7th Cir 1991) (Posner J).


\(^{458}\) Weld-Blundell v Stephens [1920] AC 956 at 986 (Lord Sumner).

duty to take reasonable care of one’s own possessions, one would say that his carelessness caused the loss of the radio.  

1.6. In insurance law, the causation inquiry arises in a contractual or statutory context. It is about whether the connection between an insured event and a loss is sufficiently close to trigger an insurer’s promise to pay. In the case of an exclusion from cover, it is about whether the connection between the exclusion and the loss takes the circumstances outside the scope of the insurer’s promise to pay.

1.7. By way of contrast, causation in the law of negligence involves a normative judgment. In the law of negligence, the causation issue arises:

in the context of the attribution of fault or responsibility: whether an identified negligent act or omission of the defendant was so connected with the plaintiff’s loss or injury that, as a matter of common sense and experience, it should be regarded as a cause of it.

1.8. In Standard Oil Co v United States, Frankfurter J said (at 66):

Unlike obligations flowing from duties imposed upon people willy-nilly, an insurance policy is a voluntary undertaking by which obligations are voluntarily assumed. Therefore the subtleties and sophistries of tort liability for negligence are not to be applied in construing the covenants of [an insurance] policy. It is one thing for the law to impose liability by its own notions of responsibility [as in a tort context] and quite another to construe the scope of engagements bought and paid for [as in an insurance context].

2. Proximate cause of an insured loss

2.1. To succeed in an insurance claim, an insured must prove, amongst other things, a connection between an insured event and an insured loss (the causation issue). Unless the contract expressly provides otherwise, an insured event must be a proximate cause of an insured loss.

2.2. In an insurance contract, ‘proximate cause’ means the operative, real, dominant, effective or most efficient cause.

2.3. The connection indicated by ‘caused by’ or ‘directly caused by’ is the same as that indicated by ‘proximate cause’.

2.4. The need for an insured to prove proximate cause is based upon the presumed intention of the contracting parties. Accordingly, the parties are free to bargain for a different connection. For example, an insurer might provide cover broader in scope than proximate cause by promising to pay for loss that ‘arose out of or in connection with’ or was ‘directly or indirectly caused by’ an insured event.

2.5. The leading insurance case on the meaning of ‘proximate cause’ is Leyland Shipping Company Ltd v Norwich Union Fire Insurance Society Ltd. In that case, Norwich Union insured the

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460 Empress Car Company (Abertillery) Ltd v National Rivers Authority [1998] UKHL 5; [1999] 2 AC 22, at [29]. See also I & L Securities Pty Ltd v HTW Valuers (Brisbane) Pty Ltd [2002] HCA 41; (2002) 210 CLR 109, in which Gleeson CJ noted (at [26]) that the inquiry is not conducted in the abstract.


463 It is an odd thing that no modern general insurance contract uses the term 'proximate cause' to describe the relevant causal connection.


steamship ‘Ikaria’ under a time policy against ‘perils of the sea’. The policy contained the following clause:

Warranted free of capture, seizure and detention, and the consequences thereof, or any attempt thereto, piracy excepted, and also from all consequences of hostilities, or warlike operations, whether before or after declaration of war.

2.6. On 30 January 1915, ‘Ikaria’ managed to make it into the nearby outer harbour of Le Havre after being torpedoed by a German submarine. The harbour authority sent the ship to a berth inside the outer breakwater to avoid the risk of her sinking in the harbour. The ship sank a few days later as a result of the action of the sea. She would not have sunk if she had remained in the harbour.

2.7. The House of Lords concluded that Norwich Union was not obliged to pay for the loss of the ‘Ikaria’ because the proximate cause of her loss was torpedoing, not the perils of the sea.

2.8. In the leading Australian case Lasermmax Engineering Pty Ltd v QBE Insurance (Australia) Ltd,[466] QBE insured Lasermmax:

  in respect of physical loss or damage to ... (b) contents ... directly caused by [fire].

2.9. A fire occurred on a power pole about 55 metres from Lasermmax’s premises, where it used laser machines to weld, cut and treat materials. The fire caused the upper arm of the power pole to fail, allowing wiring on the upper arm to come into contact with wiring supported by the lower arm. The contact caused a high voltage-low voltage intermix, which caused a power surge, which damaged a Lumonics AM 356 laser machine on Lasermmax’s premises. The question for the New South Wales’ Court of Appeal was:

Did the fire ‘directly’ cause the damage to the laser machine?

2.10. Ipp JA concluded (at [9]) that the policy responded to the claim because ‘the fire was the predominant cause of the loss’. McColl JA reached the same conclusion, saying (at [115]) that the fire was the real and effective cause of the damage to the Laser. It was the ‘active, efficient cause’:

which set in motion the train of events which brought about the damage to the Laser.

There was no intervening force which started from a new and independent source.
The effective agency which brought about the result was the fire. It was the fire which triggered the sequence of events which led to the power surge and hence ... the damage to the Laser.

3. Cover – competing proximate causes

3.1. Although the first task of a court is to determine which among the causes of an insured loss can be isolated as the proximate cause of an insured loss, a loss can result from more than one proximate cause.[467]

3.2. Subject to the following qualifications and assuming an insurance contract requires an insured to prove that a loss was proximately caused by an insured event, the insurer will be liable for an insured’s loss if one of two or more proximate causes of a loss was an insured event, even if another of the proximate causes of the loss was not an insured event.

3.3. The Miss Jay Jay,[468], concerned a luxury yacht insured under a policy for damage caused by ‘external accidental means’. The Miss Jay Jay suffered damage due to parts of her hull delaminating during a voyage across the English Channel from Deauville in France to Hamble in England in sea conditions ‘worse than average, but not exceptional’. She was badly designed and

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467 Sheehan v Lloyds Names Munich Re Syndicate Ltd [2017] FCA 1340, at [77] and [80] (Allsop CJ).
badly manufactured. If properly designed and manufactured, she would have made the voyage without any trouble.

3.4. The policyowner recovered under the policy because defective design and the insured peril ‘external accidental means’ were proximate causes of the loss and defective design was not excluded by the policy.\(^{469}\)

3.5. If one of two or more proximate causes of a loss is an insured peril, an insurer will not be liable for the loss if the contract requires the insured peril to be the sole or exclusive cause of the loss, and another proximate cause of the loss is not an insured peril.

3.6. Nor will the insurer be liable if:
   a) one of the proximate causes of a loss is an insured peril; and
   b) another concurrent and interdependent proximate cause of the loss is an excluded peril (the ‘Wayne Tank’ principle).\(^{470}\)

3.7. In these circumstances, the whole of the loss is attributable to each of the proximate causes.\(^{471}\)

3.8. The ‘Wayne Tank’ principle\(^{472}\) starts from the proposition that there can be more than one proximate cause of a loss.\(^{473}\)

3.9. In ‘The ‘Demetra K’\(^{474}\), Lord Phillips of Worth Matravers said that where a policy:

   *provides cover against one of two or more concurrent causes of a casualty, a claim will lie under the policy provided that there is no relevant exclusion. Where, however, a policy contains an express exclusion of cover in respect of loss resulting from a specified cause, underwriters will be under no liability in respect of a loss resulting from that cause, notwithstanding the fact that there may have been a concurrent cause of the loss which falls within the cover.*

   *The effect of an exception is to save the insurer from liability for a loss which but for the exception would be covered. The effect of the cover is not to impose on the insurer liability for something which is within the exception...*

3.10. Wayne Tank concerned circumstances in which Wayne Tank (engineers) installed equipment for storing and conveying liquid wax (stearine) at Harbutt’s plasticine factory. Stearine is one of the main ingredients of plasticine. It is highly inflammable at high temperatures. A fire destroyed the factory. The fire resulted from:
   a) Wayne Tank using a pipeline made of unsuitable and dangerous plastic material wrapped in heating tape and attached to a useless thermostat; and
   b) a Wayne Tank employee, as part of a trial run, switching on the heating tape and leaving it unattended overnight without first testing the equipment. The employee switched on the heating tape because Wayne Tank wanted the stearine molten the following day so that the system could be tested.

3.11. The durapipe melted and started a fire that destroyed the factory. The fire would not have occurred if the durapipe had been suitable or if the equipment had been supervised overnight.

\(^{469}\) See also *HIH Casualty & General Insurance Ltd v Waterwell Shipping Inc* (1998) 43 NSWLR 601, at 612 (Sheller JA).


\(^{472}\) The name is derived from the case *Wayne Tank & Pump Co Ltd v Employers Liability Assurance Corp Ltd* [1974] 1 QB 57.


3.12. Employers Liability Insurance Corporation Ltd agreed by a liability policy to indemnify Wayne Tank:

... against all sums which [Wayne Tank] shall become legally liable to pay as damages consequent upon .... damage to property as a result of accidents as described in the schedule.

3.13. By an exclusion, Employers Liability would not indemnify Wayne Tank:

... in respect of liability consequent upon ... (5) ... damage caused by the nature or conditions of any goods ... sold or supplied by or on behalf of [Wayne Tank] ...

3.14. The Court of Appeal concluded that the loss was proximately caused by the dangerous nature of the equipment installed, rather than the conduct of Wayne Tank’s employee, who had merely precipitated or triggered the fire.

3.15. Lord Denning and Roskill LJ said that if they were wrong and there were two proximate causes of the loss, Wayne Tank would fail because one of the causes was within an exclusion clause.

3.16. Lord Denning MR said (at 67):

... I will assume, for the sake of argument, that I am wrong about this: and that there was not one dominant cause, but two causes which were equal or nearly equal in their efficiency in bringing about the damage. One of them is within the general words and would render the insurers liable. The other is within the exception and would exempt them from liability. In such a case it would seem that the insurers can rely on the exception clause.

3.17. Cairns LJ concluded there were two proximate causes of the loss. He said that as one cause came within the exception of the policy, there could be no recovery on it.

3.18. The ‘Wayne Tank’ principle comes into play where there are two proximate causes that are concurrent and interdependent:

... in the sense that neither would have caused the loss without the other ... the two causes can be seen as inseparable and so, in effect, as joint: McCarthy v St Paul International Insurance Co Ltd.

3.19. Allsop J continued (at [103] and [104]):

... Given that the two causes are interdependent and that the loss would not have occurred without the operative effect of the excluded cause, the non-response of the policy can be comfortably and logically accepted as the intended result of the revealed agreement of the parties ...

... More difficulty may be encountered in circumstances where a policy excludes one cause, includes another and the loss is occasioned by the two causes operating concurrently, but independently, in the sense that each would have caused the loss without the other. At the outset, it may doubted that the solution in any given case is to be found in the application of any principle of insurance law, other than one which states that the rights of the parties to the policy are to be determined by reference to the terms of the contract as found. This was the principle applied by all three Lords Justices in Wayne Tank. Thus, it is always essential to pay close attention to the terms of any policy and the commercial context in which it was made, for it is out of these matters that the answer to the application of the policy to the facts will be revealed ...

[underlining added]

3.20. In McCarthy, Allsop J referred (at [107]) to the New Zealand case Countrywide Finance Ltd v State Insurance Ltd, in which a restaurant that operated from a permanently moored ferry boat


476 [1993] 3 NZLR 745.
sank in two feet of water. It sank because of worm damage and dry rot. The restaurant’s policy excluded worm damage but not dry rot. After referring to Wayne Tank, Hammond J said (at 756):

... if there are two approximately equal, or, I would say, co-mingled causes, the insurer can effectively rely on one of those causes not being within the policy.

In my view, the insurer has established that (at least) one of two effectively co-mingled causes was within the exception. If there had been appropriate evidence, it might have been possible to make a finding that both causes were within the exception, but as I have said, I decline to speculate in the absence of evidence and the law is that the insurer need demonstrate only one.

3.21 Allsop J also said in McCarthy (at [109]):

In these cases [including Countrywide Finance], even though it could be posited that the damage may or would have occurred in any event by the cause that was not excluded, the fact is that the policy in each case was construed as excluding damage caused in a particular way. As a matter of fact the damage was caused in that way (whether or not there was another concurrent cause). Thus, recognising the limits of the cover agreed upon, the loss fell outside the terms of the policy. Wayne Tank has become the best known illustration of this result. But the result is not the consequence of the application of a principle other than that which truly underlay Wayne Tank — the ascertainment and application of the contractual intentions of the parties.

4. Intervening cause

4.1. The effect of an insured peril can be brought to an abrupt end by a person’s free, deliberate and informed act or omission.477

5. Deliberate cause

5.1. Unless an insurance policy expressly provides otherwise, an insured:

a) cannot recover for a loss if they deliberately caused it.478

b) For example, an insured cannot recover for insured property destroyed by fire if he or she deliberately set fire to the property. However, there is a distinction ‘between damage caused by an intentional act of the insured, and, on the other hand, damage intentionally caused by the insured’.479 So, for example, subject to the policy wording, an insured who lights a wood-fired barbeque in the backyard which accidentally spreads to her house and destroys it can recover under a policy covering damage to or destruction of the house by fire even though he or she deliberately lit the fire that burned the house down.480

c) is not prevented from recovering for a loss deliberately caused by their employee or agent without their knowledge or consent unless, in the case of an insured company, that person acted ‘with the authority of the company or is so closely connected with the company that his acts can be said to be its acts’.481

478 Australian Associated Motor Insurers Ltd v Elmore Haulage Pty Ltd [2013] VSCA 54 at [77] (Kaye AJA).
479 Australian Associated Motor Insurers Ltd v Elmore Haulage Pty Ltd [2013] VSCA 54 at [78] (Kaye AJA).
480 Harris v Poland [1941] 1 KB 462; [1941] 1 All ER 204.
PART FOURTEEN – CLAIMS

This introduction to claims is discussed below under the following headings:

1. Anatomy of a claim;
2. Contractual requirements for making a claim;
3. Claims handling;
4. Admission of liability and payment;
5. Fraudulent claims;
6. Amount recoverable;
7. Mitigation.

The making of a claim is an important phase in the relationship between the policyowner and the insurer. The process and the management of the claim are governed by a number of different rules from different sources. Fraudulent claims, the amount recoverable and mitigation are important related issues.

1. Anatomy of a claim

1.1. Following the occurrence of an insured peril, the policy will provide for the steps to be taken by the policyowner to put forward a claim. Notification may be by telephone, online, by a claim form or by communication with the policyowner’s broker (although the last of these is valid only if the broker has been authorised by the insurer to act as its agent for the purpose). Once the claim has been notified, if there is any issue as to coverage or the measure of indemnity, the insurer may investigate the matter itself or it may appoint a loss adjuster to make a report on the matter. The loss adjuster may be authorised to make an offer, and at the very least will recommend that the insurer sets aside a sum (a reserve) likely to be required to satisfy the claim. The policyowner may appoint his own loss assessor to negotiate on his behalf. Very often in complex cases discussions take place between the two representatives and recommendations are then made to their principals.

1.2. The policyowner is required to prove on the balance of probabilities that a loss has occurred and that the loss has been proximately caused by an insured peril. The burden then shifts to the insurer to show that the loss falls within the ambit of an excluded peril. Causation was discussed in Part Thirteen. A policy on property may respond to the occurrence of an event giving rise to damage, or to the damage itself. In the latter case difficulties may arise for a policyowner where there have been two or more perils and it is not clear exactly when the damage occurred: that is a particular problem in the case of subsidence and other hidden damage cases. Liability policies may respond to the event giving rise to injury, the injury itself or – in professional indemnity cases – the date on which a claim is made against the policyowner or the policyowner becomes aware of circumstances that might give rise to a claim and has duly notified them to the insurer. Dust disease claims covered by event-based policies are particularly problematic, in that where there has been a continuing period of exposure to a harmful substance, the year in which the exposure or other act giving rise to the injury occurred may be incapable of identification. The UK has by

\[482\] Sutton, Ch 15, paras. 15.140-15.240; Pynt, Ch 20.
legislation overcome this problem in relation to asbestos, under which every exposure is deemed to be causative of the loss. 483

1.3. State legislation provides for limitation periods for contract claims. The usual limitation period for the issue of proceedings is six years, although there is some disagreement as to when the limitation period is triggered following an insurance loss. The orthodox view is that the date of the peril is the key date, but there are recent Australian authorities taking the view that there can only be a cause of action against an insurer where the insurer has wrongfully refused to pay the claim. 484

2. Contractual requirements for making a claim485

2.1. The claims process varies as between different classes of policy, but in general terms the policyowner's contractual obligations typically fall under two heads. The first is the notification to the insurer of a claim under the policy. In property, life and accident cases that is a relatively straightforward concept: the insurer has to be notified of the occurrence of a peril giving rise to loss. In the case of a liability policy the matter is less straightforward, because the insurer is ultimately liable in respect of any judgment, award or settlement under which the policyowner becomes liable to a third party in damages, and so the notification obligation relates to the happening of an event which may or is likely to give rise to a claim against the policyowner. The insurer is then in a position to defend the claim against the policyowner. Once a loss, claim or circumstance has been notified to the insurer the second part of the policyowner's obligation will be to co-operate with the insurer in the handling of the matter. In a property case, that may involve submitting proofs of loss and other documents requested by the insurer. In a liability case the policyowner will be required to assist the insurer with their conduct of the defence, not to admit liability to the third party claimant and not to settle without the consent of the insurer.

2.2. At one time policies required notification of a claim within a fixed period or immediately. The more modern trend is for notification to be flexible, by use of an obligation to notify ‘as soon as is reasonably practicable’, but even ‘immediate’ or ‘forthwith’ wording has been construed in a liberal fashion. As to the content of the notice, absent a policy term there is no particular form in which a claim has to be made against an insurer. It is not necessary for the policyowner to give notice personally, and it has been held that as long as the insurer has received due notice then it is immaterial that it came from a third party. Notice does not have to be intentional: a policyowner who discloses a loss on renewal of the policy may be treated as having notified the loss to the insurer.

2.3. At common law, the consequences of failure to comply with a policy obligation of either type rested upon the classification of the obligation. A condition precedent gave the insurer an automatic right to refuse payment on proof of breach, irrespective of the absence or presence of prejudice. If the term was not expressed to be a condition precedent, the policyowner would be able to recover but subject to deductions by way of damages for breach of contract insofar as the insurer had suffered loss. This distinction is largely of historical interest in Australia, as the effect of section 54 of the Insurance Contracts Act 1984 (IC Act) where there is a breach of a claims condition is to require the insurer to pay but subject to a reduction of the claim by the amount that fairly represents the extent to which the insurer's interests were prejudiced as a result of the policyowner's breach. There is limited authority on this provision, and most insurers have not

sought to attempt the difficult task of proving prejudice. Where the point has arisen, it has typically been in the context of liability insurance, where the insurer has been unable to investigate, or has been hampered in investigating, the cause of the loss, responsibility for it and whether any other person is fully or partly to blame. There is also state legislation (the Instruments Act 1958 in Victoria and the Insurance Act 1902 in New South Wales) that precludes reliance on breach of a policy term unconnected with the loss.\footnote{See Part Twelve.}

3. Claims handling\footnote{Sutton, para. 15.290-15.370.}

3.1. The policyowner will be under both contractual and statutory duties in the claims-handling process. Contractual duties following notification vary with the type of policy, and include: the duty of a policyowner under a burglary policy to inform the police of his loss; the duty of an employer under a fidelity policy to prosecute the defrauding employee; the duty of a policyowner under a life or accident policy to submit to medical examination; and the duty of the policyowner under a liability policy either to cede all claims-handling to the insurer, to seek the insurer's consent to any settlement or at the very least to co-operate with the insurer in the event of a third party claim as regards the provision of documents and the conduct of negotiations. More generally, policies of all types normally require the policyowner to submit all necessary proofs concerning his loss and otherwise to co-operate with the insurer. Some duties are automatic, others are triggered by a demand or request from the insurer, but in all cases it is implicit that there has to be compliance within a reasonable time. Failure by the policyowner to comply with claims obligations is excusable under section 54(1) of the IC Act.

3.2. The common law has long accepted the specific principle that a liability insurer is under a duty to negotiate in good faith on the part of the policyowner, a duty that takes effect as an implied term. One particular manifestation of the duty is the refusal of the insurer to accept an offer by a third party to settle the third party claim at policy limits, thereby exposing the policyowner to the risk of a much larger judgment. It is uncertain whether the common law goes any further and extends to property insurances – there is recent authority from New Zealand that it does – but the question is largely academic for policies governed by the IC Act. Section 13(1) lays down an overriding duty of utmost good faith in claims handling, section 14(1) specifically states that ‘if reliance by a party to a contract of insurance on a provision of the contract would be to fail to act with the utmost good faith, the party may not rely upon the provision’ and section 14A allows for regulatory intervention if an insurer has failed to comply with the duty of the utmost good faith in the handling or settlement of a claim or potential claim under the contract.\footnote{See Part Seven.}

3.3. The duty of utmost good faith is of particular importance in respect of obligations for the provision of information. The common law denies that the insurer has an absolute right to demand information, and recognises that there are reasonableness or good faith limitations. This more enlightened approach plainly holds good under the IC Act. The contractual duty of the insurer to act with the utmost good faith potentially puts them in breach of contract if they unreasonably demand proofs that are unnecessary or not readily obtainable. Even if it is the case that the policyowner is in breach of the contractual obligations imposed upon him, it does not follow that the insurer has the right to refuse to pay the claim. The onus remains upon them under section 54(1) to show that they have suffered prejudice as a result of the breach, and if the claim is found
on the balance of probabilities to be a valid one then it may not be possible for them to show such prejudice.489

3.4. Satisfying contractual requirements for proof of loss is one matter; the further question is whether it is possible for the policyowner to challenge the insurers' evaluation of the evidence presented to them. The effect of the principle of utmost good faith is that unfairness in the decision-making process is itself a breach of duty. The point often arises in the context of total permanent and disability insurance, where benefits rest upon the insurer being satisfied that the policyowner is totally and permanently disabled. The duty requires that the policyowner is advised of the contents of medical reports adverse to the claim and is afforded the opportunity to comment on them before a decision is made. Whether or not there has been a breach of the duty of utmost good faith in the insurer’s appraisal of the claim, the outcome is always open to review.490

4. Admission of liability and payment

4.1. The duty of utmost good faith requires the insurer to admit liability within a reasonable time. There is breach even if the failure results not from an attempt to achieve an ulterior purpose, but results merely from a failure to proceed reasonably promptly when all relevant material is, or ought to be, at hand sufficient to enable a decision on the claim to be made and communicated to the policyowner. Lack of good faith is possible in the absence of dishonesty.491

4.2. As regards payment, the basic remedy for late payment is interest under section 57 of the IC Act. However, a claim for interest does not preclude an action by the policyowner for damages against the insurers where late payment is the result of some form of actionable breach of duty by the insurer although there cannot be a double recovery. Where an insurer fails to pay the policyowner the indemnity due under the policy within a reasonable time, possible causes of action available to the policyowner (independently of the right of interest are an action for breach of contract based on an implied term of the contract giving rise to a claim for damages, and an action for breach of the duty of the utmost good faith under the IC Act, section 13. The common law in New Zealand has adopted an implied term of utmost good faith as the basis for damages for late payment whereas both Australia and – since 2016, legislation in England – has adopted the former approach. The competing legal analyses are likely to give rise to a difference only in a very small number of cases. The Australian cases contemplate damages where the insurer has repudiated the policy for breach, by wrongfully terminating the policy or refusing to pay a valid claim, but more recently it has been confirmed that damages are also available even though there is no repudiation. The duty is simply to pay a claim within a reasonable time.492

4.3. Although interest may be the appropriate award where the policyowner has been kept out of its money, damages may be available if the delay has caused the policyowner an additional form of loss. As long as those losses are not too remote on ordinary contractual principles then they are recoverable. Three particular heads of loss are relevant: damages for loss of business, as where the policyowner does not have the funds to make good damage to business assets and has no remaining assets against which a bank loan can be secured; damages for loss of opportunity, where the policyowner has lost the prospect of bidding for new contracts; and damages for emotional distress in consumer cases.493

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489 See Part Seven.
490 Sutton, paras. 21.120-21.165.
491 Sutton, paras. 15.290-15.370.
492 Sutton, paras. 15.600-15.670.
493 Sutton, paras. 15.600-15.670.
5. Fraudulent claims

5.1. Fraud is the underlying fear of the insurance industry. Fraud can arise at the placement stage, when the insurer is induced to write a risk that would otherwise be uninsurable at all or on standard terms, and at the claims stage. Fraudulent claiming is notoriously difficult to establish, and it is largely for that reason that insurers have sought to cling to ‘technical’ defences unrelated to merits where fraud is suspected but not necessarily provable. That approach is now more difficult under the IC Act.

5.2. Section 56 of the IC Act does not seek to define ‘fraud’. Instead, the section specifies the remedies for fraud. The provision was necessary by reason of a series of cases in Australia and other common law jurisdictions that suggested that fraud was an aspect of utmost good faith and that the remedy for a fraudulent claim was avoidance of the policy ab initio. Thus a person suffering a genuine loss, and then subsequently attempting to perpetrate a fraud within the same policy year, would be treated as never having been insured and would be stripped of the earlier genuine claim. The effect of section 56 is to render remedies prospective rather than retroactive: the fraudulent claim itself need not be paid; the policy may be cancelled by notice; and other policies with the same policyowner may also be cancelled with notice. It is noteworthy that the UK Insurance Act 2015 has adopted the same approach. There is one critical difference between the two pieces of legislation. Australia has taken the view that there may be situations where it would be harsh and unjust to refuse payment of a fraudulent claim, as where the fraud is trivial or did not have any impact on the insurer, and the court has a discretion to allow full or partial recovery. The UK legislators, at the insistence of the insurance industry, resisted any such concession. Nevertheless, there are few cases where the Australian courts have chosen to relieve a policyowner from the consequences of fraud, so the general principle remains that fraud in relation to any part of a claim will defeat the claim as a whole.

5.3. The most recent controversy has arisen over the definition of fraud. Common law jurisdictions are at one in holding that a claim is fraudulent if the policyowner is seeking to recover something to which he is not entitled. That may be because the claim is: fabricated (non-existent or deliberately self-inflicted); in excess of the amount of loss actually suffered; or is based on lies that disguise the existence of a valid defence to the claim (e.g., when the policyowner was at the time of loss in clear breach of a policy restriction). The controversy concerns ‘entitlement’ fraud, where the policyowner is entitled to make a claim but makes false statements in the claims process: in some cases the policyowner may believe that he has a valid claim but tells lies to avoid embarrassment or to persuade the insurers to pay more quickly; in other cases the policyowner may wrongly believe that he does not have a valid claim. The Australian courts initially decided that this was not fraud, but subsequently changed their minds. There are cases where discretion to give relief under section 56 has been given in relation to ‘entitlement’ fraud, but it is far from obvious that section 56 is drafted in a manner that so permits. Controversy has now been ignited by a landmark decision of the UK Supreme Court in 2016, holding that entitlement fraud is merely a collateral lie, and that a policyowner who has a genuine claim is entitled to be paid whatever lies – and for whatever reason – are told in the claims process, subject to the insurer being entitled to damages for wasted resources in investigating the claim. It is uncertain whether the Australian courts will reappraise matters following this decision.

6. Amount recoverable

494 Sutton, paras. 15.380-15.640; Pynt, Ch 23.
6.1. The measure of indemnity under an insurance policy depends upon the form of cover. A liability policy pays the sum for which the policyowner has to pay to a third party by way of damages and costs, and it is usual for the policy to provide an indemnity for the policyowner’s own costs in defending the claim. A business interruption policy indemnifies the policyowner for the economic consequences of physical damage to buildings or assets for the duration of an agreed ‘indemnity period’. Life and accident policies pay a fixed sum on the happening of an event. Property policies seek to make good the policyowner’s loss following a casualty.

6.2. As regards property insurance, the meaning of ‘loss’ differs as between non-marine and marine insurance. Non-marine insurance adopts a binary distinction between: total loss, consisting of destruction and entitling the policyowner to the full sum insured under the policy: and partial loss, consisting of repairable damage and entitling the policyowner to a sum representing the amount of the loss. The amount recoverable in either case will rest upon the terms of the policy. Total loss may be measured by market value or replacement value. Partial loss may be measured by diminution in market value or the cost of repairs. Marine insurance recognises an intermediate form of loss, constructive total loss, which arises where damage is repairable but not worth repairing, in which case the policyowner can opt to recover for total loss. The case law on these matters is complex and varies according to policy wordings, but the authorities demonstrate a lack of transparency in policy wording. A policyowner whose jewellery is stolen may believe that there is entitlement to an equivalent replacement, but the policy may hold recovery to the amount that the policyowner could have obtained had he sold the jewellery second-hand and not the amount that it would cost to buy a replacement. Buildings cases have also given rise to major problems as to the standard of repairs to be effected and whether changes in building standards are to be factored in. Many policies on real and personal property are these days written on a ‘new for old’ basis, resolving these issues, but if that wording does not appear then the policyowner is entitled only to ‘like for like’ indemnity. That can lead to the situation where the insurers agree to pay for the repair of a building to a higher standard, but the policyowner is required to contribute to the repairs in the form of ‘betterment’. Policyowners may not also understand at the outset that there is no recovery under a property policy in the absence of physical injury to the subject matter even though it has effectively been rendered worthless by an insured peril. This point was noted in the discussion of natural catastrophes, where homes have been damaged but rendered uninhabitable and insurance claims have been refused.

6.3. Leaving aside the maximum sum insured, insurers use various techniques to limit the amount of their liability. These are not always obvious, and the IC Act has imposed limits on certain types of restriction. Where the policyowner has overlapping policies and both respond to single loss, it is not permissible under section 45 of the IC Act for either insurer to rely upon an ‘other insurance’ clause so as to cast the burden of paying on the other: in such a case the policyowner remains free to recover from either insurer, subject to the overriding principle that the total recovery cannot exceed the policyowner’s actual loss. Section 44 of the IC Act has also precluded the use of ‘average’ clauses: the effect of such a clause (still used widely in the marine market) is that if the policyowner is underinsured, the policyowner is deemed to be its own insurer for the underinsured proportion, so that in the event of a partial loss the insurer and policyowner contribute their respective proportional shares. A provision unique to Australia is section 42 of the IC Act, under which if an insurer would have been prepared to give the policyowner for the same premium greater cover – had that cover been requested – than in fact provided, then the insurer is bound to provide the greater cover. Thus if the policyowner insures the contents of his house for

495 Sutton, Ch 16.
$7,000 at a premium of $100, and it transpires that this amount is a minimum premium for which cover up to $10,000 could be obtained, the insurer's maximum liability under the policy is $10,000.

6.4. One of the most important means by which insurers can control the amount of their exposure is the excess clause, whereby the policyowner has to bear the first part of any claim. The excess eliminates small claims thereby allowing premiums to be kept to a minimum, and also confers some degree of responsibility upon the policyowner.

6.5. A common issue, which has a dramatic but often hidden impact on the sum recoverable, is the operation of the maximum sum insured and excess clauses where there have been multiple losses. The question becomes whether losses can be aggregated and treated as a single loss. Assume, by way of simple example, a policyowner who has a motor policy covering liability for property damage of $100,000 per accident but subject to a $500 claim excess per accident. The policyowner loses control of his vehicle, and collides with five other cars, causing damage of $30,000 to each of them. If there is only one accident, the policyowner will recover from his insurers $100,000 minus $500, leaving him significantly underinsured. If, by contrast, there are five accidents, the policyowner can recover $150,000 but subject to five excesses totalling $2,500. So all depends upon the definition of ‘accident’. Other formulations are often found, including ‘event’, ‘occurrence’, ‘happening’, ‘claim’, ‘loss’ and ‘cause’. There is much authority on these words, but by way of summary:

a) an accident is the harm caused rather than the underlying reason why harm is caused, so the above example there would be five accidents;
b) the words ‘occurrence’ and ‘event’ are interchangeable and denote something that happens at a particular time, at a particular place and in a particular way and is to be distinguished from a state of affairs, so in the above example there would be five occurrences or events;
c) a cause is the underlying reason for a series of losses rather than the losses themselves, so in the above example there would be one cause leading to five events;
d) the cases on ‘loss’ and ‘claim’ are contradictory, and it is a matter of construction whether they refer to the policyowner’s loss or claim or the losses suffered and claims made by third parties.496

6.6. Policies may contain express clauses intended to remove all disputes. Thus, in the case of natural catastrophes, there may be a provision that all losses from, e.g., earthquake, occurring within a 72-hour period are to be treated as a single loss for policy limits and excess purposes (the ‘hours’ clause), or that all losses arising from a series of related acts or omissions, or similar acts or omissions, are to be treated as one claim.

6.7. In the absence of some sort of aggregation wording, a succession of entirely distinct losses are to be treated separately for policy limits and deductible purposes. So if the owner of a house suffers three fires in a single insurance year, there will be a separate excess and separate limit of indemnity for each fire. However, the policyowner cannot recover twice for the same loss: if there is a fire and the damage has not been repaired, followed by a separate fire, the amount recoverable by the policyowner is capped at the cumulative damage following the second fire.

7. Mitigation
The [insurer’s] submission in all its unattractive simplicity is that, although the respondent would be indemnified if it stood by and allowed the office block to

496 Pynt, Ch 24.
7.1. Mitigation involves two main issues:
   a) how mitigation works in insurance law;
   b) is it the insurer or the policyowner that bears the costs incurred by a policyowner in taking steps to mitigate an insured loss?

7.2. There is nothing in the IC Act about either issue, although sections 13 and 14 (duty of utmost good faith) may be of relevance depending on the circumstances.

7.3. This mitigation in insurance is about a policyowner’s obligation to mitigate in the context of a claim a policyowner has or will make under an insurance contract. It is not about mitigation in the context of a claim by a policyowner for damages for an insurer’s breach of contract.

7.4. In England, an insurer’s promise to indemnify is regarded as a promise to prevent a policyowner from suffering insured loss as a result of an insured event. Whilst this is hard to credit, it does mean that mitigation as understood in the law of contract is easily transplanted into English insurance law. That is because in English insurance law, a policyowner’s claim on a policy is a claim for damages for the insurer’s failure to prevent the policyowner from suffering a loss.

7.5. On the other hand, in Australia an insurer’s promise to indemnify is regarded as a promise to make good a loss suffered by a policyowner as a result of an insured event, by paying for their loss ‘in accordance with’ the terms of the insurance contract. It follows that the idea of mitigation in Australian insurance law is not derived from the law of contract, at least in circumstances where a policyowner is simply seeking payment of what an insurer promised to pay, rather than damages.

7.6. In contract law, mitigation only arises for consideration if the innocent party is claiming damages. In insurance law, mitigation becomes an issue as soon as an imminent insured event threatens insured loss. A policyowner who does not take steps to mitigate is precluded from claiming an insured loss to the extent that the loss results from not taking those steps. A policyowner is entitled to recover insured loss that results from taking steps to mitigate an insured loss even if it is different to, or beyond what the loss would have been if the policyowner had not taken mitigating steps.

7.7. An insurer will bear the cost incurred by a policyowner in taking steps to mitigate if:
   a) the mitigation costs are insured;
   b) there is an express term in the policy to that effect; or
   c) there is an implied term in the policy to that effect (an ‘exceptional’ case).

7.8. Otherwise it seems a policyowner must bear mitigation costs incurred by it. Having said that, when mitigation costs are not significant, insurers are likely to pay them as they motivate

500 Guardian Assurance Co v Underwood Constructions [1974] 48 ALJR 307, in which Mason J found that the remedial work done to prevent further damage to the excavation fell within the cover provided by the material damage section of the policy.
501 King v Brandywine Reinsurance Co (UK) Ltd (formerly Cigna Re Co (UK) Ltd) [2004] EWHC 1033 (Comm) at [143] (Colman J).
policyowners in the future to do what they can to avoid or limit what would be payable if no mitigation is attempted.
PART FIFTEEN – DISPUTE RESOLUTION

This Part discusses the resolution of insurance complaints and disputes under the following headings:

1. Introduction;
2. Complaints and disputes – overview;
3. IDR;
4. EDR;
5. Litigation.

1. Introduction

1.1. A policyowner might have a complaint about the insurer, the insurer’s agent, the policyowner’s broker, the insurance policy or an aspect of the insurer’s conduct including particularly the way the insurer manages a claim. The complaint, if not resolved, might develop into a dispute between the policyowner and the insurer or another party. This Part deals mainly with complaints and disputes in relation to an insurer. The resolution of insurance complaints and disputes is an important part of the consumer protection and market conduct regulatory framework. The framework includes an insurer’s internal dispute resolution (IDR) arrangements and an insurer’s external dispute resolution (EDR) arrangements. The Financial Ombudsman Service (FOS) is the EDR body for general insurance in Australia.

1.2. The Ramsay Report noted, in the context that 3.69 million insurance claims under retail insurance products were lodged in 2015/2016:

>This increase in interactions between individuals and the financial system inevitably increases the demand for dispute resolution. Although the number of disputes remains small compared to the overall size of the system and the number of interactions individuals have with it, the impact of financial disputes on the lives of individuals and their families can be devastating. The public debate calling for speedier, low-cost methods of resolving financial disputes, together with the number of submissions to this review, highlights the importance of this issue for many Australians.

2. Complaints and disputes – overview

2.1. The modern regulatory framework for consumer protection regulation covers not only financial product and intermediary terms disclosure, regulating the conduct of business and customer contracts: ‘conduct of business rules’; requirements for conduct towards customers; and dispute resolution arrangements. The framework applies usually to retail products and customers only.

2.2. The Wallis Report found that the deregulation which followed the Campbell Report showed four developments, one of which was that the widened choice of products and suppliers caused

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502 A reference to dispute includes complaint.
504 Ramsay Report, Ch 3, paras. 3.3-3.11; See Part 6.
increased focus on consumer protection including: the creation of alternative dispute resolution schemes.\(^{507}\)

2.3. The Financial Services Reform Act 2001 repealed Chapters 7 and 8 of the Corporations Act 2001 (Corporations Act) and substituted new provisions for those chapters. Its main object was described as promoting the making of confident and informed decisions by consumers of financial products and services, while at the same time encouraging fairness, honesty and professionalism by the providers of such services, and facilitating efficiency and flexibility in such provision. There are three main principles that are currently relevant: first, a single licensing regime for financial services providers; second, minimum standards of conduct and disclosure for a financial services provider; third, disclosure throughout the life of a financial product (Product Disclosure Statement (PDS), transaction and periodic reporting) – the product disclosure requirements are not dependent on licensing of the providers. Dispute resolution is built into both the licensing and product requirements.\(^{508}\) An insurer must hold an Australian Financial Services Licence (AFSL) for retail products\(^{509}\) – see Parts Four and Six.

2.4. Australian Financial Services Licence (AFSL) holders are required to meet general conduct obligations, which include obligations to act efficiently, honestly and fairly, have adequate arrangements for managing conflicts of interest, comply with conditions on the licence, comply with financial services laws and ensure that representatives also comply with those laws, be competent to provide financial services, have adequate resources to provide the financial services, have adequate risk management systems, and have internal and external dispute resolution systems that comply with the required standards and have adequate compensation arrangements.\(^{510}\) A financial services entity that does not comply with this obligation is in breach of its AFSL and can be subject to Australian Securities and Investments Commission (ASIC) administrative action.\(^{511}\)

2.5. The dispute resolution mechanisms must consist of:

a) an IDR procedure which complies with standards, and requirements and covers complaints against the licensee made by retail clients in connection with the provision of all financial services covered by the licence; and

b) membership of one or more EDR schemes approved by ASIC which cover complaints (other than complaints that may be dealt with by SCT)\(^{512}\) against the licensee made by retail clients in connection with the provision of all financial services covered by the licence.\(^{513}\)

2.6. ASIC is involved in dispute resolution in two main ways. First, ASIC approves standards and requirements for Internal Dispute Resolution and External Dispute Resolution.\(^{514}\) Second, under the FOS constitution, FOS must report serious misconduct or a systemic breach to ASIC.\(^{515}\)

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\(^{507}\) Sutton, para. 4.500-4.560.  
^{508} s. 912A of the Corporations Act and s. 47 of the National Consumer Credit Protection Act 2009. This obligation applies to all Australian financial services licensees, unlicensed product issuers, unlicensed secondary sellers, credit providers and credit representatives. Superannuation funds are subject to separate arrangements and under the jurisdiction of the Superannuation Complaints Tribunal; Sutton, para. 4.350; Ramsay Report, paras. 3.16-3.20.  
^{509} Corporations Act, s. 911A.  
^{510} Corporations Act, ss. 912A and 912B; Sutton para. 4.550; Parts 4 and 6.  
^{511} Corporations Act, s. 915C.  
^{512} Where the SCT can deal with all retail client complaints about the financial products and services a licensee provides, there is no need to join an ASIC-approved EDR scheme: Australian Securities and Investments Commission, submission to the EDR Review Issues Paper, pp. 24-25; s. 912A(2)(b)(ii) of the Corporations Act.  
^{513} s. 912A(2) of the Corporations Act; Ramsey Report, paras. 3.16-3.18, 3.21-3.27.  
^{514} Corporations Act, ss. 912(A)(a) and 10127G(2), ASIC RG 139: Ramsay Report paras. 3.8, 3.15,3.21,3.22, 3.27, 4.21, 4.39, 4.52, 4.94,9.9, 9.10, including Codes of Conduct, see Corporations Act, s. 1101A, ASIC RG 183.  
^{515} FOS, Terms of Reference, paras 11.3 and 11.4, FOS Constitution and Deed of Adoption; it is, in that context, implicit in the Code, s. 7; see FOS Annual Code Reviews and CCC Reports.
is not involved in the General Insurance Code of Practice (the Code) enforcement or sanctions for Code non-compliance or breach.  

2.7. The PDS is required to contain a range of information, including: the terms and conditions of the policy; the costs, any amounts that may be payable; information about the dispute resolution system and how that could be accessed; and information about the cooling off regime. 

2.8. The prime concern of regulation for consumer protection has always been the provision of a low-cost, informal, lawyer-free scheme for complaint and dispute resolution. The advantages of an accessible, low cost and quick dispute resolution scheme are now axiomatic.

3. IDR

Background

3.1. An AFSL holder must have an internal dispute resolution (IDR) system for retail business which complies with the ASIC standards and requirements that are set out in ASIC Regulatory Guide 165: Licensing: Internal and external dispute resolution (ASIC RG 165). ASIC must take into account AS ISO 10002-2014. The Code standards form a part of the IDR framework for complaints.

3.2. The Independent Code Review 2013 stated that:

The Selected Statistics indicate that over the 2009-2011 period:

a) about 1.7-2% of claims were declined;

b) 29-35% of declined claims (accepting that IDR matters include not only claims matters but others as well) became IDR complaints;

c) 67-73% of IDR matters were resolved in favour of the Code Participant;

and

d) general insurance disputes were, in 2011, about 25% of all FOS disputes. In 2010 about 12%, and in 2011 about 10% of all FOS disputes were resolved by FOS decision. Of those resolved by FOS decision, about 61% in 2010 and 61% in 2011 were resolved in favour of the financial services provider.

It is difficult to draw clear inferences from these statistics about the success or otherwise of the current IDR processes. It is reasonable to conclude that while there were some statistics which indicated that the period was one of increasing financial stress for the insurance industry that did not reflect in the industry’s conduct of claims: the IDR position remained steady although the EDR disputes increased. On the one hand, it seems reasonable that the claims decline rate is very different from

516 Sutton, para. 4.1220.
517 Commonwealth Treasury, Reforming flood insurance – Clearing the waters, Consultation paper, April 2011, paras. 41, 42; Sutton, para. 4.770.
520 See generally, Ramsay Report, Ch 10.
521 Corporations Act, ss. 912A(1)(g) and (2), and RG 165.1 and 165.2. s. 1017G(2) of the Corporations Act replicates these requirements for products not covered by an AFSL.
522 Ramsay Report, para. 3.18.
523 Corporations Regulations, 7.6.02(1) and 7.9.77(1); RG 165.32-37, 88 and Appendix 1.
525 See Appendix E.
526 The QFIC Report, para. 12.4.3 indicated higher rates in favour of Code Participants there.
the IDR and EDR result rates. It is less clear whether it is reasonable that the IDR and EDR result rates are as different as they are.

3.3. The Ramsay Report thought that there was currently no comprehensive, consistent, comparable, publicly available IDR data.527 The Ramsay Report noted that the available data on the number of IDR complaints in 2015-2016 was:

a) General Insurance – 158 Code Participants (a general insurance industry participant that is a signatory to the Code) and 21,179 complaints;

b) Insurance brokers – 324 insurance brokers and 1,023 complaints. 41% of complaints were resolved on the spot or within 5 days and 79% were resolved within 21 days.

Complaints

3.4. A complaint and a dispute, in relation to retail insurance only528, are each the subject of the IDR standards in the Code. A complaint has two meanings here. First, it can be an IDR matter which is referred beyond the original insurer decision-maker.529 Second, it can be a matter which is the subject of EDR.530 If a complainant takes a complaint directly to FOS without IDR first, FOS refers the complaint back to the insurer’s IDR process.531

3.5. A customer complaint can be about any aspect of the complainant’s relationship with the Code Participant.532 It develops in the following way.533

a) A complaint is not limited either in content or time: there is no definition of complaint in the Code – the Code adopts the AS ISO 10002-2006 definition534 – and no time limit under the Code within which it should be made.535

b) In Stage One, the Code Participant must respond in 15 days if it has all necessary information and has completed its investigation.536 If not, the Code Participant will agree alternative time frames. If alternative time frames are not agreed, the complaint moves to Stage Two.537

c) In Stage One, the Code Participant must make a decision about the complaint and inform the complainant in writing about its reasons and the decision.538

d) If Stage One does not resolve the complaint, the complainant is entitled to move the complaint to Stage Two.539 The complaint is considered by a different employee from the one who considered the issue in the first place or who was involved in Stage One.540

e) In Stage Two, the Code Participant must make a decision about the complaint and inform the complainant in writing about its reasons and the decision.541

f) The complainant is entitled then or at any time, to refer the complaint to FOS.542

g) The Code Participant has 45 days in total to resolve the matter.543

527 s. 10.3.
528 Code, s. 10.1.
529 Code, ss. 10.3-10.13.
530 Code, ss. 10.14-10.19.
531 FOS Annual Reviews 2009-2010 and 2010-2011; The Ramsay Report, Recommendation 9, endorsed this approach.
532 Code, s. 10.3
533 Code, s. 10.
534 RG 165.62,78: ‘An expression of dissatisfaction made to an organisation, related to its products or services, or the complaints handling process itself, where a response or resolution is explicitly or implicitly expected.’, Code Definitions.
535 Compare the EDR time limits in RG 139.213-216.
536 s. 10.11.
537 Code, s. 10.12.
538 Code, s. 10.13.
539 Code, s. 10.14.
540 Code, s. 10.15.
541 Code, s. 10.19.
542 Code, s. 10.19.
543 Code s. 10.10; compare RG 165.86-94, RG 165.121-123 and RG 139.55-56, 230-233.
h) The complainant is entitled to information about how and when to access an EDR scheme –
this was, for the 2011 Code Compliance Committee (CCC) review, the most frequently
breached Code standard.544

3.6. The Code IDR process must be fair, transparent and timely.545 ASIC RG 165 requires it to be
genuine, prompt, fair and consistent.546

3.7. If the complaint is resolved to the complainant’s satisfaction in five business days, the full IDR
processes do not apply, unless the complaint is about a declined claim, the value of a claim or
financial hardship.547

3.8. The IDR processes must be documented.548 IDR procedures should comply with ASIC RG 165 –
Appendix 1 which includes: visibility, accessibility, objectivity, confidentiality, customer-focused
approach, accountability, continuous improvement, commitment, resources, collection of
information and analysis and evaluation. ASIC considers it important that IDR systems interface
smoothly with EDR scheme processes.549

3.9. The Code IDR standards are subject to review.550 It is a part of the Code for which FOS and CCC
Reports had identified breaches; in 2011 there were 47 breaches of section 6 in a total of 108
Code breaches identified by FOS and 180 breaches of section 6 in a total of 2010 Code breaches
identified by Code Participants.551 FOS reports on IDR statistics552 and runs IDR workshops.553

Ramsay Review Panel Report

3.10. The Ramsay Report noted that IDR is the primary avenue for aggrieved consumers to seek redress
in the financial system and effective IDR supports effective EDR. The Ramsay Report made
recommendations to improve the effectiveness of IDR through increased reporting of IDR activity
to ASIC and increased tracking of IDR disputes by the single EDR body.554

4. EDR555

Background

4.1. An AFSL holder must have an external dispute resolution system for retail business which
complies with the ASIC standards and requirements556 that are set out in ASIC RG 165. The Code
standards form a part of the EDR framework for complaints.557

4.2. The current EDR arrangements in financial services consist of the Financial Ombudsman Service
(FOS), Credit and Investments Ombudsman (CIO) and Superannuation Complaints Tribunal
(SCT). As of 1 November 2018, these schemes will be replaced by a single EDR scheme, the

545 Code, s. 10.3.
546 RG 165.69.
547 RG 165.100; Code s. 10.9.
548 RG 165.126-129.
549 RG 165.130-132 and RG 139.64-66.
551 Now s. 10. General Insurance Code of Practice: FOS Overview of the 2008-2009 Financial Year, p. 4; General
Insurance Code of Practice: FOS Overview of the 2009-2010 Financial Year, p. 12,15,19-20,28-29; General Insurance
552 See Independent Code Review 2013, Appendix E.
555 Ian Enright has been a FOS Panel Member and consultant since 2016.
556 Corporations Act, ss. 912A(1)(g) and (2) and RG 165.1 and 165.2. s. 1017G(2) of the Corporations Act replicates these
requirements for the issue or sale of financial products not covered by an AFSL.
557 s. 10.
Australian Financial Complaints Authority (AFCA), discussed further below. The EDR framework generally provides low cost, speedy and flexible access to redress.558

4.3. In 2015-16, FOS, CIO and SCT received 41,223 disputes in total, with FOS receiving 34,095 disputes (83 per cent), CIO receiving 4,760 disputes (12 per cent) and SCT receiving 2,368 disputes (6 per cent).559

**FOS**560

*Introduction*

4.4. FOS is an accredited independent external alternative dispute resolution service under ASIC EDR requirements.561 Code Participants use FOS as the independent EDR scheme.562

4.5. FOS deals with a dispute within its **Terms of Reference** (TOR) referred by a consumer. FOS also monitors and enforces the Code.563 FOS identifies ‘systemic issues’ and refers any such to the Code Participant for remedial action.564 FOS obtains a report from the Code Participant and monitors the matter until it is resolved to FOS’ satisfaction.565 FOS reports to ASIC on complaints against insurers and on systemic issues and serious misconduct.566

4.6. FOS is independent of the Code and its EDR scheme is the subject of a separate independent review every three years.

**TOR and approach**

4.7. FOS has jurisdiction under its TOR in relation to both a ‘General Insurance Policy’, which means a contract of general insurance within the meaning of that expression in the *Insurance Contracts Act 1984* (IC Act), and a ‘Life Insurance Policy’ which includes any product or service offered by a life insurance company.567 There is a compensation cap of $309,000.568

4.8. There are important exclusions from FOS’s jurisdiction in general insurance in paragraph 5, particularly certain aspects of: privacy and confidentiality569; the amount of premium570; underwriting or actuarial factors in a non-standard offer of a life insurance policy571; factors and weightings used to determine the base premium for an insurance policy572; some decisions to refuse cover573; competing beneficiary claims574; the value of the claim exceeds $500,000575; the applicant is a large employer.576

4.9. FOS is not bound by the rules of evidence.577

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558 See the Ramsay Report, Ch 4.
560 Pynt, paras. 4.42-4.48.
561 HOR Report, paras. 2.39-2.46.
562 Code, s. 10.20.
563 HOR Report, paras. 2.44, 3.4, 3.16-3.38 and Ch 3.
564 FOS, **Terms of Reference**, para. 11.2; HOR Report, para. 3.32.
565 FOS, **Terms of Reference**, para 11.2; HOR Report, para. 3.32.
566 FOS, **Terms of Reference**, para 11.2 and 11.3; HOR Report, para. 3.33.
567 Paras. 4.2b (iii), (iv) and 20.1.
568 Schedules 1 and 2 of the FOS **Terms of Reference**. Other caps also apply depending on the type of claim.
569 FOS, **Terms of Reference**, para. 5.1(a).
570 FOS, **Terms of Reference**, para. 5.1(b).
571 FOS, **Terms of Reference**, para. 5.1(d).
572 FOS, **Terms of Reference**, para 5.1(e).
573 Para. 5.1(f).
574 Para. 5.1(j).
575 Para. 5.1(o).
576 Para. 5.1(p).
577 Para. 8.1.
4.10. FOS will do what in its opinion is fair in all the circumstances, having regard to each of the following:
   a) legal principles;
   b) applicable industry codes or guidance as to practice;
   c) good industry practice; and
   d) previous relevant decisions of FOS or a Predecessor Scheme (although FOS will not be bound by these).  

4.11. When FOS considers what is fair in the circumstances, it is strongly influenced by the duty of utmost good faith as well as the consumer protection approach and purpose of the IC Act.

4.12. While FOS is not a court of law, in dealing with disputes, it must assess liability in accordance with the FOS TOR. This means that FOS must deal with a dispute on its merits and do what, in its opinion, is fair in all the circumstances having regard to the law, general principles of good industry practice and any applicable code of practice.

4.13. The quality of information provided to FOS by insurers and policyowners is of paramount importance in resolving general insurance disputes. For that reason both parties are obliged to provide all information relevant to the dispute. The resolving of a dispute requires consideration of all the relevant evidence carefully and objectively.

4.14. FOS, under paragraph 7 of the TOR, may require a party to obtain any information that it considers necessary. Paragraph 7.2 provides instances in which information might not be provided.

4.15. FOS TOR, paragraph 7.6 provides:

   **Consequences of non-compliance by either party with a FOS request**

   Where a party to a Dispute without reasonable excuse fails to provide or procure information or to take any other step requested by FOS within the timeframe specified by FOS, FOS may take the steps it considers reasonable in the circumstances. This may include:

   a) proceeding with the resolution of the Dispute on the basis that an adverse inference may be drawn from that party’s failure to comply with FOS’s request; or

   b) where the Applicant fails to comply with a FOS request – refusing to continue consideration of the Dispute.

4.16. The IC Act section 74 requires that:

   **Policy documents to be supplied on request**

   1) Where the insured under a contract of insurance so requests in writing given to the insurer, the insurer shall give to the insured a statement in writing that sets out all the provisions of the contract.

   **Penalty:** 300 penalty units.

   2) An insurer need not comply with the requirements of subsection (1) if the insurer has already given to the insured such a statement, whether as required by this Act or otherwise.

   **Note:** A defendant bears an evidential burden in relation to the matters in subsection (2), see subsection 13.3(3) of the Criminal Code.

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578 FOS, *Terms of Reference*, para 8.2.
579 FOS, *Terms of Reference*, para 8.2.
580 FOS, *Terms of Reference*, para 7.2.
4.17. Many insurance claims involve the use of expert witnesses. The expert witnesses are expected to meet the same standards of competence and objectivity as required by the courts of expert witnesses. The evidence from expert witnesses is opinion only and must be weighed against all the other evidence in reaching a conclusion.

4.18. FOS operates on a without prejudice basis, which means that information obtained through FOS may not be used in any subsequent court proceedings unless required by court process.

**FOS Remedies**

*Determination*

4.19. A FOS determination is binding on the Code Participant under the FOS TOR. 581

*Awards*

4.20. FOS must determine whether the insurer is obliged to pay the sum insured or benefit to the claimant. If FOS so determines, FOS then would make an award in favour of the applicant or claimant.

4.21. It is not normally available under the terms of the insurance contract for the claimant to recover indirect or consequential loss or damages other than legal costs and a limited category of non-financial loss. Under the TOR, FOS will not award compensation for consequential financial loss or non-financial loss where the insurance policy the subject of the dispute excludes such liability. 582

*Other remedies*

4.22. One or both parties may be instructed to undertake a particular course of action by FOS, as opposed to FOS making a financial award. This may include an instruction to the insurer to assess, or re-assess, any entitlement of the policyowner to benefits in light of the FOS findings and interpretation of the policy.

*Factors that will affect an award*

*Offset clauses*

4.23. A policy of insurance may indicate that certain amounts may be offset, or deducted, from the base rate of benefits that may be payable under a policy of insurance. There may be disputes as the offsets are gross or net of taxation.

*Consumer obligations*

4.24. Ordinarily, a policy of insurance will specify various pieces of information that a policyowner is required to provide to the insurer before benefits may be assessed.

4.25. Where necessary, FOS may make any award conditional upon the policyowner providing particular information or taking particular action, such as attending an Independent Medical Examination.

*Interest on awards*

4.26. The IC Act section 57 requires an insurer to pay interest to cover any delay in payment under an insurance contract. The period for which an insurer is required to pay interest commences on the day from which it was unreasonable for the insurer to withhold payment.

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581 Code, s. 10.23.
582 FOS, Terms of Reference, para 9.3(c).
4.27. The right to interest does not depend on the commencement of legal proceedings. The rate of interest is prescribed in the Insurance Contracts Regulations and is calculated on the basis of the 10-year treasury bond yield plus 3%.

4.28. Paragraph 9.5 of the FOS TOR provides:
   a) Subject to paragraph 9.5 b) FOS may decide that the Financial Services Provider pay interest on a payment to be made by the Financial Services Provider to the Applicant.
   b) When deciding an award of interest:
      i) if the Insurance Contracts Act 1984 applies - FOS will calculate interest in accordance with that Act; and
      ii) otherwise:
         (A) FOS will calculate interest from the date of the cause of action or matter giving rise to the claim; and
         (B) FOS may have regard to any factors it considers relevant, including the extent to which either party’s conduct contributed to delay in the resolution of the matter.

Usual interest awards

4.29. Interest awarded by FOS is not factored into the amount that is subject to the monetary limit contained in the TOR.

4.30. The interest usually awarded is at the rate set out in the TOR, calculated from the date from which it was unreasonable for the insurer to withhold payment. This may be varied at the discretion of FOS depending on what is fair in the circumstances.

4.31. There is no requirement for the payment of compound interest under the IC Act, section 57, and as a consequence interest is normally calculated on the basis that simple interest is applicable.

Australian Financial Complaints Authority (AFCA)

4.32. The Ramsay Report found that a number of features of the design of the current EDR system meant that it was not producing the best possible outcomes for some users, in particular, consumers. The Report recommended the formation of a single EDR body for all financial disputes to replace FOS, CIO and the SCT. The AFCA is established by its eponymous Act in 2018.

4.33. A key recommendation of the Ramsay Report, adopted by government was that AFCA should, relevantly for general insurance, commence operations with a monetary limit of $1 million and a compensation cap of no less than $500,000. Another was that ASIC should be provided with a general directions power to compel performance from the single EDR body if it did not comply with legislative and regulatory requirements.

4.34. The Ramsay Report approach and recommendations suggest that otherwise there would be few changes to the TOR, approach and operations of FOS.

5. Litigation

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584 Recommendation 1.
585 Recommendation 4.
586 Recommendation 7.
5.1. The traditional right of a person to seek redress for a legal wrong is mentioned here for the sake of completeness only. A retail customer is almost always precluded by cost, delay and health from commencing court proceedings against a financial services entity. The advantages of an accessible, low cost and quick dispute resolution scheme are now axiomatic.

5.2. The Ramsay Report stated:

> Ombudsman schemes provide complainants with an alternative to the judicial system. By providing a mechanism for complainants to resolve low value disputes, ombudsman services can deal with smaller issues in a proportional manner and can prevent them from evolving into bigger issues. Ombudsman services can also assist complainants to overcome power imbalances by helping them to assert their rights when dealing with large companies.

> The traditional court system, which relies on lawyers, the rules of evidence and specific processes and procedures can be complex and intimidating for consumers. In this regard, a benefit of ombudsman schemes is that they provide claimants with a relatively simple process, led by the ombudsman, negating the need for formal legal representation. Furthermore, ombudsman services are not restricted to resolving legal issues; rather, they have scope to consider a broader range of factors.

> Where there is a general problem in an industry affecting multiple consumers and a number of similar complaints are received about a particular issue, ombudsman schemes have the capacity to instigate and conduct investigations to identify systemic issues. Once these issues have been identified and investigated, ombudsman services can alert the relevant stakeholders and regulators and assist in their resolution. This approach is more cost-effective than litigation and has the potential to provide positive outcomes for consumers by promoting good industry practice.

> Ombudsman schemes are also able to promote access to justice through their ability to adapt and innovate in response to changes in the external environment. This has been particularly relevant in the financial system, which has seen rapid changes in the types of products being sold and the types of consumers purchasing them.

> There is a general consensus among stakeholders that ombudsman services are an effective dispute resolution mechanism which promotes access to justice and decreases the burden on the judicial system.\(^{587}\)

\(^{587}\) Ramsay Report, paras. 2.18-2.22.
FURTHER READING


Peter Mann, *Annotated Insurance Contracts Act, 7th Edition* (*Mann*)
GLOSSARY

AFCA – Australian Financial Complaints Authority (AFCA)
AFSL – Australian Financial Services Licence
ALRC – Australian Law Reform Commission
APPs – Australian Privacy Principles
APRA – Australian Prudential Regulation Authority
APRA Act – Australian Prudential Regulation Authority Act 1998
ASIC – Australian Securities and Investments Commission
ASIC Act – Australian Securities and Investments Commission Act 2001
ASIC RG 183 – ASIC Regulatory Guide 183: Approval of financial services sector codes of conduct
ASIC RG 165 – ASIC Regulatory Guide 165: Licensing: Internal and external dispute resolution
Average clause – a term of an insurance policy which reduces the amount of a claim that insurer is obliged to pay: the insurer pays not the full insured loss but the amount which is in the same proportion to the full insured loss as the insured loss is to the total value of the same type of property owned by the policyowner. For example, if a policyowner’s home contents are valued at $2000 and the policyowner insures the contents for $1000, the insurer pays half of any insured loss.
Captive – a type of insurance company whose sole policyowner is the parent company of the insurer
CCA – Competition and Consumer Act 2010
CCC – Code Compliance Committee
CGC – Code Governance Committee
CGU v AMP – CGU Insurance Ltd v AMP Financial Planning Pty Ltd
CIO – Credit and Investments Ombudsman
Code – General Insurance Code of Practice
Code Participant – a general insurance industry participant that is a signatory to the General Insurance Code of Practice.
Corporations Act – Corporations Act 2001
EDR – External dispute resolution
FCS – Financial Claims Scheme
FOS – Financial Ombudsman Service
IC Act – Insurance Contracts Act 1984
ICA – Insurance Council of Australia
IDR – Internal dispute resolution
IEC – Insurance Enquiries and Complaints Scheme
KFS – Key facts sheet
Lloyd’s – Lloyd’s of London – the market for insurance first begun in about 1688.

Major Reports – Five recent reports on disaster events: NDIR Report, HOR Report, QFCI Report, Treasury Paper, FOS QF Survey

MI Act 1906 – Marine Insurance Act 1906
MI Act 1909 – Marine Insurance Act 1909
MI Act 1745 – Marine Insurance Act 1745
MTA - Mining Technologies Australia Pty Ltd

Mutual – a type of insurance company that has many policyowners all of whom are shareholders or members of the insurance company.

NDIR – National Disaster Insurance Review


NIBA – National Insurance Brokers Association

NOHCs – non-operating holding companies

PDS – Product Disclosure Statement


Reinsurance – the insurance of insurers: an insurer enters into an insurance contract with a reinsurer to cover the insurer against certain insurance risks under the insurer’s own insurance contracts.


SCT – Superannuation Complaints Tribunal

TOR – Financial Ombudsman Service Terms of Reference

UCT – Unfair Contracts Terms

Underwriter – sometimes means an insurer and sometimes means the person who decides whether or not an insurer should accept the risk.

URCT regime – unfair reliance contract term regime
APPENDIX

INSURANCE CONTRACTS ACT 1984

SECT 54 Insurer may not refuse to pay claims in certain circumstances

(1) Subject to this section, where the effect of a contract of insurance would, but for this section, be that the insurer may refuse to pay a claim, either in whole or in part, by reason of some act of the insured or of some other person, being an act that occurred after the contract was entered into but not being an act in respect of which subsection (2) applies, the insurer may not refuse to pay the claim by reason only of that act but the insurer's liability in respect of the claim is reduced by the amount that fairly represents the extent to which the insurer's interests were prejudiced as a result of that act.

(2) Subject to the succeeding provisions of this section, where the act could reasonably be regarded as being capable of causing or contributing to a loss in respect of which insurance cover is provided by the contract, the insurer may refuse to pay the claim.

(3) Where the insured proves that no part of the loss that gave rise to the claim was caused by the act, the insurer may not refuse to pay the claim by reason only of the act.

(4) Where the insured proves that some part of the loss that gave rise to the claim was not caused by the act, the insurer may not refuse to pay the claim, so far as it concerns that part of the loss, by reason only of the act.

(5) Where:
   (a) the act was necessary to protect the safety of a person or to preserve property; or
   (b) it was not reasonably possible for the insured or other person not to do the act;
   the insurer may not refuse to pay the claim by reason only of the act.

(6) A reference in this section to an act includes a reference to:
   a) an omission; and
   b) an act or omission that has the effect of altering the state or condition of the subject-matter of the contract or of allowing the state or condition of that subject-matter to alter.