

INSURANCE AND REINSURANCE

NewsWire

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Congress and Insurance: Incremental Changes Now, Maybe Fundamental Change Later

by Richard Liskov, in New York

With so many issues of broader national significance occupying the U.S. Congress from Iraq to the sub-prime mortgage mess, insurance issues have taken a decidedly less prominent role in this session, and that will likely remain so through next year. Still there are a number of federal legislative developments which will affect both U.S. and foreign players.

Members and their staffs are focused on several bills, with more sweeping initiatives essentially in the preliminary discussion stage. The measures to watch are:

TRIA Extension

The current Terrorism Risk Insurance Act expires on December 31, and the industry and supportive Members will be pushing hard for an extension of some sort. The House of Representatives has already passed H.R. 2761, a 15 year extension and even broadened the backstop to cover group life insurance claims and biological, chemical or radiological attacks.

Not surprisingly, the Administration and its Republican allies in the Senate have voiced strong objections to so long an extension and so wide an expansion of the federal backstop. A much shorter extension, possibly just for two more years stripped of the added coverage provisions but probably including higher insurer deductibles, is the most likely prospect.

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Streamlining Surplus Lines and Reinsurance Regulation

Surplus lines insurers from abroad—and possibly reinsurers—can take heart from the likely enactment in 2008 of a proposal that the House alone passed, a bill to incorporate the "home state" concept of regulation long familiar to companies in the EU. The House passed the bill earlier this year, and it is now before the Senate

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Banking Committee. The House bill and its Senate companion (H.R. 1065, S. 929) would for the first time incorporate the “home state” concept into regulation of reinsurers, surplus line insurers and surplus line brokers, and mark an important, albeit still limited, step toward nationalizing insurance regulation in the U.S.

Under the proposal only the “home state” of the prospective insured may require a surplus lines broker to be licensed in respect of a placement for that insured, and only that

ables. Moreover, the bill reserves to the reinsurer’s domiciliary state exclusive jurisdiction over financial solvency as long as the state implements solvency regulations consistent with those promulgated by the NAIC.

It is not certain that the Senate — which has tended in the past to give somewhat greater deference to the views of state insurance regulators — will adopt the House bill exactly as is. While the NAIC debates loosening the security requirements for non-admitted reinsurers, the Senate version of the bill may only deal with surplus lines, leaving reinsurance to the NAIC or at least to the next Congress in 2009.

If passed, the House bill and its Senate companion would for the first time incorporate the home state concept into regulation of reinsurers, surplus line insurers and surplus line brokers, and mark an important step toward nationalizing insurance regulation in the U.S.

state may regulate the placement. The bill defines “home state” as the state of the prospective insured’s principal place of business or principal residence. Of perhaps greatest significance for foreign non-admitted insurers, the bill specifically bars states from prohibiting placements with non-admitted insurer domiciled outside the United States that is listed on the Quarterly Listing of Alien Insurers maintained by the NAIC, without regard to whether that insurer has met all of the requirements imposed by a state for being an approved surplus lines insurer. Also, commercial insureds with qualified risk managers which meet certain financial tests would be able to buy insurance from non-admitted insurers, whether or not its broker conducted the traditional search of the admitted market to determine if a licensed insurer would write the risk.

A similar “home state” concept would streamline the regulation of reinsurance. Only the domicile of the ceding insurer could legally determine whether the cedent can take financial statement credit for the reinsurance or otherwise regulate the cession; although other states could still apply their tax laws to the reinsurance premium and reinsurance recover-

Broader Federal Initiatives

Unlike the TRIA extension that is virtually certain of enactment in some form this year, and unlike the streamlining bill, a version of which is likely to pass next year, several proposals involving much broader reforms will probably remain in the theoretical discussion mode until at least 2009. Chief among these is the bill to provide insurers with the option of being regulated exclusively by the U.S. Treasury, instead of by as many as fifty-four separate regulators as is true now (fifty States, the District of Columbia, Puerto Rico, Guam and the U.S. Virgin Islands). Although the largest insurers and their trade groups have strongly backed the federal charter idea, the combination of opponents — state regulators, smaller insurers and at least one major agents group — will again most likely be too powerful to overcome.

Also working against so fundamental a reform is the desire on the part of activist groups like the Consumer Federation of America to repeal the antitrust exemption which insurers have enjoyed since 1945. Unless the industry is prepared to forego the immunity it has long enjoyed for joint rate-making and form drafting, Democrats for certain, and even some

Republicans unhappy with the industry's response to Katrina claims, will not be inclined to grant the largest players an optional federal charter. So far there is no indication that House and Senate leadership consider either the federal charter or repeal of the antitrust exemption to be a major priority.

Inertia likewise seems to have overtaken the idea of a national catastrophe fund for windstorms and earthquakes. Although the House Financial Services Committee endorsed the idea in September, floor action is not certain, and the Senate appears resistant to doing anything more than creating a commission to study the concept. An alliance of fiscally conservative Republican and environmentally sensitive Democrats is likely to thwart enactment. Republicans outside of hurricane-prone states are loath to erect yet another potentially costly federal backstop to the insurance industry, while environmental proponents oppose the idea of making it easier for developers to build in ecologically fragile areas. As with the optional federal charter idea, some talk, but little action will probably be the order of the day. ☺

New UK Legislation Governing “Corporate Manslaughter”

by John Barlow and Jonathan Ogle, in London

Much has been written in the UK over the past ten years on the subject of corporate manslaughter, not least in view of high-profile events such as the Zeebrugge ferry disaster in 1987 and the Hatfield rail crash in 2000. Although the weight of public opinion appeared to be on the side of imposing onerous duties on companies and individuals involved in such events, interest groups representing both employers and employees also lobbied Parliament seeking to protect their members from being fixed with charges of manslaughter. Ultimately, their imprecations appear to have prevailed.

The Corporate Manslaughter and Corporate Homicide Act 2007 (the “Act”) finally received Royal Assent on 26 July 2007 and will come into force on 6 April 2008.

The Act makes provision for a new offense of corporate manslaughter (or “corporate homicide” in Scotland), applicable to companies and other incorporated bodies, government departments and similar bodies, police forces and certain unin-

corporated associations. The intention behind the legislation is to set out, more clearly, the extent of the duty of care owed by such organizations and to overcome some of the hurdles which have, traditionally, made it difficult for prosecutors successfully to secure convictions against corporate defendants.

Background

In the past, for a company to be successfully prosecuted, it was necessary to identify a senior manager who could be deemed to be the “directing mind” of the company and, therefore, could be held liable for the company's shortcomings as well as being individually guilty of manslaughter. It was not possible to combine evidence of the negligence of several individuals to demonstrate that the relevant company was “grossly negligent (the required standard for corporate manslaughter to be proven).

This was known as the “doctrine of identification” and made it difficult for convictions to be secured against companies for corporate manslaughter (again, for example, in the Zeebrugge case against P&O European Ferries). In many large organizations, management functions are devolved, making it very hard to identify the relevant senior individual. To date, there have been only a few successful prosecutions and these have involved smaller organizations with a small and simple management structure where the wrongdoer can be readily identified.

The Act only encompasses incidents that “cause” the death of an individual and those organizations covered by the Act will only be guilty of the new offense if (1) the way in which its activities are “managed or organized” by its “senior management” is deemed to have caused death and (2) this amounts to a “gross breach of a relevant duty of care owed by the organization to the deceased.”

What is a “Gross” Breach of Duty?

The Act defines a gross breach of duty as being when the conduct of the organization “falls far below what can reasonably be expected of the organization in the circumstances.” Ultimately, this will be a matter of fact for a jury to decide, but the Act details that a relevant duty of care can arise in relation to the offense of corporate manslaughter in one of the following ways:

- (i) a duty owed to employees or others working for the organization;
 - (ii) a duty owed as an occupier of premises;
 - (iii) a duty arising from the supply of goods or services (which includes health care services);
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- (iv) a duty arising from the carrying out of construction or maintenance; and
- (v) a duty arising from the use or keeping of any plant or vehicle.

There are significant carve-outs in the Act covering, for instance, a range of “military activities” and “policing and law enforcement.” Any duties of care arising out of such activities are deemed not to be a “relevant duty of care” for the purposes of the Act.

For any relevant duty of care, in determining whether or not there has been a gross breach, the Act requires that a jury

Who are “Senior Management” for the Purposes of the Act?

The term “senior management” is defined in clause 1(4) of the Act to mean those persons who play a significant role in (1) “the making of decisions about how the whole or a substantial part of [a relevant organization’s] activities are to be managed or organized” and (2) “the actual managing or organizing of the whole or a substantial part of those activities.” This covers both those in the direct chain of management as well as those in, for example, strategic or regulatory and compliance roles.

The Act is not, therefore, intended to capture immediate, operational negligence causing death, or the unpredictable

The jury’s assessment of whether there has been a gross breach of the duty of care will involve considering both the collective and individual conduct of senior management in the context of any failure in providing adequate practices and systems for managing the relevant organization’s normal operations.

must consider whether the evidence shows that the organization in question failed to comply with any health and safety legislation and any guidance relating to the subject of the alleged breach and, if so, how serious that failure was.

This will involve considering both the collective and individual conduct of senior management, in order to consider any failure in providing adequate practices and systems for managing the particular activities that the organization undertakes. The jury may also consider whether the evidence shows that there were attitudes or accepted practices within the organization that were likely to have encouraged the organization to have failed to comply with any health and safety legislation¹ or to have produced tolerance of it.

acts of employees. Nonetheless, the reference to the management of “the whole or a substantial part” of a relevant organization still means that the larger the organization, the less likely that individual managers will be deemed to be responsible for a “substantial” part of the activities of the organization. This is especially the case when one considers the roles played by divisional or regional managers of larger organizations, who may be key to the management of their particular division/region but cannot be shown to play a significant role in the management of the whole or substantial part of the overall organization’s activities.

What Punishment can be Expected for Breach of a Relevant Duty of Care?

Only relevant organizations can be liable for the new offense, not individuals.

The Act does not, therefore, impact on the potential liabilities of individual directors or managers, although they can still be held to account through health and safety legislation

¹ Such legislation was invoked this month in the case against the (London-based) Metropolitan Police for the fatal shooting of Jean Charles de Menezes in July 2005, for which the Metropolitan Police were fined £175,000 and ordered to pay £385,000 in costs.

and the common-law manslaughter offense. It is also important to note that an individual cannot be guilty of aiding, abetting, counselling or procuring the commission of the new, statutory offense.

As a result, the Act provides for an unlimited fine (of the organization) in the event of conviction, rather than a term of imprisonment. The Courts are also given powers to make remedial orders against convicted organizations, requiring them to remedy breaches of duty, and to make publicity orders requiring them to publicize the relevant conviction and the particulars of their offense(s). Failure to comply with a remedial or publicity order is itself a criminal offense punishable by an unlimited fine.

From an insurance perspective, these provisions are unlikely to trigger cover since there will normally be exclusions with regard to the payment of fines, although associated defense costs may be recoverable under certain policies. As far as company directors and officers are concerned, given that the target of the Act is the organization and not the individual, the Act is unlikely to have any impact on D&O underwriters.

Crown Immunity

One further, significant change brought about by the Act involves crown bodies (organizations that are legally a part of the Crown, such as government departments) which could not previously be prosecuted for criminal offenses under the doctrine of "Crown Immunity." Subject to the carve-outs identified above, the Act lifts Crown Immunity, therefore opening up the possibility of public authorities being prosecuted for the new offense.

As a result of a last minute amendment to the Bill in Parliament, the new offense was extended to include "deaths in custody." However, the government has indicated that this part of the Act will not be implemented for approximately three years.

Conclusion

Prior to the passing of the Act, the ability to bring prosecutions against corporations was fraught with difficulty and prosecutors tended to concentrate on specific breaches of health and safety legislation. The alternative was to bring prosecutions against identifiable individuals — which were all but impossible save in small corporates. However, it remains to be seen whether the prospect of unlimited fines and the naming and shaming of guilty corporations will, in practice, impact the behavior of corporations. ☺

Proposals for the Reform of Insurance Contract Law in the UK

by Mark Pring and Sally Mant, in London

On 17 July 2007, the Law Commissions of England/Wales and of Scotland (together, the "LC") jointly published a Consultation Paper entitled "Misrepresentation, Non-Disclosure and Breach of Warranty by the Insured."

The public consultation period for considering the LC's wide-ranging "provisional" proposals will finish on 16 November 2007. All industry representatives should take this opportunity to air their views on these fundamental issues relating to insurance contract law.

Background

The objective of the LC has been to conduct a comprehensive review of the Marine Insurance Act 1906 (the "MIA") to ensure that it meets modern-day needs. The Consultation Paper focuses on three main areas as set out below.

- ☉ non-disclosure and misrepresentation
- ☉ breaches of warranty and
- ☉ cases where an intermediary was wholly or partly responsible for pre-contract non-disclosures or misrepresentations.

From September 2006, the LC published "Issues Papers" on each of these three areas, among others¹. The Consultation Paper proposals are generally consistent with the positions taken by the LC in those Issues Papers.

The LC has concluded from its review that some of the principles embodied in the MIA are no longer appropriate to a modern insurance market and do not meet the reasonable expectations of an insured.

Again, the LC seeks responses from interested parties to the Consultation Paper by **16 November 2007**.

It should also be noted that the LC is currently considering reforms relating to other key areas, including insurable interest, damages for the late payment of claims and the continuing duty of utmost good faith (and intends to publish a separate consultation paper on such matters during 2008).

The LC aims ultimately to present a Bill to Parliament for approval in 2010.

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¹ Further details can be found on the website www.lawcom.gov.uk.

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The LC's General Position Regarding Reform

The LC has concluded that the law as it currently stands is unfairly weighted against insureds. Consequently, its aims are to ensure that:

- ⊙ the law should strike a fair balance between the interests of insureds and insurers;
- ⊙ any new law should give potential insureds confidence by ensuring that their insurance meets their reasonable expectations, while protecting the legitimate interests of insurers and not imposing undue costs or unnecessary restrictions; and
- ⊙ any new law should be coherent, clear and readily understandable.

The LC does not propose separate rules for marine, aviation or transport insurance, or for reinsurance, on the grounds that to apply such rules would be unduly complex. References below to insurance should therefore be construed as also applying to reinsurance.

The current rules on co-insurance are not to be affected by the proposed reforms, so that a “joint” insured is bound by the misdeeds of its co-insured whereas a “composite” insured is not bound by the misdeeds of its co-insured.

Non-disclosure and Misrepresentation

The Current Law

Section 18 of the MIA imposes a duty on an insured to disclose to its insurer, prior to the conclusion of a contract of insurance, every material circumstance which it knows, or ought to

One of the criticisms of the current law is that the insured ultimately has responsibility for deciding what is material even though the insured may not necessarily know what information the insurer would deem material.

The LC proposals broadly distinguish between retail insureds — any individual acting for purposes which are outside a trade, business or profession — and business insureds. If a policy is taken out for a dual purpose (e.g., where a shop owner has a flat above his business premises) then the predominant purpose determines the insured's status. As far as group insurance for employees is concerned, each employee is to be treated as a separate insured under a commercial policy, so that the rules relating to business insurances will apply.

A retail insured is to be protected by a mandatory scheme based on principles adopted by the Financial Ombudsman Service.

Businesses are governed by default regime based on good practice: “default” rules, based on generally accepted standards are to apply, but the parties to a business insurance contract are able to agree on different terms. No distinction is drawn between large and small businesses.

This paper deals with business insurance only.

know in the course of its business. A circumstance is material if it would influence a “prudent” underwriter in accepting such a risk or fixing the premium. If the insurer can prove (1) that the insured failed to disclose a material circumstance and (2) that the non-disclosure induced the insurer to enter into the contract, the insurer has a right to avoid the policy.

Section 20 of the MIA provides that an insured has a duty to provide correct material statements of facts to its insurer prior to the conclusion of the contract of insurance. If a material statement of fact is not correct and the insurer can prove that the misrepresentation induced him to enter into the contract, the insurer has a right to avoid the policy.

One of the criticisms of the current law is that the insured ultimately has responsibility for deciding what is material even though the insured may not necessarily know what information the insurer would deem material. Section 20 has also been criticized because an innocent but incorrect statement of fact may allow the insurer to avoid its policy.

The Reform Proposals — Non-disclosure

In the business context, the LC proposes that the duty of disclosure is to be retained and insurers are under no duty to warn their insureds of the duty.

Nonetheless, the LC also considers that the duty is currently too broad and penalizes those who otherwise act honestly and reasonably, simply because they do not understand what would influence a prudent underwriter. Consequently, the LC proposes a modified test for “materiality,” to ensure that an insured who was both honest and careful in providing pre-contract information should not have a claim rejected on the basis that the information was incorrect or incomplete.

The modified test for “materiality” provides that, to found a claim for non-disclosure, the insurer would have to show either that:

- ⦿ a reasonable insured in the circumstances would have appreciated that the fact in question was one that the insurer would want to know about; or
- ⦿ the proposer actually knew the fact was one that the insurer would want to know about.

The LC perceives this as a flexible test, adaptable to the many different circumstances in which insurance is bought. For example, in a sophisticated market, where both the

The proposed default principle is therefore that the insured is required to disclose all facts:

- (a) which he had or ought to have had in his possession; and
- (b) which he knew or ought to have known were relevant to the insurers.

Insurers will only have a remedy if they can prove inducement, in that they would not have entered into the contract at all or on the same terms. They will have no rights against an insured who did not know the facts to be disclosed, or who did not appreciate that the facts in question would have been relevant.

Parties to business insurance contracts have the right to contract out of these default rules and to impose stricter obligations. It will be possible, therefore, for insurers to specify that the current law is still to apply. Any modification to the default rules is, however, permissible subject to the consideration that, if the insurers wish to rely upon their standard terms and conditions, they can only do so if the “reasonable expectations” of the insured are not defeated.

The Reform Proposals — Misrepresentation

The LC proposes adding a new limit to the existing test.

The modified test proposed for materiality is that, to establish a non-disclosure, the insurer would have to show either that a reasonable insured in the circumstances would have appreciated that the fact in question was one that the insurer would want to know about or that the proposer actually knew the fact was one that the insurer would want to know about.

insurer and the insured are experts or professionally represented, the LC would expect almost no difference between the existing and the proposed law. However, a small, unsophisticated business buying off-the-shelf products, without professional help, may have little idea of what influences insurers. Here the onus would be on the insurer to ask appropriate questions and the burden of establishing that the insured does not have reasonable grounds for believing that what it said was true would be on the insurer.

Therefore, as well as proving that a material fact was incorrectly stated by the insured and that this induced it to enter into the contract of insurance, an insurer would also, under the new default rule, have to demonstrate that a reasonable person in the same circumstances would not have made such a misrepresentation.

This is, again, designed to protect an insured who has acted honestly and reasonably and ensure that such an insured should not lose cover, unless that is

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specifically agreed in the contract. An insured may act reasonably if it believes what it said was true, or if it answers a general question and reasonably does not appreciate what information was required.

Again, the LC sees this as a flexible test, because reasonableness will depend on various factors such as the type of market, whether the business received professional advice, as well as the clarity of the questions asked.

- ⊙ there should be strong incentives to encourage business insureds to act carefully.

The LC has not reached a final view, but currently considers that the position should be the same as for consumers (retail insureds):

- ⊙ if the insurers would have charged a higher premium or imposed a deductible, the claim is reduced in proportion to the degree of underinsurance;
- ⊙ if the insurers would have excluded a particular risk, the

The remedy of avoidance is seen by many as over-compensating insurers for any losses suffered they not only avoid the additional element of risk arising from the non-disclosure and/or misrepresentation, but also the risks that they did know about (and which were effectively paid for).

The Reform Proposals — Remedies: Negligence vs Dishonesty

The LC generally views the remedy of avoidance as over-compensating insurers for any losses suffered: they not only avoid the additional element of risk arising from the non-disclosure and/or misrepresentation, but also the risks that they did know about (and which were effectively paid for).

As a matter of principle, it might be argued that this remedy has a penal element.

Further, where a non-disclosure or misrepresentation is merely negligent, should an insurer be afforded a compensatory remedy? This would involve asking what the insurer would have done had it been told the truth.

It was argued, in various industry meetings responding to the Issues Papers², that avoidance should be retained as the default remedy even for negligent non-disclosures and misrepresentations for the reasons that:

- ⊙ it is difficult to prove that a corporate organization acted dishonestly;
- ⊙ for “non-standard” risks, it is difficult to prove what an insurer would have done had they known the true facts; and

claim is not payable if it would have fallen within the exclusion; and

- ⊙ if the insurers would have declined the risk altogether, the policy may be avoided and the premiums are to be returned — although, where consumers (only) are involved, the LC is considering giving the courts a discretion to refuse the avoidance remedy if other insurers would have accepted the risk but with a slightly increased premium.

In addition, in the case of a negligent misrepresentation where an insurer is required to pay a claim, the LC proposes that there should be a right to cancel at that stage.

By contrast, the LC does not think that there is any case for restricting the insurer’s right to avoid the policy where a business insured is acting dishonestly when it fails to provide information or gives inaccurate information. The LC’s definition of “deliberate or reckless” conduct states that a non-disclosure or misrepresentation should be taken to be deliberate or reckless where the insured:

- ⊙ knows it to be untrue (or is reckless as to whether it is true or not); and
- ⊙ knows it would be relevant to the insurer (or is reckless as to whether it is relevant or not).

It would not be necessary to show that the insured

² Notes of the meetings can be found on www.lawcom.gov.uk.

intended to cause a loss or otherwise acted in a way that would amount to criminal behavior. The standard of proof would be on a balance of probabilities.

Breaches of warranty

The Current Law

Section 33 of the MIA provides that a warranty must be complied with in full, whether material to a risk or not.

The insurer is not required to pay any claims that arise after the date of the breach, even if the breach is later remedied and/or had nothing to do with the loss in question. It is for these reasons in particular that section 33 has consistently been criticized.

The Reform Proposals

The LC believes that the current remedy for breach of warranty has the potential to be applied arbitrarily, so as to defeat the insured's reasonable expectations of cover. It therefore concludes that the MIA is not in line with the expectations of the international marketplace and it notes that the provisions in respect of warranties have no equivalent in civil law systems (and many common law systems have already reformed them).

claim if it can prove, on the balance of probabilities, that the event or circumstance constituting the breach did not contribute to the loss. The parties could agree other consequences if they wished (subject, as above, to controls and standard-form contracts).

- ⊙ A breach of warranty would not automatically discharge the insurer from liability, but would instead give the insurer the right to terminate cover for the future. The LC queries whether an insurer that terminates future cover should in normal circumstances provide a pro-rata refund of outstanding premiums, less damages and reasonable administrative expenses.

More specifically, warranties of fact in business cases should be permitted, subject to certain safeguards: (1) the warranty must be set out in writing (although there is no need to bring it to the insured's attention) and (2) the insurer must pay the claim unless there is some causal connection between the breach and the loss.

Where there has been a breach of a warranty as to the insured's future conduct, in a business case, the default position is that the insured is entitled to recover despite a breach as long as the insured can show that the breach did not cause or contribute in any way to the loss. Any warranty must be in

**As a default rule, a business should be entitled to be paid a claim
if it can prove, on the balance of probabilities, that the event or
circumstance constituting the breach did not contribute to the loss.
The parties could agree other consequences if they wished.**

The LC believes that specific reform is required to prevent insurers from relying on technical breaches that have no connection with the claim and that the following rules should be applied generally to warranties (as narrowly defined):

- ⊙ Any warranty should be clearly set out in writing, to ensure that it is easy to distinguish it from another type of contractual term (and "basis of the contract"-type clauses are to be abolished in both consumer and business cases).
- ⊙ As a default rule, a business should be entitled to be paid a

writing (although, again, there is no need for it to be brought to the insured's attention).

The LC proposes that, where parties contract on the insurer's written standard terms of business, the insurer should not be permitted to rely on a warranty, exception or definition of the risk if this would render the cover substantially different from what the insured reasonably expected. In practice, this will depend on how the insurer presents the policy to the insured. The LC believes this would create less uncertainty than other proposed approaches.

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The Responsibility of Intermediaries for Non-disclosures/Misrepresentations

The Current Law

Section 19 of the MIA recognizes that intermediaries, such as brokers, are often used to arrange insurance cover and it provides that any misrepresentation or failure to disclose by the intermediary entitles the insurer to avoid the policy, even though the insured may be innocent of any wrongdoing.

for an insurer who then completes the proposal form for an insured (normally, “tied” brokers, offering products from a single insurer or limited number of insurers) is to be treated as remaining the insurer’s agent. (This reverses the common law rule that in such a case the agency is transferred to the insured, and applies to both business and consumer policies.)

Contracting Out of the “Default” Rules

The LC suggests that the easiest and clearest way for parties to agree different rules would be through a specific fact warranty. However, under the default regime this would not protect the insurer if the insured genuinely and reasonably did

The Law Commission has asked whether, where the broker has failed to disclose facts known to him but not to the insured, the insurer should not have the right to avoid but should instead have the right to claim damages from the broker.

The Reform Proposals

The LC finds Section 19 of the MIA a surprising provision, in particular the consequence that an agent placing insurance must disclose every material circumstance that the agent knows, even if the insured does not know it.

The future of section 19 in commercial cases is uncertain. The LC has asked whether, where the broker has failed to disclose facts known to him but not to the insured, the insurer should not have the right to avoid but should instead have the right to claim damages from the broker. The LC has also raised a number of subsidiary questions in relation to the operation of section 19: does it apply if the placement is in England, even though the policy is not governed by English law?; does it only apply to placing brokers?; is it subject to the rules of confidentiality where a broker has received information from a third party?

This is likely to be the most fruitful area for debate once all consultation papers are returned.

The LC sees no basis for transferring the agency of a broker from the insured to the insurer, but an agent already acting

not know that the warranty was untrue. Under the LC’s proposals, the warranty would have the following effect, in the absence of an agreement to the contrary:

- ⊙ Liability for the breach would remain “strict.” In other words, it did not matter whether the insured should have been aware of the conviction.
- ⊙ If the fact warranted is not true, the insurer may refuse to pay the claim, provided that:
 - ⊙ the breach was material. For example, the insurer could not refuse a claim for a minor conviction that would not have influenced its decision; and
 - ⊙ the breach had some connection to the loss.

If the parties wish to agree other consequences (such as avoidance for any material breaches), they would need to spell this out explicitly and clearly in the contract.

However, the parties should not be allowed to convert all the answers on a proposal form into warranties, as in a “basis of contract” wording. The contract would still need to specify which facts are to be given warranty status.

Controls on Standard Term Contracts

The LC recognizes that problems can arise when businesses that are not insurance experts contract on an insurer's standard terms. Even if the insured understands the provisions, it may lack the ability to alter them.

This is not likely to apply to the generality of contracts negotiated, for instance, in the Lloyd's market, where a broker usually puts forward terms on behalf of the insured. In those circumstances, it would be up to the broker to negotiate terms that best reflect its client's interests. In other situations, however, where a business buys an off-the-shelf product, on terms which the insurer has already devised, more "controls" are warranted — and the LC proposes, again, that if the insurers wish to rely upon their standard terms and conditions, they can only do so if the "reasonable expectations" of the insured are not defeated.

Practical Effects of the Proposed Reforms

Although the views of the market participants will become clearer once the consultation period is over, insurers have, for instance, already begun extensive reviews of proposal forms, to ensure that they draw out all the specific information that the insurer wants to know, and to draw up clearer underwriting guidelines. Equally, policy documents will need to be checked to ensure that the status of warranties can be clarified and protected. ©

New English Court Guidelines on the Notification of "Circumstances" Under Claims-Made Policies

by Sally Mant, in London

In a recent judgment¹, the English Commercial Court has provided valuable guidance on a number of issues relating to the notification of "circumstances" under professional indemnity policies.

¹ HLB Kidsons (A Firm) v Lloyd's Underwriters and Ors [2007] EWHC 1951 (Comm).

Whilst Mrs Justice Gloster, DBE (the "Judge") stressed that it was not possible to be too prescriptive as to the scope of an assured's responsibilities in relation to notification, which will vary from case to case, depending on the contract wording, the Judge's comments and findings (including in relation to market practice) should be studied closely by parties to all claims-made policies that provide for notification of circumstances.

Background

The assured claimant ("Kidsons"), a firm of accountants, during the relevant period owned a company, S@FI, which designed and marketed tax avoidance schemes. The claimant was insured against liability under three professional indemnity policies (covering various Lloyd's and companies markets, but all with materially identical terms), which incepted on 1 May 2001 for a period of 12 months (together, the "Policy").

The Policy was written on a claims-made basis. The Policy's Insuring Clause provided that Underwriters would indemnify

"the Assured against any claim or claims first made against the Assured during the period of insurance... in respect of any Civil Liability whatsoever or whensoever arising (including liability for Claimant's costs) incurred in connection with the conduct of any Professional Business carried on by or on behalf of the Assured [underlining added]."

General Condition 4 ("GC4") to the Policy provided that

"The Assured shall give to the Underwriters notice in writing as soon as practicable of any circumstance of which they shall become aware during the period specified in the Schedule which may give rise to a loss or claim against them. Such notice having been given any loss or claim to which that circumstance has given rise which is subsequently made after the expiration of the period specified in the Schedule shall be deemed for the purpose of this Insurance to have been made during the subsistence hereof."

Kidsons received claims from third parties after the expiry of the policy period, in respect of S@FI's tax avoidance scheme work (the "Claims"). When Underwriters refused to indemnify Kidsons on the basis of an alleged breach of the notification provisions, Kidsons commenced proceed- / *continued page 12*

Claims-Made Policy Guidelines

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ings. Kidsons argued that there had been a valid notification of circumstances during the currency of the Policy, relying for this purpose on two letters that it wrote during the policy period, dated 31 August 2001 and 28 March 2002 (the “Letters”).

The Key Issues

The Judge was required to decide upon two key issues (although those were broken down further in the course of her detailed judgment):

- whether the Letters constituted valid and effective notification of any (and, if so, what) circumstance relating to S@FI (the “Notification Issue”); and
- whether the Claims that arose in relation to S@FI fell within the scope of any such circumstance as may have been notified (the “Claims Issue”).

The Notification Issue

The Construction of GC4

Consistent with the general approach of the English courts to the construction of commercial contracts, the Judge stressed that the Policy must be construed in its proper “factual matrix.”

the period of the policy that might mature into claims against him.”

More specifically, a clause such as GC4 allows insurers to investigate potential claims at the earliest possible opportunity and to take any appropriate steps to minimize their liability under the relevant policy. Insurers required commercial certainty and “finality” in terms of their exposure. Proper notification under claims-made policies enables them to calculate reserves with more certainty (and to calculate premiums for following years of cover with more precision).

Equally, a clause such as GC4 benefits assureds by enabling them to obtain an extension of cover in respect of claims made after the expiry of the policy (and otherwise falling outside the scope of its insuring clause that arise out of circumstances of which the assured became aware during the policy period. In the case of the Policy, Kidsons were obliged under GC4 to give notice of any circumstances “in writing” and “as soon as practicable.”

The Judge recognized, therefore, that (contrary to the import of Kidsons’ argument) it was not in the interests of either party to an insurance contract for notification of circumstances to be delayed until the end of the policy period, or even beyond, for perhaps an indeterminate period of time.

The Judge considered and rejected elaborate arguments raised on behalf of Kidsons that other terms incorporated in the Policy allowed Kidsons to circumvent this notification regime.

The Judge recognized that insurers require commercial certainty and finality in terms of their exposure. Proper notification under claims-made policies enables them to calculate reserves with more certainty (and to calculate premiums for following years of cover with more precision).

In this regard, she focused in particular upon the practice in the London market of writing professional indemnity insurance on a “claims-made” basis, as opposed to an “occurrence-occurring” basis. Such claims-made cover above all allows insurers “to know by the end of the claims made period, or very soon thereafter, what claims have been made against the assured during the policy period and what circumstances have become first known to the assured during

What Was Valid and Effective Notice Under GC4?

The Judge found that, even though a document might not be intended by Kidsons to constitute notice of circumstances under GC4, this did not preclude it in principle from qualifying as a valid notification. Previous authorities made it clear that an objective approach is required. The subjective intentions and understandings of the party providing notice are only relevant to the extent that its state of mind at the time

of giving notice would help determine the extent to which it was “aware” of — and therefore capable (objectively) of notifying — circumstances that might give rise to a loss or claim under the terms of GC4.

Further, the relevant circumstance should be one which, objectively evaluated, creates a reasonable and appreciable possibility that it will give rise to a loss or claim against the assured. There need not be a certainty that it will do so; all that need exist is a state of affairs from which the prospects of the claim or loss emerging in the future are “real” as opposed to false, fanciful or imaginary.

the wording of GC4 created in effect a condition precedent, so that, if the assured did not notify circumstances as soon as reasonably practicable it was not possible for the assured to submit a notification at some later point; and

GC4 required notice to be given to each underwriter, or its duly authorized agent, in view of the “composite” nature of the Policy (subject always to any agreement to the contrary).

Amongst other findings, the Judge considered that the loss or claim should be sufficiently causally-related to the fact, event, happening or condition which comprises the notified circumstance, that it can be fairly said to have arisen out of it.

Consistent with this, the Judge held that:

the written communication should be sufficiently clear and unambiguous that it would leave a “reasonable” recipient in no reasonable doubt that the assured was thereby purporting to give notice of a circumstance (under GC4) for the purposes of triggering coverage under the Policy. The function of the notice was to make a statement on which the insurer could then act;

the notice must not be premature: if, at the time the assured purports to give notice in writing (or at any relevant time subsequently), it is not aware of the relevant circumstance, then the notice would be ineffective;

the loss or claim should be sufficiently causally-related to the fact, event, happening or condition which comprises the notified circumstance, that it can be fairly said to have arisen out of it;

Did the Letters Satisfy the Requirements of GC4?

Again, the test to be applied was whether a reasonable person in the position of the actual parties would have understood the two letters to be notifications of circumstances under GC4.

The First Letter

The Judge noted that the first, 31 August 2001 letter relied upon by Kidsons in support of its case was addressed to a placing broker at Miller Services Limited, rather than the claims broker who would ordinarily receive notices.

In addition, the Judge considered the letter, couched as it was in very broad, vague terms, to be “coy in the extreme” about the specific allegations that had already been made regarding the tax avoidance schemes. It referred to possible criticisms from the Inland Revenue, in respect of some of the procedures Kidsons had followed in relation to certain schemes. It also stated that Kidsons were fully investigating the matter and would submit a report to Underwriters shortly. In the meantime, “[t]he Board has taken the view that this might be regarded as material information for insurers. There is no sign of a claim arising at the present time, but the Board feels that it is appropriate in the circumstances to advise what is happening and to take your instructions.” / *continued page 14*

Claims-Made Policy Guidelines

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The Judge analyzed Kidsons' objective as being to mention, almost in passing, the merest possibility of a third party claim — without expressly notifying a circumstance until and unless it was established that it was necessary, following receipt of its report. The letter did not specifically refer to any "circumstances" (contrary to notifications made on Kidsons' behalf in previous years); instead it merely referred to "material information for insurers."

The letter also failed to identify any error, act or omission, or potentially negligent or otherwise wrongful conduct on the part of Kidsons; it did not identify any specific victim or possible claimant.

The Judge therefore found the letter far too vague and nebulous to be construed as a valid notification under GC4. She took comfort from the evidence that, when the 31 August 2001 letter was presented to Underwriters, they did not treat it as notification of a circumstance; it was "noted" by the Lloyd's lead underwriter "for information only" and on a "WP"

The Second Letter

The second, 28 March 2002 letter reported that "in some instances there might be procedural difficulties involving the Trustees for each scheme affecting the implementation of the scheme and this might lead to the possibility of criticism in the future." The letter also stated that a QC had raised "observations" in relation to two transactions involving "Discounted Option Schemes."

After further detailed analysis, the Judge concluded that this letter, together with the bordereau documentation enclosed with it, in principle amounted to a notification of circumstances — at least to the Lloyd's lead and the second lead underwriter² — for the purposes of GC4. Although the information provided "was still exiguous, the reasonable recipient would at this stage ... have appreciated that, in the light of the adverse observations of [the QC], Kidsons was indeed notifying the possibility of claims arising from procedural defects ("difficulties") involving the Trustees in relation to the implementation of two Discounted Option [S]chemes, or two transactions in relation to such Schemes."

The Judge therefore found the first notice relied upon to be far too vague and nebulous to be construed as a valid notification under the Policy. When it was presented to Underwriters, they did not treat it as notification of a circumstance; it was noted by the Lloyd's lead underwriter for information only and on a WP basis.

basis (and was not treated any differently by the second lead underwriter and the following market). Even when the 31 August 2001 letter was re-presented in October 2001 along with bordereau material that referred to "NATURE OF CLAIM: Possible tax errors in fiscal engineering work" that was not enough to extend the scope or extent of what had been communicated in the underlying letter: "a bordereau file, if used, may be part of the notification process, but it cannot have any greater effect than the information contained in the underlying claims files, which constitute the primary notification material."

Significantly, the Judge also concluded, however, that the notification was limited to that extent and rejected Kidsons' argument that the scope of the notification could be extended to all the tax avoidance products it marketed: "I

² Which the Judge found had waived any right to review claims files routinely. Presentations to the company market were found to have been given "as soon as practicable" (from a "start date" of 27 March 2002). By contrast, since the Second Letter was not presented to the following Lloyd's market until 24 July 2002 - after the policy period had expired - notification to those underwriters was not given as soon as practicable and was therefore in breach of GC4.

reject the wider contentions ... that the documents presented amounted to notification of any more extensive concerns in relation to the whole range of tax avoidance products marketed by S@FI and which were said to be (but which were in fact not) the subject of the [independent] investigation.”

the parties was not sufficient for her to analyze whether in this instance there was sufficient causal relation between the notified circumstance and the actual Claims. That issue was reserved for further directions from the Court.

The Judge also confirmed that, under a composite, claims-made policy such as the one in issue, taken out by a partnership for all of the partners, the partnership and all of its partners were aware of notifiable circumstances if the partnership’s controlling organ (or any other entity charged with authority and responsibility for handling the firm’s professional indemnity insurance) was so aware.

The Claims

The Claims made against Kidsons covered a variety of tax schemes and alleged almost exclusively that Kidsons was negligent in (i) advising its clients in relation to the schemes, (ii) making false representations about the schemes and (iii) failing to give its clients adequate warning of the risks, if not the likelihood, of the schemes being challenged and rejected by the Inland Revenue because of their inherent defects. The Claims allegedly arose as a result of Kidsons’ poor advice and because the schemes were fundamentally flawed in their design and concept — therefore ineffective to avoid tax. The clients who entered into the tax avoidance schemes said that they would never have done so, had they been competently advised by Kidsons.

The Judge confirmed that, “in order for a claim to come within the scope of a circumstance notified under GC4, the claim must be one “to which th[e notified] circumstance has given rise.” This requires that the loss or claim should be sufficiently causally related to the fact, event, happening or condition which comprises the notified circumstance, such that it can be fairly said to have arisen out of it [underlining added].”

Whilst the Judge had concluded that the notification of circumstances was confined to procedural difficulties affecting the implementation of the two DOS schemes, the information available to her relating to sample Claims identified by

Notification of Circumstances by a Partnership

The Judge also confirmed that, under a composite, claims-made policy such as that purchased by Kidsons, taken out by a partnership for all of the partners, the partnership and all of its partners were “aware” of notifiable circumstances (as per GC4) if the partnership’s “controlling organ” (or any other entity charged with authority and responsibility for handling the firm’s professional indemnity insurance) was so aware.

Therefore, even if certain partners were not aware of notifiable circumstances, that could not serve to postpone (indefinitely) the obligation to notify. ☺

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