The law relating to insurance is a mixture of common law and statute.

The general law of contract is relevant, but with special considerations arising in relation to insurance contracts.

The provision of insurance is a financial service regulated by the financial services legislation.

European Union law is of central relevance, and directly or indirectly influences new legislation on insurance matters.

Much of the history of insurance law relates to shipping, and to this day the development of shipping law and of the law of insurance are closely related.

**Nature of insurance**

In English Law the most cited definition of insurance is derived from the judgment of Channell J. in *Prudential Insurance Company v Inland Revenue Commissioners* [1904] 2 K.B. 658 at 663-664. A contract of insurance is one whereby one party (the insurer) promises, in return for a consideration (the premium), to pay to the other party (the insured) a sum of money or provide him with someone corresponding benefit, upon the occurrence of one or more specific events. There must be either uncertainty whether the event will happen or not, or, if the event is one which must happen at some time, there must be uncertainty as to the time at which it will happen. Generally it is a necessary part of making a recovery under a contract of insurance to prove that what caused the loss was a fortuity.

**Contract of Indemnity**

Insurance contracts may be divided into non-indemnity insurance and indemnity insurance. Non-indemnity insurance includes life and personal accident insurance where on the occurrence of an insured event the insured will be entitled to recover the amount set out in the policy. In indemnity insurance the insured is entitled to recover only the amount which he has lost and no more. The indemnity principle underlies the whole of this area of the law of insurance. Brett L.J. in *Castellain v Preston* (1883) 11 Q.B.D. 380 at 386 said:
“The very foundation, in my opinion, of every rule which has been applied to insurance law is this, namely, that the contract of insurance contained in a marine or fire policy is a contract of indemnity, and of indemnity only, and that this contract means that the assured, in case of a loss against which the policy has been made, shall be fully indemnified, but shall never be more than fully indemnified. That is the fundamental principle of insurance, and if ever a proposition is brought which is at variance with it, that is to say, which either will prevent the assured from obtaining a full indemnity, or which will give to the assured more than a full indemnity, that a proposition must certainly be wrong.”

The insured’s loss is limited by the sum insured but is not calculated by reference to that sum. The fact that an article is insured for a particular sum will only entitle the insured to that sum if he produces proof that the article was actually worth that sum unless, as is common in marine insurance, it is a valued policy entitling a claimant to recover the agreed value of the damaged property, see e.g. Quorum A/S v Schramm (Damage) [2002] 1 Lloyd’s Rep. 249 at 259 and following; see also Maurice v Goldsborough, Mort & Co Ltd [1939] A.C. 452 at 466-467; and Thor Navigation Inc v Ingosstrakh Insurance Company Ltd [2005] EWHC 19 (Comm), per Gloster J. at para.25. The pleader therefore needs to include in his particulars the value of the article or building lost or destroyed and not merely the sum insured. If there has been a recovery from a third party that sum needs to be brought into account (and pleaded) to reduce the sum claimed from the insurer, otherwise the indemnity will be breached.

Subrogation

It is convenient to deal with the subrogation immediately after the indemnity principle because the two are closely connected. The insured is not entitled to recover under his contract of insurance and also to recover his loss from a third party. Thus, as has been said above, if he has recovered part of his loss from that third party he must bring that sum into account to reduce his loss. Once the insurer has indemnified the insured that insurer can then stand in the shoes of the insured and exercise the rights, and obtain the remedies which would otherwise have been available to the insured: H Cousins & Co Ltd v D&C Carriers Ltd [1971] 2 Q.B. 230; and Castellain v Preston (1883) 11 Q.B.D. 380 at 388. Any subrogated claim brought by an insurer to recover from a third party the loss suffered as a result of indemnifying the insured must be brought by the insurer in the name of the insured: Mason v Sainsbury (1782) 3 Doug., K.B. 61 at 63. The fact that it is in reality a claim brought by the insurer should not appear on the face of the statement of case. Should an insurer, having paid out a claim,
thereafter discover that the insured has made a recovery from a third party or has, for example, recovered the goods, that insurer may bring an action in its own name against the insured at common law for monies had and received to recover the money paid out, to the extent that there has been recovery in excess of the indemnity principle: *Yorkshire Insurance Co Ltd v Nisbet Shipping Co Ltd* [1961] 2 W.L.R. 1043, per Diplock J. at 1049. Where subrogation is dealt with in the contract of insurance, an insurer seeking to assert its rights under that clause should specifically plead the old cases were revisited see *Caledonia North Sea Ltd v British Telecommunications Plc* [2002] Lloyd’s Rep. I.R. 261, particularly paras 11-16.

*Insurable Interest*

The insured must have an insurable interest in the event insured against. Insurance needs to be distinguished from a mere wagering contract where the risk is merely loss of the wager. Such contracts are void: s.18 of the Gaming Act 1845. The insured must plead the nature of the insurable interest held.

*Utmost good faith*

Contracts of insurance are contracts of the utmost good faith. This gives rise to a legal obligation upon the insured, prior to the contract being made, to disclose to the insurer all material facts and circumstances known to the insured which affect the risk being run Lord Mansfield’s words in *Carter v Boehm* (1766) Burr. 1905 have stood the test of time:

“Insurance is a contract of speculation. The special facts upon which the contingent chance is to be computed lie most commonly in the knowledge of the assured only; the underwriter trusts to his representation and proceeds upon confidence that he does not keep back any circumstances in his knowledge to mislead the underwriter into a belief that the circumstances does not exist and to induce him to estimate the *risqué* as if it did not exist. The keeping back such circumstances is a fraud, and therefore the policy is void. Although the suppression should happen through mistake, without any fraudulent intention, yet still the underwriter is deceived and the policy is void; because the *risqué* run is really different from the risk understood and intended to be run at the time of the agreement … The policy would be equally void against the underwriter if he concealed … The governing principle is applicable to all contracts and dealings. Good faith forbids either party, by concealing what he privately
knows to draw the other into a bargain from his ignorance of the fact and his believing the contrary ...”

The obligation of good faith is mutual and owed by the insurer as well as the insured and if it not observed by either party, the contract may be avoided by the other party: *Carter v Boehm* (above) and *Banque Kayser Saturday v Skandia (UK) Insurance Company Ltd* [1990] I.Q.B. 665 at 770F-G (affirmed [1991] 2 A.C. 249, reversed on another ground). The legal basis of the obligation is not obvious and is perhaps best explained as “an incident of the contract of insurance” per Hobhouse J. in *The Good Luck* [1988] 1 Lloyd’s Rep. 514 at 546 (affirmed [1989] 2 Lloyd’s Rep. 238, per May L.J. at 264 reversed on other grounds 1992 1 A.C. 233). It is settled law that the principles (given statutory form in the Marine Insurance Act 1906 ss.17-20) are equally applicable to marine and non-marine insurance, as they are to reinsurance: *Pan Atlantic Insurance Co v Pine Top Insurance Co* [1995] A.C. 501 at 518D-E and 554D-G and *Highlands Insurance Co v Continental Insurance Co* [1987] 1 Lloyd’s Rep. 109 at 113-114.

The defences of non-disclosure and misrepresentation are frequently run together. In a non-disclosure defence the burden is on the insurer to prove:

(i) that a *material circumstance*, which was *known to our ought in the ordinary course of his business to have been known to the insured* and which was *not known to and not deemed to be known to the insurer*, was *not disclosed*; and/or

(ii) that a person acting as an *agent to insure* failed to disclose a *material circumstance* which was *known to that agent or which ought in the ordinary course of business to have been known by him or ought to have been communicated to him* but which was *not known and not deemed to be known* to the insurer: and

(iii) that the insurer was *induced* by the non-disclosure to write the risk on the relevant terms.

(See the Marine Insurance Act 1906 ss.18, 19,) Each of the parts in italics should be specifically pleaded in the insurer’s statement of case.

The test for materiality is set out in the Marine Insurance Act 1906 s.18(2):
“Every circumstance is material which would influence the judgment of a prudent insurer in fixing the premium or determining whether he will take the risk.”

Under the common law rule, the materiality of information is a question of fact, determined at the time that disclosure is due, by reference to the judgment of the prudent insurer. For the purpose of materiality is not necessary for the insurer to prove that he would not have written the risk or would have charged a higher premium. It is sufficient if the fact or circumstance not disclosed would have had an effect on the thought processes of the insurer in weighing up the risk: per Lord Mustill in *Pan Atlantic Insurance Co v Pine Top Insurance Co* [1995] A.C. 501 at 531.

It is also necessary for the individual insurer to prove that he was induced, as a matter of fact, by the non-disclosure, i.e. that, but for the non-disclosure, he would not have entered the particular contract, at all or on the same terms: *Decorum Investments Ltd v Atkin (The Elena G)* [2001] 2 Lloyd’s Rep. 378, per David Steel J. at 382.

In his response to the insurer’s statement of case alleging that the policy has been avoided on the grounds of non-disclosure, the insured, apart from challenging the various matters pleaded against him, may have available to him an answer by way of waiver at placing. Waiver may arise from the questions posed in a proposal form. If an insurer seeks certain limited information he may be deemed to have waived further or wider disclosure: *Schoolman v Hall* [1951] 1 Lloyd’s Rep. 139 per Asquith L.J. at 143. Thus a motor insurer who seeks three years’ claims history cannot complain if various claims made four years earlier are not disclosed, even though they might otherwise have been material to the risk.

The insurer’s remedy for non-disclosure and/or misrepresentation is a right to avoid the policy. In the absence of fraud on the part of the insured, the insured is entitled to return of the premium on avoidance: *Marine Insurance Act 1906 s.84(1); Tyrie v Fletcher* (1777) 2 Cowp. 666 at 668, per Lord Mansfield and *Anderson v Thornton* (1853) 8 Ex. 425 per Parke B. at 428-429. There is no right to damages for breach of duty of good faith but only a right to avoid the policy: *Banque Keyser SA v Skandia (UK) Insurance Company Ltd* [1990] Q.B. 665, CA at 774-781.

If an insurer with full knowledge of a material non-disclosure or misrepresentation on the part of an insured does an unequivocal act affirming the contract of insurance or waiving the non-disclosure or misrepresentation, for example, by paying a claim, he will not thereafter be able to rely on the non-
disclosure: see Container Transport International v Oceanus Mutual Underwriting Association (Bermuda) Ltd (No. 1) [1984] 1 Lloyd’s Rep. 46, per Kerr L.J. at 498 and Stephenson L.J. at 529 and The Kanchenjunga [1990] 1 Lloyd’s Rep. 391, per Lord Goff at 398-399. On the distinction between waiver by election and waiver by estoppel, see now Kosmar Villa Holidays Plc v Trustees of Syndicate 1243 [2008] EWCA Civ 147; [2008] 2 All E.R. (Comm) 14 (paras 36-38). In Lexington Insurance Co v Multinacional de Seguros Saturday [2009] 1 All E.R. (Comm) 35 (paras 61-68) it was held that no waiver by election had occurred where the reinsurers were not presented with a choice between two mutually inconsistent rights.

INSURANCE CONTRACTS: GOOD FAITH

A contract of insurance is a contract of utmost good faith, in Latin: uberrimae fidei. This requires the contract to be made and performed openly, fairly and honestly. The principle of good faith requires the prospective assured to disclose all material circumstances, and refrain from misrepresenting any material information, to the prospective insurer before the contract of insurance is concluded.

The duty of good faith is reciprocal; however, a breach by the insurer is rarely, if ever, relied upon by the assured.

The requirements of the duty of good faith, and the remedies for breach of the duty, differ according to whether the Marine Insurance Act 1906 ("MIA") or the Insurance Act 2015 ("IA15") applies to the insurance policy. The MIA applies to commercial contracts entered into before 12 August 2016; IA15 applies to commercial contracts agreed on or after 12 August 2016 and also to variations of contracts agreed prior to that date. The two regimes are discussed below.

There is a separate regime for consumer insurance, which is subject to the Consumer Insurance (Disclosure and Representations) Act 2012. Amongst other things, this provides the insurer with a range of remedies for breach of duty, which are proportionate to the nature and severity of the breach. Further examination of the position in relation to consumer insurance contracts is, however, beyond the scope of this article.

Whenever policyholders supply information to enable insurers to make a decision about cover, they must observe a legal duty of good faith, a duty which continues throughout the insurance period at a level appropriate to the decision in question. The duty ends as regards a particular claim when the claim has been paid, or rejected; in the event of rejection the policyholder must accept the rejection
or commence proceedings (The Star Sea [2003] 1 AC 469). Evidently a fraudulent claim is not one made in good faith.

Circumstances which an insurer may be expected to know can include details normally associated with the type of risk proposed, items of public knowledge and matters of law and the general course of losses affecting the market in which he operates. In Sea Glory Maritime Co v Al Sagr National Insurance Co (The Nancy) [2013] EWHC 2116 (Comm); [2013] 2 All E.R. (Comm) 913 the Commercial Court considered whether information accessible on an online database could be regarded as matters of common notoriety or knowledge, and matters which an insurer in the ordinary course of his business, as such, ought to know. Mr Justice Blair concluded (obiter) that the availability of online information did not necessarily give rise to a presumption of knowledge on the part of an insurer. The key question was whether there had been a fair presentation of the risk in all the circumstances. The circumstances may include the availability of online information - namely databases - but whether the insurer should be treated as having knowledge of online information must be judged on the particular facts.

An insurer is not generally required to make its own investigations but is entitled to rely upon information about a risk as presented. Accordingly, unless there is an express waiver of relevant facts, an insurer is likely to be found to have waived the requirement for any material circumstances to be disclosed only if it has been presented with material which is capable of "putting it on notice" that there are further material facts which it chose not to enquire about, or if it made limited requests for information (for example in a proposal form) which implicitly excludes disclosure of additional facts otherwise material. The assured bears the burden of proving waiver.

The principle of good faith requires the prospective assured not only to disclose all material facts, but also not to misrepresent material information. The assured must ensure that every material representation made to the insurer is true. This aspect of the duty of good faith is codified in s.20 of the MIA:

"20. Representations pending negotiation of contract
(1) Every material representation made by the assured or his agent to the insurer during the negotiations for the contract, and before the contract is concluded, must be true. If it be untrue the insurer may avoid the contract
(2) A representation is material which would influence the judgment of a prudent insurer in fixing the premium, or determining whether he will take the risk.
(3) A representation may be either a representation as to a matter of fact, or as to a
matter of expectation or belief.

(4) A representation as to a matter of fact is true, if it be substantially correct, that is to say, if the difference between what is represented and what is actually correct would not be considered material by a prudent insurer.

(5) A representation as to a matter of expectation or belief is true if it be made in good faith.

(6) A representation may be withdrawn or corrected before the contract is concluded.

(7) Whether a particular representation be material or not is, in each case, a question of fact."

If, in breach of the duty of good faith, the prospective assured (or its broker) misrepresents a material fact the insurer can avoid the contract of insurance from inception. The assured is only required to ensure that statements of fact are true. If the assured innocently misrepresents a statement of opinion or intention, so long as the statement is made in good faith, the remedy of avoidance is not available. If, however, it can be shown that the prospective assured expressing the opinion did not hold it, or did not have the will or the ability to carry out a stated intention at the time it was made, such statements of opinion or intention may be regarded as misrepresentations of fact in respect of which the insurer can avoid the contract of insurance.

Materiality: the duty of utmost good faith set out in the MIA requires a prospective assured to disclose all material circumstances to the insurer and not to misrepresent material information. The test for materiality was considered in detail by the House of Lords in Pan Atlantic Insurance Co Ltd v Pine Top Insurance Co Ltd [1995] 1 A.C. 501. In that case, the House of Lords set out a two-limb test for materiality: (i) would a prudent underwriter have been influenced by the information; and (ii) was the actual underwriter influenced by the assured's failure to disclose the information in question?

In respect of the first limb of this test, the question to ask is whether the information would have had an effect on a prudent underwriter's thought processes. It matters not whether the information would have had a decisive influence on a prudent underwriter. This is an objective test which usually requires evidence from an independent expert underwriter. The second limb of the test is subjective: the actual underwriter must show that he was induced to enter into the contract of insurance at all, or on the terms which he did, as a result of the withheld or misrepresented information. For example, he may show that, if he had the material information,
he would have refused cover or increased the premium or amended the terms. Although there is no mention of this requirement in the MIA itself, the House of Lords held that it should be implied in order to bring insurance law into line with general contract law.

The test for materiality does not require any connection between the information withheld and any subsequent loss, and nor does it take into account the views of the assured or those of a theoretical prudent assured.

Breach of Duty: The insurer's remedy for a business assured's breach of the duty of good faith (i.e. non-disclosure or misrepresentation of a material fact) is avoidance ab initio of the contract of insurance.

Avoidance is a draconian remedy as it works retrospectively to free the insurer of any liability under the contract of insurance from inception. Accordingly, if a contract is avoided the assured must return any claim monies already paid and the insurer is usually required to return any premium collected (unless the breach is fraudulent in which case the insurer can keep the premium). The remedy of avoidance is available regardless of whether the breach was innocent, negligent or intended and regardless of whether it has in fact led to any loss to the insurer.

It should also be noted that if the policy is composite in that there are two or more assureds with different interests, the position of each assured is to be considered separately. Similarly, it is generally accepted that, since in a subscription market each insurer subscribing to a risk enters into a separate contract of insurance with the assured, a misrepresentation or non-disclosure to one insurer may not be relied upon by any other insurer to whom a fair presentation of the risk was made: Bank Leumi le Israel BM v British National Insurance Co Ltd [1988] 1 Lloyd's Rep. 71. It has been held, however, that a misrepresentation made to a leading underwriter at Lloyd's but not repeated to the following market, nevertheless entitled the entire Lloyd's market to avoid the contract in issue on the basis of the non-disclosure of the fact that a misrepresentation had been made to the leader: Aneco Reinsurance Underwriting Ltd (In Liquidation) v Johnson & Higgins Ltd [1998] 1 Lloyd's Rep. 565. This decision was reached on the basis of expert evidence given to the effect that the Lloyd's underwriters further down the slip would have relied on the leader's acceptance, terms and rating of the risk as having been procured through a proper presentation when they agreed to subscribe to the contract themselves. The judge in this case
stated that his findings were based only on the evidence in this case and were not intended to lay down any general rule and as such each claim will need to be assessed on its own facts.

Waiver: The insurer can lose its right to avoid the contract of insurance by waiver in the form of either affirmation (election) or estoppel. An insurer will be held to have affirmed the contract of insurance where he unequivocally elects not to exercise his right of avoidance. Such election must be with full knowledge of such right (i.e. he needs to know of the non-disclosure or misrepresentation and his right of avoidance). The insurer will waive his right to avoid by estoppel when the assured relies, to its detriment, on an unequivocal representation (either expressly or impliedly) by the insurer that the insurer will not exercise its right to avoid.

Damages are not normally recoverable for breach of the duty of good faith. If the assured or broker makes a fraudulent or negligent false statement, however, the insurer will have the right to claim damages under the Misrepresentation Act 1967 for any loss they have suffered if they choose not to avoid the policy or have contracted out of their right to do so.

MISREPRESENTATION

An insurer is entitled to avoid a contract of insurance for misrepresentation by the insured (Marine Insurance Act 1906. S.20(1); Graham v Western Australian Instructions. (1931) 4 Lloyd’s Rep 64 at 66, per Roche J.). The misrepresentation can be made fraudulently, negligently or innocently. Before an insurer can succeed in a defence of misrepresentation he must prove that the insured made a statement concerning a fact relating to the past or present which was untrue. It is not sufficient that the insured made an untrue statement or promise about the future or gave an opinion which turned out to be wrong: Pawson v Watson (1778) 2 Cowp. 787, per Lord Mansfield at 788. A statement as to the future in which the insured has no belief may be a fraudulent misrepresentation: The Dora [1989] 1 Lloyd’s Rep. 69 at 90, per Phillips J. For a recent application of this principle, see Limit No.2 Ltd v Axa Versicherung AG (formerly Albingia Versicherung AG [2008] Lloyd’s Rep. I.R. 396, CA. Normally a statement of opinion is coupled with the implication that the opinion is genuinely held. However, there may not be any implied representation that the insured had reasonable grounds for his belief: see the differing judgments in Economides v Commercial Union Assurance Co Plc [1998] Q.B. 587 at 598-599 (Simon Brown L.J.), 606 (Peter Gibson L.J.) and 608-609 (Sir Iain Glidewell); see also s.20(5) of the Marine Insurance Act 1906.
Except in a case of fraudulent misrepresentation, the misrepresentation must also be proved by the insurer to be material to the risk (as to materiality see above, in relation to non-disclosure). The misrepresentation must have been relied upon by the insurer such that he was induced to write the risk. As to inducement, it is sufficient if it was “actively present” in the mind of the insurer when he wrote the risk: see Edgington v Fitzmaurice (1885) 29 Ch.D. 459 at 483, per Bowen L.J. The misrepresentation has to be an effective cause of the particular insurer entering into the contract but it does not need to be the sole cause: Assicurazioni Spa v ARIG (see above) para.59. As in the case of non-disclosure, the test here will be a higher one than for judging materiality and the insurer will have to prove on the balance of probabilities that he would not have written the risk, or at least not written it on the same terms. If it were otherwise the necessary reliance would be missing and it could not be said that the insurer had been induced to write the risk by the misrepresentation.

**BREACH OF WARRANTY**

In a contract of insurance a “warranty” is a (usually express) term of the contract by which an insured “warrants” that certain facts are true or are true and will remain so, or that he will perform some particular obligation. The scope of a warranty, like that of any other term of the contract of insurance, is determined by construing the warranty and, in so doing, the court is allowed to consider the purpose of the warranty. The warranty must be strictly adhered to. If the warranty is broken it terminates the contract from the date of breach: see The Good Luck [1992] 1 A.C. 233, per Lord Goff at 262. There is no requirement that the breach of warranty should be material to the loss claimed. An insurer may, either expressly or impliedly by conduct, render himself estopped from relying upon it: see s.34(3) of the Marine Insurance Act 1906. For a detailed discussion of the operation of estoppel in such cases, see HIH Casualty & General Insurance Ltd v AXA Corporate Solutions [2003] Lloyd’s Rep. I.R. 1. This payment of a claim or the acceptance of premium with full knowledge of the breach will often found such an estoppel: Jones v Bangor Mutual (1889) 61 L.T. 727, per Mathew J. at 729. An insurer was estopped from alleging the breach of a “hold harmless” warranty as a defence to a claim, having failed to raise that defence seven years previously at the time when the insurer first rejected the insured’s claim: Argo Systems FZE v Liberty Insurance (PTE) [2011] EWHC 301 (Comm), per Judge Mackie QC at paras 24-35.

The insurer must set out all the facts upon wheelchair he relies to establish the breach. The burden is on the insurer to prove a breach of warranty: Barrett v Jeremy (1849) 3 Ex. 535 per Parke B. at 542.
CONDITIONS PRECEDENT TO LIABILITY

Notification of loss or circumstances. Whether a failure to provide timely notification of a loss, or of circumstances which may give rise to a loss, results in an insured being unable to recover in respect of that loss depends on the construction of the insurance contract. If it is a true condition precedent to liability, a breach of the notification clause will provide the insurer with a complete defence to the claim, even where no prejudice is caused thereby: Pioneer Concrete (UK) Ltd v National Employers Mutual General Instructions. Assn Ltd [1985] 2 All E.R. 395 at 400 (approved by the Privy Council in Motor and General Ins. Co Ltd v Pavey [1994] 1 Lloyd’s Rep. 607). The same principle applies to claims co-operation causes and the implied obligation to provide information to insurers within a reasonable time: Shinedean Ltd v Alldown Demolition London Ltd [2006] Lloyd’s Rep I.R. 846. As to when a clause is to be construed as a condition precedent see George Hunt Cranes Ltd v Scottish Boiler and General Insurance Company Ltd [2002] Lloyd’s Rep. I.R. 178 CA. If the notification clause is not a condition precedent, it is unlikely to be construed as a condition subsequent allowing the insurer to treat the contract as a whole as repudiated: the only remedy available to the insurer for breach of the term is likely to be damages: Friends Provident Life and Pensions Ltd v Sirius International Ltd [2006] Lloyd’s Rep. I.R. 45.

For a case which considers the various types of conditions and warranties and their effect in a policy of insurance see K/S Merc-Scandia at please provide.811-812. The notification to the insurer should be pleaded.

What amounts to a circumstances which may (or sometimes “is likely to”) give rise to a claim will depend on the facts. In considering the interpretation of these clauses under claims made policies, the courts will often have regard to the difficulty of obtaining cover from new insurers where circumstances exist which may give rise to a claim. This makes notification to existing insurers more easy to justify: see J. Rothschild Assurance v Collyear [1999] 1 Lloyd’s Rep. I.R. 6 at 22, per Rix J. In HLB Kidson (a firm) v Certain Lloyd’s Underwriters [2009] 2 All E.R. (Comm) 81 a clause requiring notice to be given “as soon as practicable” was construed as a condition precedent. Whether or not the purported notification was effective depended upon what is reasonably conveyed to its recipient. In the same case, the Court of Appeal determined that the question of whether a relevant circumstance might give rise to a claim or loss against the assured, and therefore require notification by the assured to the insurer, was to be ascertained objectively: see the views expressed on this question by Rix L.J. (at paras 72-76) and Toulson L.J. (at paras 137-141). The objective test was approved by the Court of
Appeal in *Laker Vent Engineering Ltd v Templeton Insurance Ltd* [2009] 2 All E.R. (Comm) 755 at 774 (para.82).

The courts have applied the general rules of waiver and estoppel to the breach of procedural conditions in insurance contracts: see, e.g. *Ayrey v British Legal & United Provident Assurance Co Ltd* [1918] 1 K.B. 136, per Atkin L.J. at 142.

**RIGHT OF ACTION LIMITATION**

Once an insured has suffered a loss as the result of an insured event a cause of action arises against an insurer: see, for example, *Sprung v Royal Insurance Co (UK) Ltd* [1991] even before any notice has been given to the insurer and before any obligations to supply particulars, or proof, of loss have been complied with. In indemnity insurance the action against the insurer will be for unliquidated damages and not debt (see, for example, *Forney v Dominion Insurance Company Ltd* [1969] 1 Lloyd’s Rep. 502 at 509). While the CPR commencing proceedings, the cause of action arises from the moment of loss.

In liability insurance the cause of action generally arises once the liability has been established either by judgment, award or agreement: *Post Office v Norwich Union Fire Ins.* [1967] 2 Q.B. 363 at 373; *Bradley v Eagle Star* [1989] A.C. 957 at 966. In practice if there is a dispute on coverage which it is appropriate to have dealt with immediately following the determination of liability in the main proceedings: *Brice v Wackerbarth* [1974] 2 Lloyd’s Rep. 274.

Actions based on a contract may not be brought more than six years after the date on which the cause of action accrued (Limitation Act 1980 s.5). In the absence of fraud or concealment this period will not be extended.

**DAMAGES FOR LATE PAYMENT**

There is no right to obtain damages for late payment by an insurer even where the insured has suffered loss and the insurer has behaved unreasonably. This has been restated recently by the Court of Appeal in *Sprung v Royal Insurance* [1999] 1 Lloyd’s Rep. I.R. 111, following the House of Lords’ decisions in *President of India v Local Authority Pintada Compania Navigacion SA* [1985] A.C. 104 and *President of India v Lips* [1987] 3 W.L.R. 572 and the judgment of Hirst J. in *The Italia Express No 2* [1992] 2 Lloyd’s Rep. 281.
MARINE INSURANCE

A contract of marine insurance is one “whereby the insurer undertakes to indemnify the assured in a manner and to the extent thereby agreed, against marine losses, that is to say, the losses incident to marine adventure” (Marine Insurance Act 1906 s.l.).

The law of marine insurance is codified in the Marine Insurance Act (MIA 1906). A contract of marine insurance is inadmissible in evidence unless it is embodied in a marine policy in accordance with the MIA 1906 s.22, although the policy may be issued and executed at the time the contract is concluded or afterwards. A marine policy must specify:

(a) the name of the assured or of some person who effects the insurance on his behalf (the MIA 1906 s.23);

(b) the subject-matter insured with reasonable certainty (the MIA 1906 s.26; Hewitt v. Wilson [1915] 2 K.B. 739, CA).

The sum(s) insured and the name(s) of the insurers, who generally subscribe at the foot of the policy their names and the percentages for which they agree to be respectively liable, are also usually specified.

Risk insured

The risk underwritten must be clearly defined in the policy. Thus in a voyage policy the destination must be stated (Royal Exchange Assurance Corporation v Sjoforsakring Akt Vega [1902] 2 K.B. 382 per Collins M.R. at 392-393), and in a time policy the duration of the risk (Kynance Sailing Ship Company v Young (1911) 27 T.L.R. 306). In the latter, the time period is sufficiently stated if the policy specifies a period, even if that period may be determined on notice or automatically renewed or extended in the absence of such determination (Compania Maritima San Basilio Saturday v Oceanus Mutual Underwriting Association (Bermuda) Ltd (The “Eurysthenes”) [1977] Q.B. 49).

Open cover. It is an implied term of a policy written on open cover against charterer’s liability to the owners of vessels chartered by the insured charters that they should make declarations within a
reasonable time; nevertheless, it is in the nature of open cover that declarations of risks are made after the insurer comes on risk and a declaration is not creative of any rights or obligations; where the cover note does not expressly make the timing of declaration of the essence, the duty to make a timely declaration is an innominate term breach of which might entitle underwriters to a separate action for damages (in the form of interest on the premium not collected) or to reject the declaration; charters’ liability insurance comes into existence when the vessel starts to perform her duty under the charter although no declaration has been made at that stage: *Glencore International A.G. v Ryan (The “Beursgracht”) [2002] EWCA Civ 2051.*

Valued/unvalued policies

If the policy specifies an agreed value for the subject-matter insured, it is called a “valued policy”, and in the absence of fraud the value so fixed is conclusive “as between the insurer and assured” (MIA 1906 s.27). If no value is stated in the policy, it is called an “unvalued policy” and the insurable value is left to be subsequently ascertained in accordance with the MIA 1906 s.16, though it cannot exceed the limit of the sum insured (s.28).

The interest may be valued in the policy at a fixed sum independently of its real value (s.27(2)). This is usually the case in most modern policies on the hull and machinery of vessels. Under a “valued” policy the insured is entitled to recover such fixed sum for a total loss, or a proportionate sum for a partial loss. With an “unvalued” policy the actual value of the vessel or goods lost must be pleaded and proved.

Burden of proof

Generally. It is always for the insured to establish that the vessel (or cargo) was lost fortuitously and by a peril insured against or that the loss comes within the terms of the policy (Rhesa Shipping Co SA v Edmunds, (The “Popi M”) [1985] 1 W.L.R. 948, H.L.; Panamanian Oriental SS Corpn. v Wright [1971] 2 All E.R. 1028; Seashore Marine S.A. v Phoenix Assurance Plc (The “Vergina”) (No. 2) [2001] 2 Lloyd’s Rep. 698; Brownsville Holdings Ltd & Anor v Adamjee Insurance Co Ltd (The “Milasan”) [2000] 2 Lloyd’s Rep. 458). The claimant is required to prove his case on the “balance of probabilities only” (National Justice Compania Naviera Saturday. v Prudential Assurance Co. Ltd (The “Ikarian Reefer”) [1995] 1 Lloyd’s Rep. 455 at 459). Where a policy covers “loss of or damage to the vessel” the burden rests
upon the insured to establish its actual or constructive total loss (Handelsbanken AS SOON AS v Dandridge [2002] 2 All E.R. (Comm) 39 at 57).

If, on the evidence, the insured fails to prove on the balance of probabilities the real cause of the loss, he has failed to prove his case. Although it is open to insurers to suggest and seek to prove some other cause of loss, against which the ship was not insured, there is no obligation on them to do so and if they choose to do so, there is no obligation on them to prove, even on the balance of probabilities, the truth of that alternative case (The “Popi M”) (applied at first instance in Lamb Head Shipping Co Ltd v Jennings (The “Marel”) [1992] 1 Lloyd’s Rep 624). The principle that it is not the duty of fact-finders to reach conclusions of fact, one way or the other, in every case, was re-affirmed by the Supreme Court (at para. 193) in Sienkiewicz v Greif (UK) Ltd; Willmore v Knowsley MBC [2011] UKSC 10; [2011] All E.R. (D) 107 (Mar).

However, where the policy covers all risks, not merely risks of a specified class or classes, “the claimant discharges his special onus when he has proved that the loss was caused by some event covered by the general expression, and he is not bound to go further and prove the exact nature of the accident or casualty which, in fact, occasioned his loss” (British and Foreign Marine Insurance Co. v Gaunt [1921] 2 A.C. 41, PER Lord Birkenhead at 47; applied in Berk & Co v. Style [1956] 1 Q.B. 180 at 187). Further, where the defendants had agreed to insure the claimant under marine open cargo-cover, which included a clause excluding cover in respect of “mysterious disappearance and stability losses”, the onus of establishing the fact that the loss fell within the exclusion clause rested on the insurer: AXL Resources Ltd v Antares Underwriting Services Ltd [2010] EWHC 3244 (Comm).

Under an all risks policy which provides cover against accidental damage, the insured bears a burden to show on the balance of probabilities that the relevant loss was accidental but he does not necessarily have to explain what caused the damage; it is for underwriters who make a positive plea of arson to establish that the accusation is true: Aquarius Financial Enterprises Inc v Certain Underwriters at Lloyd’s (The “Delphine”) [2001] 2 Lloyd’s Rep. 542, 543 at para. 11.

Where the insurer claims rectification of the policy terms, it bears the burden of proving “convincingly” that there was a common mistake in entering into the written policy (Kiriacoulis Lines S.A. v Compagnie D’Assurances Maritime Aerienne et Terrestres (CAMAT) (The “Demetra K”) [2002] 2 Lloyd’s Rep. 581/ and see American Airlines Inc. v Hope [1974] 2 Lloyd’s Rep. 301).
On an allegation of scuttling. Where the insurers plead a positive defence that the vessel (or cargo) was wilfully cast away with the knowledge and connivance of the insured, the burden of proof rests with them. While the insurers are required to prove their case “on the balance of probabilities”, the standard of proof is commensurate with the gravity of the allegation made—the burden on the insurers is heavier than that which rests upon the ship owners: *The Gloria* (1936) 54 L1. L. Rep. 35 at 50-51; *National Justice Compania Naviera SA v Prudential Assurance Co Ltd* (the “Ikarian reefer”) [1995] 1 Lloyd’s Rep. 455 at 459, CA. See also *Hornal v. Neuberger Products* [1957] 1 Q.B. 247; *Piermay Shipping Co SA v Chester* [1979] 2 Lloyd’s Rep. 1 at 13, CA; *Aquarius Financial Enterprises Inc v Certain Underwriters at Lloyd’s (The “Delphine”)* [2001] 2 Lloyd’s Rep. 542, 544 at para. 15. For a recent analysis of the case law in which the civil standard of proof is discussed, see the judgment of the House of Lords in *R. (on the application of D) v Life Sentence Review Commissioners* [2008] UKHL 33; [2008] 4 All E.R. 992, per Lord Carswell at paras 23-29.

On an allegation of non-disclosure. Where the insurer pleads that a material fact was not disclosed, he must adduce evidence to prove such non-disclosure: *Visscherrij Maatschappij Niew Onderneming v Scottish Metropolitan Assurance Company* (1922) 38 T.L.R. 458, CA. On the importance of pleading the risk to which the alleged non-disclosure is said to be material, see *Decorum Investments Ltd v Atkin (The “Elena G”)* [2001] 2 Lloyd’s Rep. 378, 382 in which it was said that the underwriters had to establish that there were facts or circumstances known to the assured (other than mere speculations, vague rumours or unreasoned fears: see *Carter v Boehm*, (1766) 3 Burr. 1905) which went to establish a real risk that a Russian enemy of the assured would seek to destroy or damage the assured’s yacht within its trading limits or that it would be damaged or destroyed in the course of an attempt to kill or attack the assured or his family. However, in *North Star Shipping Ltd v Sphere Drake Insurance Plc* [2006] 2 Lloyd’s Rep 183, the Court of Appeal emphasised that whether or not a matter was “material” was a question of fact not law; and pointed out that usually recent allegations of serious dishonesty would be disclosable even if they were said to be wholly unfounded.

However, where there is a prima facie evidence of non-disclosure, the onus shifts to the assured to prove that he disclosed the fact: *Glicksman v Lancashire and General Assurance Co Ltd* [1925] 2 K.B. 593, CA; affirmed [1927] A.C. 139, H.L.

**Duty of insured to disclose material facts**
A contract of marine insurance is a contract of utmost good faith and the general principles set out in Section 58; General Introduction, above, apply.

**Insurable interest**

Insurable interest is defined in the MIA 1906 s.5(2), as set out in Section 67: General Introduction, above. The owner or mortgagee of the ship or any portion of the cargo, the person to whom the freight is payable, the assured for the charges of insurance, or the master or any member of the crew in respect of his wages all have an insurable interest (see the MIA 1906 ss.10, 11, 12, 13, 14). Likewise anyone who has an interest in the “marine adventure” i.e. anyone who is so placed with respect to the thing insured as to have either benefit from its safety or due arrival or suffer prejudice from loss or damage to it or its detention, or incur liability in respect of it (see s.5).

Effecting a policy. Broadly, no-one can effect a valid policy of marine insurance unless he has, at the time, either an interest in or lien on the ship, cargo or freight or else a bona fide expectation of acquiring such an interest or lien (see *Mark Rowlands Ltd v Berni Inns Ltd* [1986] Q.B. 211 at 228 where Kerr L.J. relies upon the definition of insurable interest by Lawrence J. in *Lucena v Craufurd* (1806) 2 B. & P. (NR) 269, 302). A policy effected by owners may sometimes ensure for the benefit of charterers (see *The Yasin* [1979] 2 Lloyd’s Rep. 45).

Claiming under a policy. In order to recover under a contract of marine insurance, the insured must have an insurable interest in the subject matter insured (i.e. ship, cargo or freight) at the time of the loss, though he need not have had an interest at the time when the insurance was effected (s.6(1)). If, however, the policy is on “lost or not lost” terms then the insured may recover if he acquired his interest after the loss unless at the he effected the contract of insurance he was aware of the loss and the insurer was not: (s.6(1)). No one can acquire an insurable interest after he is aware that the subject-matter insured is lost (s.6(2)).

Parties claiming

The action on a policy of marine insurance may be brought in the name of the party nominally effecting the insurance (i.e. the agent or insurance broker), or in the name of the principal or party interested. Where the insurance has been effected by an agent in his own name on behalf of his principal, the
principal may sue on the policy, although it contains nothing to show the agency (Williams v North China Insurance Co. (1876) 1 C.P.D. 757; The Yasin [1979] 2 Lloyd’s Rep. 45).

Payment of premium

Unless otherwise agreed, where a broker effects a marine policy on behalf of the insured, the broker is directly responsible to the underwriter or insurer for the premiums (MIA 1906 s.53(1)) and entitled to sue the insured, by whom he is employed, for them (Heath Lambert Ltd v Sociedad de Corretaje de Seguros [2005] 2 All E.R. 225). The insured is liable to his broker for the premium, whether or not it has actually been paid to the insurer (see also Bain Clarkson v Owners of Sea Friends [1991] 2 Lloyd’s Rep. 322, CA, where the failure to pay premiums did not entitle the brokers to arrest the ship; see also Allianz Insurance Co Egypt v Aigaion Insurance Co SA [2008] EWHC 1127 (Comm), per Judge Chambers QC at paras 58-68 (affirmed by the Court of Appeal at [2009] 2 All E.R. (Comm) 745)). A broker has a lien upon the policy for the amount of the premium and his charges for effecting the policy (MIA 1906 s.53(2); see Heath Lambert Ltd v Sociedad de Corretaje de Seguros (above)) and in respect of any balance on any insurance account due to him from a policyholder with whom he has dealt as principal.

But, in the case of composite insurance, where a person placed insurance with a broker on behalf of both himself and other interests, the broker was not dealing with the co-insured “as a principal” and accordingly was not entitled to assert a lien against one co-insured in respect of the liability of another co-insured (Eide UK Ltd v Lowndes Lambert Group Ltd [1999] Q.B. 199, CA).

Assignment

A marine policy is assignable either before or after loss (MIA 1906 s.50(1)). To identify when the beneficial interest passes, it is necessary to distinguish between situations of assignment before and after loss; an assured does not make an effective assignment where he retains an insurable interest e.g. as mortgagor or operator of a vessel, even if he has assigned the entire right to the benefit of any claims which arise in respect of his interest: see Raiffeisen Zentralbank Österreich v Five Star Trading CA [2001] 2 W.L.R. 1344, 1366-7. (On the facts it was held that the bank was an equitable assignee). However, where the insured has parted with or lost his interest in the subject-matter insured, and has not, before or at the time of so doing, expressly or impliedly agreed to assign the policy, any subsequent assignment of the policy is inoperative (MIA 1906 s.51). “After loss, the interest in the damages, the chose in action, is the only property which is covered by the policy” (Lloyd v Fleming (1872) L.R. 7 Q.B. 299). Where an assignment is in the ordinary form, the assignee has the right to sue
in respect of any claim which the assignor has on the policy, although the assignee was not at the time of the loss interested in the subject matter (Aron & Co. v Miall (1928) 139 L.T. 562; Law of Property Act 1925 s.47). Where a marine policy has been assigned, the insurer is entitled to raise any defence arising out of the contract which he would have been entitled to raise if the action had been brought in the name of the person by or on behalf of whom the policy was effected (MTA 1906 s.50(2)).

Unseaworthiness. For voyage policies, there is an implied warranty (s.39(1) of the MIA 1906) that at the commencement of the voyage, the ship shall be seaworthy (i.e. reasonably fit in all respects to encounter the ordinary perils of the seas of the adventure insured (s.39(4)).

In a time policy, there is no implied warranty that the ship shall be seaworthy at any stage of the adventure, but s.39(5) MIA 1906 provides a defence to a claim under the policy where “with the privity of the assured, the ship is sent to sea in an unseaworthy state”. If proven, the insurers will not be liable for any loss attributable to unseaworthiness. There are three elements to the defence: first, that there was unseaworthiness at the time the vessel was sent to sea; secondly, that the unseaworthiness was causative of the relevant loss and, thirdly, that the assured must have been privy to sending the ship to sea in that condition. An assured cannot be said to be privy to the unseaworthiness of his vessel by virtue of “blind eye knowledge” unless it is shown that the assured had had a suspicion or belief that the vessel was unseaworthy and had deliberately refrained from making relevant enquiries: Manifest Shipping Co. Ltd v Uni-Polaris Shipping Co. Ltd [2001] 2 W.L.R. 170; [2001] UKHL/1, considered in Agapitos v Agnew [2003] 3 W.L.R. 616, CA.

Total Loss/Constructive Total Loss

A loss may be total or partial, or what is termed a “constructive total loss”. Where the insured brings a claim for a total loss, but there is only evidence of a partial loss, then, unless the policy otherwise provides, the insured may recover for a partial loss (MIA 1906 s.56(4)). Section 55 indicates those losses included in and excluded from the insurer's liability, in the absence of express provisions in the policy. Generally an insurer is only liable for losses proximately caused by a peril insured against under the policy terms (s.55(1)). See also, the MIA 1906 s.57(1), 58.

It is for the insurer to prove that the proximate cause of the loss is not a peril insured against. In a recent judgment of the Supreme Court, it was held that the destruction of an oil rig on a sea voyage
was covered under a marine insurance policy which covered all risk of loss or damage to the subject matter but excluded “loss, damage or expense caused by the internal vice or nature of the subject matter insured”: Global Process Systems Inc v Syarikat Takaful Malaysia Bhd [2011] UKSC 5; [2011] I All E.R. 869. In so deciding the court held that there was no authority for the proposition that inherent vice or nature of the subject matter insured was established by showing that the goods in question had not been capable of withstanding the normal incidents of the insured voyage, including the weather reasonably to be expected, but that where the only fortuity operating on the goods came from the goods themselves, the proximate cause of the loss could properly be said to be the inherent vice or nature of the subject-matter insured.

Total Loss. There may be a "total loss" although the ship does still exist, for instance, in the case of capture and sale upon condemnation where capture is a peril insured against (Cossman v West (1887) 13 App. Cas. 160), but not where cargo was not sent forward because it was reasonably expected to be lost by the perils insured against, and therefore abandoned before the cause of those perils had begun to operate (Kacianoff v China Traders Insurance Co. [1913] 3 K.B. 407). Where a cargo was insured against total loss “by total loss of the vessel” and the cargo was totally lost and the vessel all but submerged, the total loss of the vessel was held to have resulted (Montreal Light, Heat and Power Co v Sedgwick [1910] A.C. 598). Where there is a partial loss covered by insurance, and during the currency of the policy but before the damage is repaired there is a total loss by a risk not covered by the policy, the insurer is not liable for the unrepaired partial loss (British & Foreign Insurance Co. v Wilson Shipping Co. [1921] A.C. 188).

Where a vessel was seized by Somali pirates, then released six week afterwards, the shipowners could not claim prior to that release that upon the removal of the vessel into Somali waters its cargo had become an “actual total loss” under MIA 1906 57(1) because, on the facts of the case the insured had not been “irretrievably deprived” of its cargo: Masefield AG v Amlin Corporate Member Ltd [2010] 2 All E.R. 593 (affirmed on appeal [2011] EWCA Civ 24). In upholding the judgment of the court below, the Court of Appeal held, per Rix L.J. at para. 56 that, in the circumstances of the case, piratical seizure was not an actual total loss because upon the seizure of the vessel there was not only a chance, but a strong likelihood, that payment of a ransom of a comparatively small sum, relative to the value of the vessel and her cargo, would secure recovery of both (as in fact happened).

Constructive Total Loss. A "constructive total loss" is defined by the MIA 1906 s.60(1). The concept is peculiar to marine insurance. It will not be applied in English law, outside
that sphere unless the particular terms of the policy require that it should be \textit{(I.C.I. Fibres SA v MAT Transport [1987] 1 Lloyd’s Rep. 354 at 358-359 per Staughton J.)}

Section 61 provides that “where there is a constructive total loss the assured may either treat the loss as a partial loss, or abandon the subject-matter insured to the insurer and treat the loss as if it were an actual total loss.”

There may be a constructive loss where a prudent uninsured owner would not think it worthwhile to repair the damaged ship, in which case he is entitled to add the breakup value of the ship to the estimated cost of repairs \textit{(Macbeth & Co. Ltd v Maritime Insurance Co. Ltd [1908] A.C. 144, overruling, on the latter point, Angel v Merchants Marine Insurance Co. [1903] 1 K.B. 811; see also Helmville Ltd v Yorkshire Insurance Co. Ltd (The “Medina Princess”) [1965] l Lloyd’s Rep. 361). Under a policy against “total loss only” a constructive total loss may be recovered \textit{(Adams v McKenzie (1863) 12 L.J.C.P. 92)}. The criteria for a constructive total loss, as defined by MIA 1906 s.60(1) was not met where shipowners had every intention of recovering a vessel seized by Somali pirates and there was no reasonable basis for regarding an actual total loss as unavoidable: \textit{Masefield AG v Amlin Corporate Member Ltd [2010] 2 All E.R. 593 (affirmed on appeal: [2011] EWCA Civ 24).}

Notice of abandonment is a condition precedent to the right of the assured to claim for a “constructive total loss” \textit{(s.62(1); Knight v Faith (1850) 15 Q.B. 649; Kaltenback v Mackenzie (1878) 3 C.P.D. 467; considered in Kastor Navigation Co. Ltd v AGF MAT [2003] All E.R. (Comm) 277 (affirmed on appeal: [2004] EWCA Civ 277)) and if the assured failed to give such notice, the loss can only be treated as a partial loss. But the notice is not an integral element of a constructive total loss \textit{(Roura & Fourgas v Townend [1919] 1 K.B. 189; Robertson v Petros M Nomikos Ltd [1939] A.C. 371 at 381, per Lord Wright) but rather “a notification of an election between two alternative quantaums of damage” (Bank of America National Trust and Savings Association v Christmas (The “Kyriaki” (1993) 1 Lloyd’s Rep. 137 at 151, col. 2, per Hirst J.). Where, however, there is substantially nothing to abandon and the insurer would gain nothing by the notice of abandonment, the giving of such notice is held excused or waived \textit{(s.62(7); Rankin v Potter (1873) L.R. 6 H.L. 83; cf. Kaltenback v Mackenzie above, where the omission to give notice was not excused by a subsequent justifiable sale of the ship).}

Where a CTL caused by an insured peril of which the insured was unaware was followed, before the insured acquired such knowledge, by a total loss caused by an uninsured peril or excepted peril, the insured can still recover for the CTL. In such a case the abandonment of the insured vessel takes place by operation of law when the underwriter settles the claim. In any event, notice of abandonment was unnecessary where there was no possibility of benefit to the insurer if notice had been given to it
(Kastor Navigation Co. Ltd v. AGF MAT [2003] 1 All E.R. (Comm) 277 (affirmed on appeal [2004] EWCA Civ 277). For an analysis of the legal standing of a notice of abandonment, and consideration of the question of what interest insurers obtain following payment of a CTL without either claiming or disclaiming the insured’s interest in the vessel, see Dornoch Ltd v Westminster International BV [2009] EWHC 889 (Admiralty Court).

General Average Loss

The cause of action for a claim on a policy of marine insurance in respect of a general average loss arises as soon as the events giving rise to the general average loss have occurred (MIA 1906 s.66; Chandris v Argo Insurance Co. [1963] 2 Lloyd’s Rep. 65 approved by the House of Lords in Castle Insurance Co. Ltd v Hong Kong Islands Shipping Co. Ltd [1984] A.C. 226 at 238).

Section 66(4) provides that, subject to any express provision in the policy, where the insured has incurred a general average expenditure, he may recover from the insurer in respect of the proportion of the loss which falls upon him. If the shipowner has financed the whole of the general average expenditure and the value of his ship represents a proportion of the total contributory values, the shipowner can proceed against the insurers for his proportion only and must recover the balance from the cargo interests.

By contrast, on a general average sacrifice (subject to any express provision in the policy), the insured may proceed directly and immediately against the insurers for the whole of his loss, without having enforced his right of contribution from the other parties liable to contribute (MIA 1906 s.66(4)). On payment, the insurers are subrogated to the general average contributions eventually recovered from the other parties to the common adventure.

Institute Clauses

Most marine insurance policies that are effected at Lloyd’s or in the London market are subject to standard conditions which are universally accepted in the market. These “institute clauses” are produced by the Institute of London Underwriters (a body which merged with the International Underwriting Association of London (IUAL) on January 1, 1999) and are revised from time to time. The most commonly used are the institute time clauses (hulls) (used in connection with a time policy on the hull and machinery of a vessel, which excludes war-type risks); the institute cargo clauses (of which
there are several types), used in connection with insurance freight. There are three sets of hull clauses in current use in the London market: the Institute Time Clauses Hulls (1/11/95) and Voyage Clauses Hulls (1/11/95); and the International Hull Clauses (1/11/03). The present institute cargo clauses (A, B and C) in use are those dated January 1, 1982. The clauses define the insured perils, set out the exceptions to cover and also define the terms on which the insurance is made and upon which claims can be made.

All the institute clauses (in addition to some American clauses) are contained in the Reference Book of Marine Insurance Clauses, published annually by Witherby & Co. and in the Markets Wordings Database (available from Lloyd’s Policy Signing Office, Commercial Services in CD-ROM format and online).


THE MARINE INSURANCE ACT 1906

The law governing disclosure and representations in the non-consumer context is contained in sections 17 to 20 of the Marine Insurance Act 1906 (Sections 18 to 20 do not apply to consumer insurance, by virtue of the Consumer Insurance (Disclosure and Representations) Act 2012). The 1906 Act codifies principles developed in the eighteenth and nineteenth centuries. Although the 1906 Act only appears to relate to marine insurance, most of its principles (including sections 17 to 20) have been taken to apply to all insurance on the basis that it embodies the common law (see, for example, Lord Mustill’s comment in Pan Atlantic Insurance Co Ltd v Pine Top Insurance Co Ltd [1995] 1 AC 501 at 518).

SECTION 17: A CONTRACT OF THE UTMOST GOOD FAITH

Section 17 of the 1906 Act states:
A contract of marine insurance is a contract based upon the utmost good faith, and, if the utmost good faith be not observed by either party, the contract may be avoided by the other party.

Insurance contracts are therefore one of a small number of types of contract that are of the “utmost good faith”.

The requirement on the policyholder to disclose relevant information before entering into the contract is one example of the duty of good faith. It contrasts with the law which applies to other (non-insurance) commercial contracts, where a party must not misrepresent facts but is under no obligation to disclose facts about which it is not asked.

The principle of good faith is wider than the policyholder’s duties to provide the insurer with pre-contract information.

SECTION 18: THE DUTY OF DISCLOSURE AND EXCEPTIONS TO THE DUTY

Section 18 of the 1906 Act places a duty on the policyholder to disclose information to the insurer.

Section 18(1)

The essential duty is set out in section 18(1), which states:

Subject to the provisions of this section, the assured must disclose to the insurer, before the contract is concluded, every material circumstance which is known to the assured, and the assured is deemed to know every circumstance which, in the ordinary course of business, ought to be known by him. If the assured fails to make such disclosure, the insurer may avoid the contract.

Below we look at these words in more detail.

“Before the contract is concluded”
The duty to disclose arises only before the contract is formed or varied. Unlike in some civil law systems, there is no general duty to inform the insurer of changes to the risk while the contract subsists.

In the UK, most insurance policies are for a fixed term, typically a year. At the end of the year, most policies fall due for renewal. The legal position is clear: a renewal is a new contract, and the duty to disclose arises again.

When negotiating a variation to the contract, policyholders must disclose facts “material to the additional risk being accepted by the variation” as a matter of good faith (Manifest Shipping Co Ltd v Uni-Polaris Insurance Co Ltd (The Star Sea) [2001] UKHL 1, [2003] 1 AC 469 by Lord Hobhouse of [54] (emphasis in original). Variations are not mentioned in section 18. Instead, the duty to disclose on variation is seen as part of the more general duty of good faith.) There is no requirement to disclose information relating to the rest of the original policy (Lishman v Northern Maritime (1875) LR 10 CP 179).

“Known to the assured”

Policyholders must disclose information which they “know”, or which they ought to know “in the ordinary course of business”. This is a complex test involving the law of agency and attribution of knowledge. It raises difficult questions about whose knowledge is relevant and how far an organisation should go to gather information not already known by its senior management and people arranging the insurance.

The issue has considerable practical relevance as, before presenting a risk, each policyholder must search for relevant information. We have been told that there is a need for greater clarity about how policyholders should go about this task. We look at this more fully in Chapter 8.

“Every material circumstance”

Material circumstances are defined in section 18(2) of the 1906 Act:

Every circumstance is material which would influence the judgment of a prudent insurer in fixing the premium, or determining whether he will take the risk.
The issue is therefore looked at from the point of view of a hypothetical “prudent insurer”. The policyholder is required to understand what information would influence the judgment of a prudent underwriter.

In *Pan Atlantic Insurance Co Ltd v Pine Top Insurance Co Ltd* ([1995] 1 AC 501, the case mainly concerns non-disclosure, but the matters discussed in this context apply equally to misrepresentation) the House of Lords confirmed that a material circumstance is one that would have an effect on the mind of the prudent insurer in assessing the risk. It is not necessary that it would have a decisive effect on the insurer’s acceptance of the risk or on the amount of premium charged.

The Scots law, the *Pan Atlantic* test of materiality does not apply to life insurance, but it has been applied to other forms of insurance (the test in *Life Association of Scotland v Foster* (1873) 11 M 351 (materiality to the reasonable person in the position of the insured) has been held to apply to life and health insurance cases in Scotland; see *Hooper v Royal London General Insurance Co Ltd* 1993 SLT 679 and *Cuthbertson v Friends’ Provident Life Office* 2006 SLT 567. In all other types of insurance, however, the relevant test is that in *Pan Atlantic*; see for example *Gaelic Assignments Ltd v Sharp* 2001 SLT 914 and *Mitchell v Hiscox Underwriting Ltd* [2010] CSIH 18, 2010 GWD 13 – 244.)

“The insurer may avoid the contract”

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

Exceptions to the duty to disclose

Section 18(3) of the 1906 Act sets out four exceptions to the general duty of disclosure. Unless the insurer makes an enquiry, an insured need not disclose:

(a) any circumstance which diminishes the risk;

(b) any circumstance which is known or presumed to be known to the insurer. The insurer is presumed to know matters of common notoriety or knowledge, and matters which an insurer in the ordinary course of his business, as such, ought to know;
(c) any circumstance as to which information is waived by the insurer;

(d) any circumstance which it is superfluous to disclose by reason of any express or implied warranty.

Waiver and a “fair presentation of the risk”

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

In most legal contexts, waiver is a relatively narrow doctrine. It applies where a party makes an unequivocal representation in full knowledge of the facts (See Chitty on Contracts (31st ed 2010), in particular para 24 – 007 and following. For Scots law, see E C Reid and J G W Blackie, Personal Bar (2006), Ch 3 (IV) and (V)). In the insurance context, an insurer may waive by omission. The courts have held that if a policyholder makes a fair presentation of the risk which would prompt a reasonably careful insurer to make further enquiries, the insurer who fails to make such enquiries has waived the information which further enquiries would have revealed (The Scots law position on waiver is similar; see E C Reid and J G W Blackie, Personal Bar (2006), pp 238 to 242). The waiver exception has therefore been used to encourage insurers to take a more active role in assessing the risk.

The following key passage in a leading textbook, MacGillivray, was affirmed by the Court of Appeal in WISE (Underwriting Agency) Ltd v Grupo Nacional Provincial SA: ([2004] EWCA Civ 962, [2004] 2 All ER (Comm) 613 at [63].)

[T]he assured must perform his duty of disclosure properly by making a fair presentation of the risk proposed for insurance. If the insurers thereby receive information from the assured or his agent which, taken on its own or in conjunction with other acts known to them or which they are presumed to know, would naturally prompt a reasonably careful insurer to make further inquiries, then, if they omit to make the appropriate check or inquiry, assuming it can be made reasonably, they will be held to have waived disclosure of the material fact which that inquiry would have necessarily revealed. (MacGillivray on Insurance Law (10th ed 2003)

Lord Justice Rix elaborated on the principle as follows:

Ultimately, it seems, the question is: Has the insurer been put fairly on inquiry about the existence of other material facts, which such inquiry would necessarily have revealed? (*WISE (Underwriting Agency) Ltd v Grupo Nacional Provincial SA* [2004] EWCA Civ 962, [2004] 2 All ER (Comm) 613 by Rix LJ at [64]).

This test is an objective one, the relevant standard being that of a reasonably careful insurer. Lord Justice Rix described his hypothetical insurer as being “neither a detective on one hand nor lacking in common sense on the other”, noting that “mere possibilities will not put him on inquiry” ([2004] EWCA Civ 962, [2004] 2 All ER 613 at [64]).

**How far must the insurer ask questions?**

There is discussion within the case law about how often the insurer is obliged to ask questions. In some formulations, it has been suggested that issues of waiver arise rarely, and only after the policyholder has shown that it made a fair presentation of the risk. This was the view taken by Mr Justice Hobhouse in *Iron Trades Mutual v Companhia de Seguros Imperio*:

> If a proposer has made a fair presentation of the risk, he has discharged his duty; if he has not, then a failure by an insurer to inquire will not relieve the proposer of his duty to make proper disclosure. ([1991] Re R 213 at 224).

By contrast, in *WISE (Underwriting Agency) Ltd v Grupo Nacional Provincial SA*, Lord Justice Rix suggested that there is a more extensive doctrine, “found on the concept of fairness”:

> It would not in my judgment be fair to castigate a presentation as unfair and thus put an assured in peril of the draconian remedy of avoidance where an insurer had waived the relevant information ([2004] EWCA Civ 962 at [46]).
Thus the requirement to ask questions arises not simply from the doctrine of waiver, as set out in section 18(3), but also from the mutual duty of good faith.

**Limited questions**

The doctrine of waiver can be used to curtail the duty of disclosure in several other ways. In particular, an insurer who asks an expressly limited question may be taken to indicate that it has no interest in information which falls outside the scope of that question. If so, it will be deemed to have waived such information (See Lord Justice Longmore in *Doheny v New India Assurance Ltd* [2004] EWCA Civ 1705, [2005] Lloyd’s Rep IR 251 at [29]).

An example would be a form which asks about claims in the last five years. An insurer who asks such a question would normally be taken to have waived information about claims made more than five years ago.

It is important to note, however, that these cases all involved specific and limited information. The courts have not been willing to accept waiver arguments in cases in which the category of information supposedly waived has been too wide or difficult to define (See, for example, *Synergy Health (UK) Ltd v CGU Insurance Plc* [2010] EWHC 2583 (Comm), [2011] Lloyd’s Rep IR 500: a request to fill out a Declaration of Material Facts covering moral hazard (such as convictions and bankruptcies) was found not to obviate the obligation to disclose the unrelated fact that an intruder alarm had not been installed on the premises).

**The disclosed information must not be misleading**

This can be illustrated by the case of *CTI v Oceanus* ([1984] 1 Lloyd’s Rep 476). The policyholders insured damage to their containers, and the brokers presented the risk to the insurer by relying on summaries which they had prepared of claims rates under earlier policies. These rates turned out to be highly inaccurate. The brokers also gave the insurers a full file of information, including lengthy policy documents from which the actual rates could have been ascertained.

The court found that there was nothing in the brokers’ presentation which would have prompted a reasonable insurer to make further enquiries. The insurer was entitled to take the summaries at face value, and no waive arose. As Lord Justice Parker put it:
So long as [the] summary is fair, the insurer cannot complain that the full details of the experience were not disclosed. He must however be entitled to assume that the summary is fair. From this follows that, if he then proceeds to negotiate on the basis of the summary without enquiry as to its accuracy, he waives nothing. He can assume both that it is accurate as far as it goes and that, if it covers only part of the past experience, there is nothing in the part omitted which would vitiate the summary ([1984] 1 Lloyd’s Rep 476 at 511 to 512).

On the other hand, the insurer “cannot shut his eyes to obvious incompleteness and then complain of his bargain made in ignorance of the whole story”. The insurer will be taken to have waived information if “through negligence or stupidity or inexperience or pig-headedness” he does not “pursue enquiries which a prudent underwriter would have pursued” (Above, by Stephenson LJ at 529 for those non-disclosures or misrepresentations which are not dishonest).

**SECTION 19: DISCLOSURE BY THE BROKER**

Section 19 of the 1906 Act extends the insured’s duty of disclosure where insurance is placed through a broker or other agent, requiring information known to the agent to be disclosed. The only remedy for breach of the section is that the insurer may avoid its contract with the policyholder. The effect of section 19, therefore, is to extend the policyholder’s duty to the insurer, not only to disclose information which the policyholder knows or ought to know, but also to disclose some additional circumstances which are known only to the broker.

The law on section 19 is confused, with several contradictory judicial statements about what it covers (for more detail see CP3, Part 7).

**SECTION 20: MISREPRESENTATIONS**

Section 20(1) of the Marine Insurance Act 1906 Act provides:

> Every material representation made by the assured or his agent to the insurer during the negotiations for the contract, and before the contract is concluded, must be true. If it be untrue the insurer may avoid the contract.
The definition of a material representation in section 20(2) repeats the test for “material circumstances” in section 18(2): it must influence the judgment of a prudent insurer in fixing the premium or deciding whether to take the risk.

Section 20(3) of the 1906 Act provides:

A representation may be either a representation as to a matter of fact, or as to a matter of expectation or belief.

Section 20(4) applies to factual representations:

A representation as to a matter of fact is true, if it be substantially correct, that is to say, if the difference between what is represented and what is actually correct would not be considered material by a prudent insurer.

By contrast, section 20(5) applies to representations of expectation or belief:

A representation as to a matter of expectation or belief is true if it be made in good faith.

The courts have confirmed that, where a statement by an insured is a matter of opinion rather than fact, it is sufficient that the opinion is given in good faith. It is not necessary that it should be based on reasonable grounds (Economides v Commercial Union Assurance Co Plc [1998] QB 587). However, as Lord Justice Peter Gibson said:

Of course the absence of reasonable grounds for that belief might point to the absence of good faith for that belief. But in a case such as the present where the bad faith of the plaintiff is not alleged, I can see no basis for implication of a representation of reasonable grounds for belief (Economides v Commercial Union Assurance Co Plc [1998] QB 587 at 606).

In practice, misrepresentation and non-disclosure are often pleaded together, in respect of the same set of facts. In commercial litigation, the law of non-disclosure has tended to dominate, with relatively little attention being given to misrepresentation in an insurance context. As one textbook writer explains:
Historically, misrepresentation in the strict sense has not been of particular importance in the insurance context. This is partly because the extreme width of the duty to disclose material facts ... has meant that often non-disclosure has subsumed questions of misrepresentation. Cases have frequently failed to distinguish between the two defences taken by an insurer and indeed it appears to be standard practice for an insurer, where possible, to plead both defences (J Birds, Birds’ Modern Insurance Law (9th ed 2013) pp 114 and 115).

THE INSURER’S REMEDIES FOR BREACH

The inducement test

For many years, the courts have said that the insurer should only have a remedy for an insured’s non-disclosure or misrepresentation under the 1906 Act if it can satisfy the “inducement test” (Pan Atlantic Insurance Co Ltd v Pine Top Insurance Co Ltd [1995] 1 AC 501). This requires the insurer to show that, without the non-disclosure or misrepresentation, it would have acted differently in its assessment of the risk: that is, it would not have entered into the contract at all, or would have entered it only on different terms.

Although the inducement test is an important part of the case law, it does not appear on the face of the statute. In Chapter 11, we recommend including this requirement within the legislation.

Avoidance

At present, the law provides only one remedy for non-disclosure or misrepresentation: avoidance of the contract. In other words, the contract is treated as if it has never been made, and all claims made under it are refused. In Chapter 11, we argue that avoidance is often unfair to the insured and can over-protect the insurer. We recommend an alternative scheme of more proportionate remedies.

Return of premiums

Avoidance normally requires restitution: the parties must be restored to the positions they were in prior to the contract being made, except where one is guilty of fraud. For marine insurance, section 84(3)(a) of the 1906 Act provides:
Where the policy is void, or is avoided by the insurer as from the commencement of the risk, the premium is returnable, provided that there has been no fraud or illegality on the part of the assured ...

THE INSURED’S KNOWLEDGE

Section 18(1) of the Marine Insurance Act 1906 (the 1906 Act) requires a non-consumer insured to disclose to the insurer:

every material circumstance ... which is known to the assured, and the assured is deemed to know every circumstance which, in the ordinary course of business, ought to be known by him.

In other words, before entering an insurance contract a prospective insured must disclose material information which it knows or which it ought to know in the ordinary course of business. This leads to difficult questions.

(1) Whose knowledge is relevant to determining what the insured “knows” (the attribution question)?

(2) What more “ought” the insured to know, and what must it do to discover it (the constructive knowledge question)?

The issue is particularly difficult where the policyholder is not an individual (or natural person) but some entity (which may or may not have a separate legal personality) (The status of partnerships in Scotland, but not in England and Wales (though for some practical purposes they are treated as if they do have legal personality). For further details, see Partnership Law (November 2003) Law Com No 283; Scot Law Com No 192. http://lawcommission.justice.gov.uk/docs/lc283_Partnership_Law.pdf and http://www.scotlawcom.gov.uk/index.php/download_file/view/266.) While deciding what an individual knows is simply a matter of fact and evidence, deciding what an organisation “knows” first involves an analysis of whose knowledge counts towards the organisation’s “knowledge” from a legal perspective.

34
Where a natural person seeks insurance, the issue of knowledge is relatively straightforward: as one case put it, “the actual knowledge of a natural person means what it says – he knows what he knows” (PCW Syndicates v PCW Reinsurers [1996] 1 WLR 1136 by Lord Justice Staughton at 1141).

Where a corporation seeks insurance, however, the position is more complex. The issue is not unique to insurance law: it arises frequently within the general law, and section 18 of the 1906 Act must be interpreted against that background.

**Attributing knowledge: general legal principles**

The traditional approach to attributing knowledge within a corporation is to identify its “directing mind and will”. In *HL Bolton (Engineering) Co Ltd v TJ Graham & Sons Ltd*, Lord Denning distinguished between a company’s directors and managers and other employees:

Some of the people in the company are mere servants and agents who are nothing more than hands to do the work and cannot be said to represent the mind or will. Others are directors and managers who represent the directing mind and will of the company and control what it does. The state of mind of those managers is the state of mind of the company and is treated by law as such ([1957] 1 QB 159 at 172).

In some cases, however, “the directing mind and will” test is too narrow. For example, when a supermarket sells a video classified as “18” to a 14 year old, it is clearly the knowledge of the sales clerk rather than the board which is relevant. The courts have therefore developed a broader test, based on the purpose of the relevant statute or regulation (For further general discussion, see Law Commission, Criminal Liability in Regulatory Contexts (August 2010), Law Commission Consultation Paper No 195.http://lawcommission.justice.gov.uk/docs/cp195_Criminal_Liability_consultation.pdf.)

In *Meridian Global Funds Management Asia Ltd v Securities Commission*, Lord Hoffmann held that the court should not look solely at the corporate hierarchy but should also consider the purpose of the provision in question:

Whose act (or knowledge, or state of mind) was for this purpose intended to count as the act etc of the company? One finds the answer to the question by applying the usual canons of
interpretation, taking into account the language of the rule (if it is a statute) and its content and policy ([1995] 2 AC 500 at 507).

This broader test recognises that it is sometimes necessary to attribute the acts or thoughts of individuals who were not part of “the directing mind and will” of the corporation. Otherwise directors could insulate the corporation by delegating their functions and claiming to have no knowledge of what was done.

The courts have stressed, however, that the broader test does not necessarily extend to all employees – it depends on the facts of the case (Re supply of Ready Mixed Concrete (No 2), Director General of Fair Trading v Pioneer Concrete (UK) Ltd [1995] 1 AC 456 at 511.) For example, in the context of Health and Safety at Work etc. Act 1974, the court applied a directing mind test and found it included store management level responsibilities (R v Gateway Foodmarkets Ltd [1997] 3 All ER 78, (1997) 94(3) LS Gazette 28). In Real Estate Opportunities v Aberdeen Asset Managers, the judge said that, for the purposes of section 348 of the Financial Services and Markets Act 2000, the company could be taken to know generally what was known by its employees in the course of their employment ([2007] EWCA Civ 197, [2007] Bus LR 971 at [57]).

The broader test preserves flexibility but at the cost of considerable uncertainty.

Attributing knowledge for the purposes of section 18

The next consideration is how knowledge is attributed to further the purpose of section 18 of the 1906 Act. In PWC Syndicates, Lord Justice Staughton applied the broader test:

I can see no reason to restrict the knowledge of a company under s18 to what is known at a high level, by the directing mind and will. I would have thought that knowledge held by employees whose business it was to arrange insurance for the company would be relevant, and perhaps also the knowledge of some other employees ([1996] 1 WLR 1136 at 1142).

We think that this is broadly correct and applies to all corporate policyholders. Section 18 must clearly apply to anything known to the directing will and mind of the company. In the case of a large, publicly quoted company, this would normally be members of the board. If the board know (or any member
of the board knows) material circumstances, these should be disclosed. It should be no excuse that the board concealed information from their risk manager.

It is also appropriate that knowledge should be attributed to the employees and agents who arrange insurance.

We think, however, that it is unhelpful to talk about “perhaps” including the knowledge of some other employees. This is an issue on which businesses and insurers need more certainty. We think that the more helpful way of including information known by other employees is to place the persons arranging insurance under a duty to make reasonable enquiries (including questioning other employees). Below we consider the extent to which insurance managers should investigate.

What ought the insured to know?

The next question is what a policyholder ought to know in the ordinary course of business. \ there are several difficult issues with this test. The first is whether it is limited only to “blind eye” knowledge – things which the policyholder would have known had it not deliberately avoided acquiring the information. Alternatively, does it extend to a positive duty to make enquiries?

There is also a debate over whether the test is objective or subjective. Does it extend to information which a risk manager would have discovered in a reasonably well-run company, or only to information which a risk manager would have discovered through reasonable inquiries in the fallible, and sometimes negligent, company which actually sought insurance?

The current law on these issues is malleable and driven by the facts of individual cases. The various issues are often considered together, which obfuscates the true meaning of section 18(1) of the 1906 Act.

Blind eye knowledge

It is well accepted that knowledge includes circumstances to which a prospective policyholder has “turned a blind eye”. The courts have consistently interpreted knowledge to include cases where someone has deliberately failed to make an enquiry in case it results in the receipt of unwelcome information. In *The Star Sea*, Lord Scott described the concept in the following terms:
“Blind-eye” – knowledge approximates to knowledge. Nelson at the battle of Copenhagen made a deliberate decision to place the telescope to his blind eye in order to avoid seeing what he knew he would see if he placed it to his good eye. It is, I think, common ground – and if it is not, it should be – that an imputation of blind-eye knowledge requires an amalgam of suspicion that certain facts may exist and a decision to refrain from taking any step to confirm their existence (Manifest Shipping Co Ltd v Uni-Polaris Insurance Co Ltd (The Star Sea) [2001] UKHL 1, [2003] 1 AC 469 at [112]. See similarly Lord Denning in Compania Martima San Basilio SA v Oceanus Mutual Underwriting Association (Bermuda) Ltd (The Eurysthenes) [1977] QB 49 at 68).

In The Eurysthenes Lord Denning MR explained that:

This “turning a blind eye” is far more blameworthy than mere negligence. Negligence in not knowing the truth is not equivalent to knowledge of it (Compania Maritima San Basilio SA v Oceanus Mutual Underwriting Association (Bermuda) Ltd (The Eurysthenes) [1977] QB 49 at 68).

It is clearly right that one should look not only at what the relevant people knew but also at information they had deliberately avoided acquiring for fear it might confirm their suspicions. Below we recommend that knowledge should include not only actual knowledge but also “blind eye” knowledge.

A duty to enquire?

The difficult question is whether the test goes beyond “blind eye” knowledge to a positive duty on the policyholder to make enquiries (CPS, from para 633).

If the policyholder has an obligation to make reasonable enquiries under the current law, how is that to be judged? There has been debate over whether the test is subjective, by reference to the way the policyholder actually runs its business, or objective, by reference to the way a reasonable policyholder would run its business.

In the 16th edition, the editors of Arnould said that the standard must be subjective:
To hold otherwise would be tantamount to saying that underwriters only insure those who conduct their business prudently, whereas it is a commonplace that one of the purposes of insurance is to obtain cover against the consequences of negligence in the management of the assured’s affairs (Arnould’s Law of Marine Insurance and Average (16th ed 1997) para 640, quoted in Arnould’s (17th ed 2008) at para 16 – 36. See also CP3, para 6.37).

However, in the 17th edition, the editors noted a move towards a more objective standard:

There is a subjective element, that the insured is a member of a class (such as in the PCW case a Lloyd’s syndicate) but beyond that the question should be judged objectively, by reference to a reasonable, prudent insured in that class (Arnould’s Law of Marine Insurance and Average (17th ed 2008) at para 16 – 46, citing PCW Syndicates v PCW Reinsurers [1996] 1 WLR 1136).

Australia & New Zealand Bank Ltd v Colonial & Eagle Wharves Ltd is used to justify a subjective standard ([1960] 2 Lloyd’s Rep 231; see Arnould’s Law of Marine Insurance and Average (17th ed 2008), para 16 – 38; Birds, Lynch and Milnes, MacGillivray on Insurance Law (12th ed 2012), para 17 – 014)). In that case the judge also found on the facts that any reasonable enquiries the board could have been expected to make would not have revealed the information the underwriter claimed was material, because it would have required an employee to admit his own negligence. We think that this is a key issue in considering the limits of what a reasonable search would reveal (see from para 8.80 below, and particularly from para 8.83).

It also demonstrates the importance of separating the attribution question from the question of constructive knowledge. If a person’s knowledge is attributed to an entity, then the entity is deemed to know any information which that person may fraudulently or negligently withhold. If, however, the entity is only required to make enquiries of that person, the entity does not have constructive knowledge of information which it would not have uncovered even if it had made those enquiries.

THE BROKER’S KNOWLEDGE

Section 19 of the Marine Insurance Act 1906 addresses the role of the insured’s broker in making pre-contract disclosure to the insurer. It is a confusing provision. At first sight it appears to place a duty on the broker to disclose information, but we think this is misleading. The effect of a breach of section
19 falls on the insured, not the broker. Effectively, section 19 extends the insured’s duty to disclose information beyond that which it knows or ought to know, to include information which the broker knows or ought to know.

THE CURRENT LAW

Section 19 of the 1906 Act applies where the insured uses a broker to effect insurance. It reads:

Subject to the provisions of the preceding section as to circumstances which need not be disclosed, where an insurance is effected for the assured by an agent, the agent must disclose to the insurer –

(a) Every material circumstance which is known to himself, and an agent to insure is deemed to know every circumstance which in the ordinary course of business ought to be known by, or to have been communicated to, him; and

(b) Every material circumstance which the assured is bound to disclose, unless it comes to his knowledge too late to communicate it to the agent.

It has been taken to apply to non-marine as well as marine insurance (see PCW Syndicates v PCW Reinsurers [1996] 1 WLR 1139). The law on section 19 is confused, with several contrary judicial statements about what it covers (Section 19, and any equivalent rule of (common) law, no longer apply to consumer insurance contracts. See Consumer Insurance (Disclosure and Representations) Act 2012, ss.11(1)(b) and 11(2)(b)).

The nature of the duty

Although section 19 of the 1906 Act appears to place a duty on the agent, this is misleading. The section does not impose any penalty on the agent. In HIH Casualty and General Insurance Ltd v Chase Manhattan Bank, the court found that breach of section 19 did not give the insurer the right to claim damages against the agent ([2003] UKHL 6, [2003] 2 Lloyd’s Rep 61. The agent would be liable too but only where the agent’s conduct amounted to a negligent or fraudulent misrepresentation, assuming that the necessary common law requirements for such an action could be established. See also CP3 at para 7.13 and following).
Instead, a breach of section 19 gives the insurer the right to avoid the contract against the policyholder (Colinvaux’s Law of Insurance (9th ed 2010), para 6 – 044.) It is therefore the policyholder who has the interest in making sure that the insurer receives full disclosure, as it is the policyholder who stands to lose should the section be breached.

Since the insurer’s only remedies for breach of section 19 are against the insured, it is best seen as an extension of the insured’s duty to disclose. The insured must not only disclose the information which it knows or ought to know, but must also ensure the disclosure of any information which the agent knows or ought to know. If not, the insured may suffer harsh consequences.

**Section 19(b)**

This section requires the agent to disclose every fact that the applicant for insurance is bound to disclose. At first sight, this seems reasonable. However, where a policyholder has failed to disclose something it should have disclosed, the insurer already has a right to avoid on that basis. Section 19(b) appears to add little to an insurer’s existing remedies for non-disclosure under section 18, given that it does not provide a remedy against the agent.

**Section 19(a)**

Section 19(a) of the 1906 Act is more problematic, because it appears to extend the limits of disclosure beyond section 18. Under section 18(1), the policyholder need only disclose information which it knew or ought to have known. Under section 19(a), the policy may also be avoided if there was a failure to disclose circumstances which the agent knew or ought to have known, even if there was no reason for the policyholder to be aware of them. This leads to difficult questions. First, to which agents does the duty extend, and, secondly, what information is included?

If taken at face value, section 19(a) could extend widely, to any information received by an agent in any capacity. As the broker market consolidates, brokers may act for hundreds if not thousands of clients, receiving sensitive market information over vast numbers of claims throughout the industry. Is a broker expected to disclose confidential claims information relating to other clients? The general view appears to be that it is not, as discussed below. The courts have restricted the application of
section 19(a) to cases in which the broker received or held the information in its capacity as agent of the policyholder.

To which agents does the section 19 duty extend?

Section 19 is titled “Disclosure by agent effecting insurance”. Section 19(a) then refers to “an agent to insure”. As discussed in CP3, it has sometimes been held that only the final placing broker falls within section 19 (PCW Syndicates v PCW Reinsurers [1996] 1 WLR 1136. See CP3, from para 7.21). However, the better view seems to be that it also applies to intermediate agents (see CP3, paras 7.21 to 7.26. See also Blackburn Low & Co v Haslam (1888) LR 21 QBD 144; Baker v Lombard Continental Insurance plc (unreported) 24 January 1997; and GMA v Unistorebrand International Insurance [1995] LRLR 333).

We said in CP3 that this debate makes little practical difference in most cases. Section 19 states that the final placing agent must not only disclose every material circumstance “known to himself”, but also every material circumstance which ought “to have been communicated to him”. This means that the insurance may be avoided not only if the placing agent fails to disclose information which it knows, but also if an intermediate agent has failed to pass information up the chain.

What information held by the agent is caught?

At first sight, section 19(a) suggests that an agent should tell the insurer about information it has received in any capacity, if that information would influence a prudent insurer in fixing the premium or deciding whether to take the risk.

There are various observations in the case law which suggest that the section does indeed require an agent to disclose information, regardless of the capacity in which it was received (See Lord Justice Hoffmann in El Ajou v Dollar Land Holdings Plc and another (No 1) [1994] 2 All ER 685 at 702 and in Société Anonyme d’Intermediaries Luxembourgeois (SAIL) v Farex Gie [1994] CLC 1094 at 1111). However, the best reading of the current law appears to be that section 19 of the 1906 Act has a limited application (CP3, from para 7.27). It only applies to information which is received or held by agents in their capacity as agents for the policyholder (PCW Syndicates v PCW Reinsurers [1996] 1 WLR 1136 by Lord Justice Staughton at 1147). The courts appear reluctant to allow an insurer to avoid an
insurance contract against an innocent policyholder for something which the policyholder did not know, and had no reason to know, but which the broker knew in an entirely different capacity.

Another limit on the scope of section 19 was confirmed in *Group Josi Re v Walbrook Insurance Co Ltd* ([1996] 1 All ER 791). In this case, the Court of Appeal found that section 19 did not require the agent to disclose, on behalf of its client, that it was defrauding that client. This is an example of the Hampshire Land Principle (from para 8.67).

Section 18(3) of the Marine Insurance Act 1906 sets out four exceptions to the general duty of disclosure. Unless the insurer specifically asks a relevant question, a policyholder need not disclose:

a) any circumstance which diminishes the risk;

b) any circumstance which is known or presumed to be known to the insurer. The insurer is presumed to know matters of common notoriety or knowledge, and matters which an insurer in the ordinary course of his business, as such, ought to know;

c) any circumstance as to which information is waived by the insurer;

d) any circumstance which it is superfluous to disclose by reason of any express or implied warranty.

Of this list, the most important is (b), which provides that the insured need not disclose anything which the insurer already knows or is presumed to know. The legislation and subsequent case law give some guidance about this test.

**SECTION 18(3)(B): THE CURRENT LAW**

The effect of section 18(3)(b) is that a policyholder need not disclose:

(1) matters which the insurer knows;

(2) matters of “common notoriety or knowledge”; or
(3) matters which an insurer ought to know in the ordinary course of business.

The onus is on the policyholder to prove that section 18(3)(b) applies.

It is important to note that the subsection does not apply to misrepresentations under section 20 of the 1906 Act. If an insurer asks a question about these matters, the policyholder must give a truthful answer. Thus the policyholder is only excused from disclosure “in the absence of enquiry” (See Brotherton v Aseguradora Colseguoros SA (No 3) [2003] EWHC 1741 (Comm), [2003] Lloyd’s Rep IR 762).

Section 18(3)(b) has proved complex and its meaning is not entirely clear. In CP3 we distinguished between:

(1) general public knowledge;

(2) industry knowledge which an insurer ought to know about; and

(3) other matters, such as the policyholder’s individual circumstances.

Below we look at each of these in turn.

**General public knowledge**

Under section 18(3)(b) of the 1906 Act, a prospective insurer is presumed to know “matters of common notoriety or knowledge”.

The standard appears to be an objective one. A major textbook, MacGillivray, explains that insurers are credited “with knowledge of matters of public knowledge or notoriety which a generally well-informed person might fairly be expected to know” Birds, Lynch and Milnes, *MacGillivray on Insurance Law* (12th ed 2012) at 17-079.

**Industry knowledge**
An insurer is also presumed to know specialist matters which an insurer in the ordinary course of his business ought to know, including the normal practices and risks present in any trade which it underwrites. In *Noble v Kennaway* Lord Mansfield explained this requirement as follows:

> Every underwriter is presumed to be acquainted with the practice of the trade he insures, and whether it is established or not if he does not know it, he ought to inform himself ((1780) 2 Doug KB 511 at 512).

Insurers are expected to take positive steps to acquire knowledge of the trade they are insuring, (see *Colinvaux & Merkin’s Insurance Contract Law*, para A-0895 and the cases cited there) restricting the prospective policyholder’s duty of disclosure (for example, in *Société Anonyme d’Intermediaries Luxembourgeois (SAIL) v Farex Gie* [1995] LRLR 116, Saville LJ treated the relevant test as being simply an objective test of what an insurer ought to know (at 156)).

Again, we think that the standard is appropriate but that it could be expressed more clearly in the legislation.

**Other knowledge**

Section 18(3)(b) also applies to other knowledge, such as information about the policyholder’s individual circumstances. Typically, the issue arises when the policyholder has told the insurer information in connection with another policy, or another claim, but that information has not been passed to the underwriter who makes the decision. This raises questions of attribution: whose knowledge is relevant for the purposes of section 18(3)(b), and what procedures should they carry out?

**Whose knowledge is attributed to the insurer?**

Traditional thinking would impute only the knowledge of individuals who were the organisation’s “directing mind and will” (generally directors). More recently however, the courts have considered the purpose of each statutory provision, and decided the issue with a view to furthering that purpose (following *Meridian Global Funds Management Asia Ltd v Securities Commission* [1995] 2 AC 500).
For the purposes of section 18(3)(b) of the 1906 Act, the most important person is the person who makes the underwriting decision to fix the premium or determine whether to take the risk. In *Evans v Employers Mutual Insurance Association Ltd*, the relevant decision was delegated to a clerk, and the clerk’s knowledge was imputed to the insurers ([1936] 1 KB 505). We think this is a sensible result.

Information will also be known to the insurer if it was received by an agent of the insurer who is under an obligation to channel the information to the underwriter in question (M A Clarke, *The Law of Insurance Contracts* (Issue 23, 1 June 2011) 23-9A2, pp 23 to 41). In *Joel v Law Union & Crown Insurance Company* ([1908] 2 KB 863), a doctor commissioned by an insurer to examine a prospective policyholder was considered to be the agent of the insurer for the purpose of channelling information. Information which the doctor acquired by his examination was attributed to the insurer. We think it must be correct that the insurer is taken to know this type of information, particularly when it has been prepared specifically for the purpose of assisting the underwriter in the assessment of the risk.

**Information acquired in a different context**

An insurer may receive information relevant to a future proposal before it ever contemplates issuing a policy. Generally an insurer is not treated as having actual knowledge of a fact if it has no reason to draw a connection between the policyholder’s proposal and information acquired previously (for example, see *Bates v Hewitt* (1866-67) LR 2 QB 595 and Birds, Lynch and Milnes, *MacGillivray on Insurance Law* (12th ed 2012) at 17-080).

In *The Grecia Express* (*Strive Shipping Corp v Hellenic Mutual War Risks Association (Bermuda) Ltd* (*The Grecia Express*) [2002] EWHC 203 (Comm), [2002] 2 Lloyd’s Rep 88), Mr Justice Colman concluded that a policyholder is not entitled to presume that an underwriter will retain knowledge of previous casualties and relate the information to the new policy. This proposition, together with an 18 month delay between the previous casualty and the new risk, led the court to find that the insurer did not know information for the purposes of section 18(3)(b), despite knowing of the casualty at the time it occurred.

**An obligation to search records?**

The issue has arisen in the context of waiver. In *Mahli v Abbey Life Assurance Co Ltd* ([1996] LRLR 237), the insurer disclaimed liability on a 1984 life insurance policy on the ground of non-disclosure of
the deceased policyholder’s alcoholism and malaria. The policyholder’s wife claimed that the insurer had waived its right to avoid the policy when it accepted premiums after it had been informed of these circumstances.

In 1986 the insurers were told about Mr Mahli’s medical problems in the context of an application for a second policy, but they failed to relate them to his 1984 application. The underwriter checked the computer system, which noted that Mr Mahli had a previous policy, but failed to find the relevant documents. The court heard expert evidence that it was not the practice of underwriters to check earlier policies: “the pressure of work in the offices is such that this would be quite impracticable”. On this basis the majority of the Court of Appeal upheld the trial judge’s finding that the insurer did not have constructive knowledge of the non-disclosure when it continued to accept premiums.

However, Lord Justice McCowan dissented on the grounds that the insurer had all the relevant information in its systems. He accepted that individuals are not expected to personally remember information received, but thought that the insurer should be taken to be aware of information held in its computer system or in hard copy files. Lord Justice McCowan said:

I fail to see why the information in it was not in the knowledge of the company in September 1986 every bit as much as in May 1988 when that company used that knowledge to repudiate the policy. There is no question at either date of the information having been forgotten or lost ([1996] LRLR 237 at 245 by Lord Justice McCowan).

FRAUDULENT CLAIMS

Where there is no express term in the insurance contract dealing with fraud, the courts must look to the general law to determine the consequences when a policyholder makes a fraudulent claim. Under the common law, the fraudster forfeits the fraudulent claim (see the discussions in Manifest Shipping Co Ltd v Uni-Polaris Insurance Co Ltd (The Star Sea) [2001] UKHL 1, [2003] 1 AC 469 at [62] to [67] and Fargnoli v GA Bonus Plc 1997 SCLR 12, [1997] CLC 653. Forfeiture was applied in the recent case of Versloot Dredging BV v HDI-Gerling Industrie Versicherung AG (The DC Merwestone) [2013] EWHC 1666). However, section 17 of the Marine Insurance Act 1906 gives the insurer a statutory remedy of avoidance of the whole contract in the event of a breach of good faith. In theory, this allows the insurer not only to refuse to pay any part of the fraudulent claim, but also to avoid the entire policy from the outset, with the parties being
returned to their pre-contract position. This means the insurer could recover from the policyholder any sums previously paid out on genuine claims. Although, in practice, the courts have been reluctant to apply the remedy of avoidance, its status is still uncertain.

As a result, the insurer’s liability to pay genuine claims for losses suffered after the fraudulent act is also unclear. Arguably, such claims could be denied on the basis that the fraudulent claim constitutes a repudiatory breach of contract giving the insurer a right to terminate. However, that termination would be prospective, leaving the insurer liable for genuine claims between the date of the fraud and its discovery and subsequent termination of contract. Insurers have strongly objected to this possibility.

**COMMON LAW: FORFEITING THE CLAIM**

If a claim is made in the absence of a genuine loss, then clearly the insurer is not required to pay the claim. However, where only an element of a claim is fraudulent, the common law has long recognised that a fraudster should risk more than the non-payment of the fraudulent part. Since the nineteenth century, the courts have held that a person who fraudulently exaggerates a claim forfeits the whole claim, and not just the fraudulent element of it. The point was put forcefully in 1866 in *Britton v Royal Insurance Co* ((1866) 4 F&F 905 at 909).

> It would be most dangerous to permit parties to practise such frauds, and then, notwithstanding their falsehood and fraud, to recover the real value of the goods consumed.

Forfeiture of the entire claim was confirmed in *Galloway v Guardian Royal Exchange (UK) Ltd* ([1999] Lloyd’s Rep IR 209), in which the policyholder made a fraudulent claim for £2,000 of damage on top of a genuine loss of around £16,000. The Court of Appeal rejected the whole claim, including the £16,000 of genuine loss. Lord Justice Millett noted that this was a “necessary and salutary rule” needed to discourage insurance fraud.

The forfeiture rule is relatively settled.

**SECTION 17 OF THE MARINE INSURANCE ACT 1906**
The central problem is the mismatch between the common law rule and the duty of good faith in section 17 of the 1906 Act. The section states:

A contract of marine insurance is a contract based upon the utmost good faith, and, if the utmost good faith be not observed by either party, the contract may be avoided by the other party (We discuss our recommendations for the amendment of section 17 in Chapter 30 of this Report).

The duty has been held to apply to all types of insurance (see for example Pan Atlantic Insurance Co Ltd v Pine Top Insurance Co Ltd [1995] 1 AC 501 by Lord Mustill at 518 and Banque Keyser Ullmann SA v Skandia (UK) Insurance Co Ltd [1990] 1 QB 665 by Steyn J at 701).

Section 17, as currently drafted, specifies only one remedy for failing to observe utmost good faith: avoidance of the contract. This means avoiding the contract from the start, that is, returning the parties to the position they would be in had the contract never existed. In the event of a policyholder’s breach of good faith, the insurer could seek repayment of all claims paid under the policy, including genuine claims finalised and paid before the fraud arose.

However, finality is a core value of the law in the UK: if a valid claim is paid under a valid contract, it seems wrong to attempt to overturn that payment on the basis of subsequent events. In practice, the courts have been reluctant to allow insurers to recoup payments on valid claims which arose before the fraud took place. The courts have sought to escape the conclusion that the remedy for fraudulent claims is avoidance of the contract, but at the expense of some convoluted reasoning and uncertainty.

GOOD FAITH AND FRAUD: THE EVOLVING CASE-LAW

The Star Sea: reinterpreting the post-contract duty of good faith

In the 2001 case The Star Sea (Manifest Shipping Co Ltd v Uni-Polaris Insurance Co Ltd (The Star Sea) [2001] UKHL 1, [2003] 1 AC 469), the House of Lords limited the section 17 duty of good faith in two ways.
Firstly, it said that the duty of good faith did not continue once legal proceedings had begun. Once a writ was issued, the parties’ duties were governed by the rules of court procedure, which set out disclosure requirements and appropriate sanctions for non-compliance.

Secondly, the House of Lords distinguished between the pre-contract and post-contract duty of good faith. Whereas the duty to disclose information pre-contract was a strict one, after the contract the duty of good faith was flexible and varied according to the context.

Lord Scott noted that in the context of making a claim, all that was required was “a duty of honesty”. Professor Clarke suggests that “when a claim is made nothing short of fraud in the presentation of the claim will amount to a breach of the duty of disclosure and of good faith” (M A Clarke, The Law of Insurance Contracts (5th ed 2006), para 27-2B).

This, however, leaves a question where the claimant does act fraudulently. If fraud is a breach of good faith, does section 17 give the insurer the right to avoid the contract? Lord Scott described this as “debatable” but refrained from deciding the point (The Star Sea, above).

Lord Hobhouse severely criticised the remedy of avoidance. He thought that avoidance may be appropriate where “the want of good faith has preceded and been material to the making of the contract”. But, where the want of good faith occurs later, “it becomes anomalous and disproportionate”. He noted that many traditional authorities did not use the language of avoidance, but referred to “forfeiture”. Accordingly, he suggested that the appropriate remedy for fraud was forfeiture of the claim.

**Applying The Star Sea**

Subsequent cases have attempted to apply these principles, which has not been an easy task.

In *The Aegeon (No 1) (Agapitos v Agnew (No 1) (The Aegeon) [2002] EWCA Civ 247, [2003] QB 556)* Lord Justice Mance tentatively suggested that section 17 did not apply to fraudulent claims. He thought that a solution to the “present imperfect state of the law” would be to:
Treat the common law rules governing the making of a fraudulent claim (including the use of fraudulent devices) as falling outside the scope of section 17 ... On this basis no question of avoidance *ab initio* would arise).

He argued that the common law provides a separate rule that the appropriate remedy for fraud is forfeiture of the claim.

Academics and textbook writers have also struggled to make sense of the current law. MacGillivray takes the view that there are “two separate principles of insurance law, each of which can be invoked in defence by the insurer” (*MacGillivray on Insurance Law* (12th ed 2013), para 20-057). Thus, the common law rule referred to by Lord Justice Mance exists side by side with the remedy of avoidance under section 17. The insurer can choose which to pursue (This is evident in a subsequent judgment of Lord Justice Mance in which he refers to the common law principle having a separate origin and existence to any principle which exists under section 17. See *Axa General Insurance Ltd v Gottlieb* [2005] EWCA Civ 112, [2005] 1 All ER (Comm) 445 at [20]).

By contrast, Professor Clarke considers there to be a single doctrine: the fraudulent claim fails entirely and the insurer may terminate the contract. Past outstanding honest claims remain enforceable, however, and the insurer cannot recover insurance money paid out in respect of other claims (M A Clarke, *The Law of Insurance Contracts* (5th ed 2006), para 27-2C3).

*Axa v Gottlieb*: the insurer may not recoup previous claims

The case of *Axa General Insurance Ltd v Gottlieb* ([2005] EWCA Civ 112, [2005] 1 All ER (Comm) 445) lends support to Professor Clarke’s view. Lord Justice Mance again explained that the rule against fraudulent insurance claims was a special common law rule, distinct from section 17. Under the rule, the appropriate remedy was “to forfeit the whole of the claim to which the fraud relates”. It did not affect prior separate claims settled under the policy before the fraud occurred. He did not reach a conclusion on whether the insurer would be obliged to pay separate claims which were still unpaid at the time of the fraud. However, he saw some force in the argument that forfeiture should be confined to the fraudulent claim – although it is worth noticing that this was a consumer claim where the sums were relatively small and the policyholder less sophisticated.

**THE EFFECT OF FRAUD ON SUBSEQUENT CLAIMS**
In spite of section 17, the prevailing approach seems to be to apply the common law remedy of forfeiture and to find that genuine claims made in relation to losses occurring before the fraud are valid.

A further question is the effect of fraud on a subsequent genuine claim. Suppose an insured householder fabricates some aspect of a water damage claim, but the house burns down during the investigation. Does the policyholder forfeit the subsequent valid claim? There are two possible approaches:

(1) The fraud is characterised as a breach of the contract, which gives the insurer the right to terminate cover. However, the policy continues to exist until termination, and any claim arising between the date of the fraud and the date of termination must be paid.

(2) The presentation of the fraudulent claim automatically brings the contract to an end, invalidating any claim which arises after the fraud but before the fraud is discovered.

There is no definitive ruling on the issue. However, some judicial statements suggest that the first view is favoured. Normal contractual rules apply. On this basis, the fraud amounts to a repudiatory breach of contract, permitting the insurer to terminate the contract. The contract continues, however, until the insurer has exercised its right to terminate. In *Axa General Insurance Ltd v Gottlieb*, Lord Justice Mance put the point as follows:

There seems to me some force in the argument that the common law rule relation to fraudulent claims should be confined to the particular claim to which any fraud relates, while the potential might in some circumstances also require consideration [2005] EWCA Civ 112, [2005] 1 All ER (Comm) 445 at [22]).

In *Fargnoli v GA Bonus Plc*, Lord Penrose made a similar observation. He said that fraud would amount to a repudiatory breach of the contract, entitling the insurer to rescind in accordance with general contract principles. He added, however, that:

Rescission does not absolve parties from primary obligations already due for performance at the time of rescission (1997 SCLR 12 at 22. Rescission is the standard Scots law term for termination of a contract for material breach. Rescission in Scots law is, generally, prospective

**CAN THE INSURER SUE FOR DAMAGES?**

Generally, no claims for damages may be made. This was confirmed by *London Assurance v Clare* ([1937] 57 Li L Rep 254 by Goddard J at 270), which held that the cost of investigation is not recoverable under an implied term not to commit fraud.

It remains open to an insurer, however, to argue that it is entitled to claim damages for deceit following a fraudulent claim. In *Insurance Corporation of the Channel Islands Ltd v McHugh* ([1997] LRLR 94), allegations of deceit were pleaded by the insurers but not pursued at trail. If they had been, Mr Justice Mance noted that an action for deceit might have been arguable in principle.

**EXPRESS TERMS IN CONTRACT**

Many insurance policies include express terms setting out the consequences of fraud and the courts are usually willing to enforce such terms (for example, *Joseph Fielding Properties (Blackpool) Ltd v Aviva Insurance Ltd* [2010] EWHC 2192, [2011] Lloyd’s Rep IR 238). Indeed, it has been held that since fraud clauses are common, there is no need to bring the clause to the insured’s specific attention (*Nsubuga v Commercial Union Assurance Co Plc* [1998] 2 Lloyd’s Rep 682 at 686). That said, the clause must be clear and unambiguous (*Fargnolo v GA Bonus Plc* 1997 SCLR 12, [1997] CLC 753).

In consumer insurance contracts, a fraud clause is subject to the Unfair Terms in Consumer Contracts Regulations 1999. Consumers also have recourse to the Financial Ombudsman Service (FOS). In its consultation response, the FOS said it took broadly the same approach as we are recommending:

We agree that those who commit fraud should forfeit the whole claim to which the fraud relates and any claim where the loss arises after the date of the fraud – although previous claims should remain valid. This mirrors our current approach to the issue (see also the FOS guidance on how it deals with fraudulent claims: *Ombudsman News*, Issue 21, October 2002).

This means that while a clause permitting an insurer to avoid the whole contract can apply in non-consumer insurance, it may be more difficult to apply such a clause against the consumer.
Excluding liability for fraud

In the unlikely event that an insurer agreed to a clause which excluded the policyholder’s liability for fraud, the courts have held that it would not be valid for public policy reasons (*HIH Casualty & General Insurance v Chase Manhattan Bank* [2003] 1 All ER (Comm) 349). In Scots law, parties may not, by virtue of contractual terms, exclude liability for fraud; see *The Laws of Scotland (Stair Memorial Encyclopaedia)*, Obligations (Volume 15), para 683).

LATE PAYMENT

Under the law in England and Wales, an insured who has suffered losses because their insurer has wrongly refused to pay or has delayed paying a valid insurance claim is not entitled to damages (*Sprung v Royal Insurance (UK) Ltd* [1999] 1 Lloyds Rep IP 111). The prohibition against damages for late payment does not apply to non-indemnity insurance such as life insurance, or where the insurer has agreed to reinstate the property.

LIFE INSURANCE

A contract of life insurance is a contract for the payment of a fixed or ascertainable sum of money upon another contingency, namely the death of a particular individual or the happening of another contingency dependent on the duration of a human life. It is to be contrasted with an indemnity policy where the obligation on the insurer is to pay a sum equal to the loss actually suffered (*Dalby v India & London Life Asce* (1854) 15 C.B. 365; and *Feasey v Sun Life Assurance Co of Canada* [2003] EWCA Civ 885, cf. *Gerling Konzern v Polygram* [1998] 2 Lloyd's Rep. 544 at 550-551).

No insurance may be made on the life of any person unless the person for whose use or benefit or on whose account the contract is made has an interest in that life (s.l of the Life Assurance Act 1774 ("the LAA ").

The interest must exist at the time the contract is entered into but it is not necessary for it to continue until the time of death (*Dalby v India & London Life Asce* (1854) 15 C.B. 365, *Law v London Indisputable Life Policy* (1855) 1 K.&J. 223). It is presumed that an individual has an unlimited interest in his/her own life and that spouses have an unlimited interest in the life of each other (*Griffiths v Fleming* [1909]
In other instances insurable interest will have to be proved. A pecuniary liability recognised by law which arises on the death of the life insured is likely to be sufficient. Precisely what short of that will suffice remains unclear following the Court of Appeal decision in *Feasey*. If no insurable interest can be proved, the contract is illegal and premiums paid under it are irrecoverable (*Harse v Pearl Life Assurance* [1904] 1 K.B. 558, *London County Commercial Re-Insurance Office, Re* [1922] 2 Ch. 67).

The policy containing the terms of the contract must contain the name of the person(s) interested in it or for whose use or benefit or on whose account the contract was made (s.2 of the LAA), although it is sufficient if the description is of a specific class of persons. Further, the insured cannot recover more than his interest in the life insured at the moment of making the contract (s.3 of the LAA) although if the interest is unlimited s.3 of the LAA is of no practical significance.

The liability to pay generally crystallises upon proof of death to the satisfaction of the insurer within the terms of the relevant contract. Proof normally requires at the least provision of a death certificate although there can be instances where no death certificate is available. The personal representative of someone who has insured his own life can claim against the insurer as can an assignee and a trustee in bankruptcy. Indeed, the simplest of the insurance (own-life cover) is a covenant to pay the insured’s executors, administrators or assigns.

There will be no liability to pay where the death occurs in a manner excluded from cover by the terms of the contract, for example by suicide or by participation in proscribed activities such as dangerous sports (*Scragg v UK Temperance & General Provident* [1976] 2 L.L.R. 227). An assignee of a life policy can be in no better position than the insured. Thus where a policy of life insurance was proved to have been procured by fraud, the assignee’s claim for payment failed: *Patel v Windsor Life Assurance Co Ltd* [2008] EWHC 76 (Comm).

Similarly (and as in other types of insurance) the non-disclosure or misrepresentation of a material fact known to the assured may vitiate the contract. In life insurance where the insured insures his own life the position is straightforward: he must disclose that which he knows (*Winter v Irish Life Assc*ce [1995] 2 L.L.R. 274). Where the insured insures the life of another and the insurer seeks a declaration from that other, the position is more complex. A false statement will not be attributed to the insured unless the person making the declaration does so as the agent of the insured.
Since the adoption by the industry in this country of the Association of British Insurers’ Statement of Long-Term Insurance Practice, whether or not the insurer will seek to enforce any right to avoid the contract or to rely on a breach of warranty is likely to depend on the terms of that Statement, whose effect is, in broad terms, to limit the circumstances in which such defences can be run by insurers (see, in particular, paragraphs 3.1 and 3.2. of the Statement).

An insured cannot benefit from a life insurance on another if the person whose life was insured has been murdered by the insured because a person cannot benefit from his own crime (Cleaver v Mutual Reserve Fund Life Assoc [1892] 1 Q.B. 147 and the Forfeiture Act 1982). For examples of the exercise of the discretion under s.2 of the Forfeiture Act 1982 in connection with life policies see S (Deceased), Re [1996] I W.L.R. 235 and Dunbar v Plant [1998] Ch. 412.

**Insurance contracts: disclosure**

The duty of utmost good faith is particular to contracts of insurance and reinsurance and is discussed in detail in a separate entry Insurance contracts: good faith. One aspect of this duty is the requirement that a business assured disclose relevant information to the insurer prior to the contract being entered into.

**Commercial insurance:** For contracts agreed on or before 12 August 2016, this obligation is codified in s.18 of the Marine Insurance Act 1906 (the "MIA"). This provides that an assured must disclose to the insurer, before the contract is concluded, every material circumstance which is known to the assured. Section 19 MIA imposes a similar duty on the agent affecting insurance. If the duty of disclosure is not observed by the assured (or its agent), the insurer is, subject to certain restrictions which are discussed below, entitled to avoid the contract from inception.

For contracts agreed on or after 12 August 2016, the Insurance Act 2015 ("IA15") applies. Under s.3(1) IA15 the assured is required to make to the insurer "a fair presentation of the risk". Under s.3(4) this duty will be satisfied by the disclosure of every material circumstance which the insured knows or ought to know, or, failing that, disclosure which gives the insurer sufficient information to put the insurer on notice that it needs to make further enquiries for the purpose of revealing those material circumstances. In contrast to the MIA, there is not one single remedy of avoidance should the duty be breached. If the breach of duty was deliberate or reckless, the insurer may still avoid the contract and keep the premium whatever it would have done in the event of a fair presentation. If the breach was innocent or negligent, however, there is a system of graduated remedies based on what the insurer would have done had a fair presentation been made.
Consumer Insurance: Since the coming into force of the Consumer Insurance (Disclosure and Representations) Act 2012 on 6 April 2013, consumer assureds no longer have an obligation to volunteer information. Instead, the applicant for consumer insurance has a statutory duty to take reasonable care not to make a misrepresentation.

Sections 18 and 19 of the MIA set out the duty of disclosure imposed upon the business assured and the business assured's agent (usually his insurance broker) during negotiations for an insurance contract up to the point at which the contract is made. The principal elements of the duty of disclosure are contained in s.18(1) MIA which provides that, subject to certain exceptions:

"the assured must disclose to the insurer, before the contract is concluded, every material circumstance which is known to the assured, and the assured is deemed to know every circumstance which, in the ordinary course of business, ought to be known by him..."

Section 19 MIA imposes an equivalent duty on the business assured's agent requiring the insurance/broker to disclose material information known to it. The duty of disclosure under both ss.18 and 19 MIA is strict and the assured may be in breach of duty even if he does not intend to mislead the insurer by his non-disclosure and is not negligent. The duty is breached even where the assured or his broker has acted innocently (see Hazel (for Lloyd's Syndicate 260) v Whitlam [2004] EWCA Civ 1600; [2005] Lloyd's Rep. I.R. 168).

Section 20 MIA imposes a duty on the business assured not to misrepresent material information to the insurer during the negotiation for the insurance. The distinction between a non-disclosure and a positive misrepresentation has been described as "imperceptible" (Pan Atlantic Insurance Co Ltd v Pine Top Insurance Co Ltd [1995] 1 A.C. 501. Whilst in general mere silence will not be enough to assert that an assured has misrepresented something (see HIH Casualty & General Insurance Ltd v Chase Manhattan Bank [2003] UKHL 6; [2003] 1 All E.R. (Comm) 349) an omission to speak could amount to a misrepresentation in certain circumstances. For example, a non-disclosure coupled with an otherwise truthful representation could constitute a misrepresentation (see Perrins v The Marine and General Travellers' Insurance Society 121 E.R. 119). Second, whilst the representation might be true at the time it is made, if it becomes untrue between that time and the making of the contract and the insurer is not told, the representation will become a misrepresentation (St Paul Fire & Marine Insurance Co (UK) Ltd v McConnell Dowell Constructors Ltd [1996] 1 All E.R. 96.
The duty of disclosure contains a number of separate elements. Thus it requires the disclosure "before the contract is concluded" of "circumstances", which are "material" and which are "known to the insured". We discuss these various elements further below.

Circumstance: For the purposes of the assured's duty of disclosure, a "circumstance" may be anything relating to the characteristics or history of the risk to be insured. This will include obviously relevant material relating to the nature of the risk and previous claims experience. In appropriate circumstances, it may also include information concerning the assured’s intentions as to the subject matter of the insurance, or even rumours or allegations going to the "moral hazard" of the assured (s.18(5) MIA).

"Materiality": A circumstance is material if it "would influence the judgment of a prudent insurer in fixing the premium, or determining whether he will take the risk" - s.18(2) MIA. Whether a particular circumstance satisfies this test is a question of fact which is to be judged objectively, from the point of view of a reasonably prudent underwriter. The assured (and its broker) must therefore make an assessment of what circumstances a "prudent insurer" would consider material to the risk. Since the risk of non-disclosure lies with the assured, he would be well advised to err on the side of generosity in his presentation to underwriters; it is important to note, however, that the assured is also under an obligation to make a "fair presentation" of the risk and should be careful, therefore, not to overwhelm the insurers with irrelevant information from which they may have difficulty extracting the material data.

The leading case on the meaning of materiality in the context of the MIA is Pan Atlantic Insurance Co Ltd v Pine Top Insurance Co Ltd [1995] 1 A.C. 501. In this case the House of Lords set two hurdles that an insurer must overcome if he is to establish that a circumstance or misrepresentation was "material".

Objective Materiality: The first hurdle is an objective test as to what a hypothetical "prudent underwriter" would want to know. The test was expressed in Pine Top as being whether a circumstance would have "an effect on the thought processes of the insurer in weighing up the risk" (at 531). This does not, however, mean that the circumstance must be of "decisive influence" in the sense that it would have to affect the decision of the prudent underwriter as to whether or not he would take the risk or as to the level of the premium. This test was refined in St Paul Fire & Marine Insurance Co (UK) Ltd v McConnell Dowell Constructors Ltd [1996] 1 All
E.R. 96 to the simpler formulation: "the prudent underwriter would have appreciated that it was a different ... risk". In practice, courts (and most arbitral tribunals) will need expert evidence as to what a "prudent insurer" would consider material (Commonwealth Insurance Co. of Vancouver v Groupe Sprinks SA [1983] 1 Lloyd's Rep. 67) since it will vary with the class of business and the particular nature of the risk to be insured.

Subjective Inducement: In Pine Top, the House of Lords also introduced a second, subjective, hurdle which an insurer must overcome if it is to avoid an insurance on the basis of a breach by the assured of its disclosure obligations at placement. Once a circumstance is held to be objectively material, the insurer can only avoid the policy if he can prove that the misrepresentation or non-disclosure in question in fact induced the actual insurer to write the risk on the terms that he did; this has become known as the "actual inducement" test. If, therefore, the underwriter who wrote the risk was not influenced by the misrepresentation or non-disclosure, then the contract cannot be avoided: even if the hypothetical prudent underwriter's judgement might have been affected by the particular circumstance. To amount to inducement, the Court of Appeal has stated that the circumstance must make an "effective" contribution to the underwriter's decision to write the risk on the terms agreed. It need not, however, be the dominant or sole cause of that decision (see Assicurazioni Generali SpA v Arab Insurance Group (BSC) [2002] EWCA Civ 1642, where the Court of Appeal held that the underwriter must "show at least that, but for the relevant non-disclosure or misrepresentation, he would not have entered into the contract on those terms. On the other hand, he does not have to show that it was the sole effective cause of his doing so").

In Pan Atlantic, Lord Mustill expressed the view that once a circumstance is proved to be material, the court will make a rebuttable presumption that the misrepresentation or non-disclosure in question did induce the actual underwriter to enter the contract on the relevant terms. This presumption has been applied on several occasions and was discussed in Marc Rich & Co AG v Portman [1997] 1 Lloyd's Rep. 225. In that case, the court held that a presumption would arise only where, first, the actual underwriter was not available to give evidence and, second, there was no reason to assume that he acted other than prudently in writing the risk. Where the actual underwriter does give evidence, then the presumption will not apply and the burden of proving inducement will remain on the insurer. The suggestion that a court ought to look at an underwriter's previous underwriting practice in ascertaining whether the underwriter was in fact induced was rejected by the court. The decision was upheld by the Court of Appeal.
Knowledge: What is "Known to the Assured"? Knowledge for these purposes can be of three types:

- actual knowledge;
- imputed knowledge; or
- constructive knowledge.

An assured will have "actual knowledge" of a "material circumstance" for the purpose of the Act if he knows the fact or circumstance: regardless of whether or not he appreciates that the circumstance is material. If that material circumstance is not disclosed to the insurer, the assured will be in breach (see Joel v Law Union & Crown Insurance Co [1908] 2 K.B. 863). An assured will also be held to have "actual knowledge" of a material fact or circumstance where he wilfully shuts his eyes to the fact in order to avoid actually knowing it (so called Nelsonian blindness: see Manifest Shipping Co Ltd v Uni-Polaris Insurance Co Ltd (The Star Sea) [1997] 1 Lloyd's Rep. 360, a decision of the House of Lords). Further, for the purpose of insurance, a fact will be known to an assured company if it is known by the "directing mind and will" of that company (see The Star Sea): this will usually be the senior managers and the insurance buyer of the company.

A corporate assured will have imputed to it the knowledge of certain categories of individuals within the company who have knowledge of the subject matter of the insurance. This is a complex area and whilst the knowledge of a junior employee will not usually be deemed to be known to the assured (Australia & New Zealand Bank Ltd v Colonial & Eagle Wharves Ltd [1960] 2 Lloyd's Rep. 241) the persons in a company whose knowledge will be imputed to the assured is a question of fact and will vary in each case (see the general principles of corporate attribution set out in Meridian Global Funds Management Asia Ltd v Securities Commission [1995] 2 A.C. 500). Where a fact is known by an agent of the assured, then that knowledge will usually be imputed to the assured (see Simner v New India Assurance Co Ltd [1995] L.R.L.R. 240). Where, however, the knowledge concerns an agent's own fraud against his or her principal (see Arab Bank Plc v Zurich Insurance Co [1999] 1 Lloyd's Rep. 262), then that knowledge will not be imputed to the assured so that he does not have to disclose that fraud to the insurer when he does not know of it.
Finally, the assured can be held to have constructive knowledge of a circumstance. Section 18(1) of the MIA (see s.19 for the equivalent provision with regard to brokers) states "...the assured is deemed to know every circumstance which, in the ordinary course of business, ought to be known by him...". Whilst the general principle is that this does not require an assured to make enquiries or investigations as to facts outside his knowledge (Simner v New India Assurance Co Ltd [1995] L.R.L.R. 240), the key issue is what precisely falls within "the ordinary course of business" and this will be a question of fact in each case. It is clear that a consumer assured is not fixed with any knowledge "in the ordinary course of business" (see Economides v Commercial Union Assurance Co Plc [1998] Q.B. 587).

Section 19: The Broker's Duty: An insurance broker negotiating cover on behalf of his principal, the intended assured, owes a personal and independent duty of disclosure under the MIA (see s.19). Where the assured appoints a broker (a "producing broker") who then subcontracts the duty of placing the insurance to a sub-broker (a "placing broker"), it is the placing broker who will usually be subject to the duties in s.19 (see further PCW Syndicates v PCW Reinsurers [1996] 1 W.L.R. 1136; Group Josi Re Co SA v Walbrook Insurance Co Ltd [1996] 1 W.L.R. 1152). It may be, however, that material circumstances known by the producing broker would fall within the placing broker's deemed knowledge under s.19(a): this would be decided on a case by case basis.

Time: "Before the Contract is Concluded": A contract is concluded when offer and acceptance coincide. In most markets the time will vary according to circumstance but need not coincide with the date the policy is issued or the date of inception of cover. Insurance in a subscription market such as Lloyd's presents its own issues since each subscribing underwriter contracts separately with the insured and usually at different times. The duty of disclosure applies to each separate underwriter on a subscription slip and if a material circumstance comes to the attention of the assured or his broker in between one insurer contracting and the next, that material fact must be disclosed to the second underwriter (though it will not affect the contract with the first).

After the contract is made, further material circumstances need only be disclosed to the underwriters where further information is required for a relevant underwriting decision: e.g. where there is an endorsement or variation of the contract of insurance. An argument that the duty of disclosure will exist throughout the policy because the underwriter has a right of

Exceptions to the Duty of Disclosure: Certain exceptions to the assured's duty of disclosure are listed at s.18(3) of the MIA and are all subject to the key qualification: "in the absence of enquiry [by the insurer]". If the insurer has, therefore, asked about the relevant information within these categories then the assured will not be able to rely on the four exceptions to excuse a failure to disclose that information.

Circumstances that diminish the risk need not be disclosed. Whether or not a circumstance does in fact diminish the risk is a question of fact for the court (Inversiones Manria SA v Sphere Drake Insurance Co, Malvern Insurance Co and Niagara Fire Insurance Co (The Dora) [1989] 1 Lloyd's Rep. 69).

The assured need not disclose a circumstance which is "known or presumed to be known to the insurer". An insurer is "presumed to know matters of common notoriety or knowledge, and matters which an insurer in the ordinary course of his business, as such, ought to know". This begs the question of what an insurer ought to know. In Sea Glory Maritime Co v Al Sagr National Insurance Co (The Nancy) [2013] EWHC 2116 (Comm); [2013] 2 All E.R. (Comm) 913 the Commercial Court concluded that the availability of online (database) information did not necessarily give rise to a presumption of knowledge on the part of an insurer which did not subscribe to that database.

Information known by one branch of an insurer will not always be held to be known by another (Gunns v Par Insurance Brokers [1997] 1 Lloyd's Rep. 173) and the knowledge in question must reasonably have been present in the insurer’s mind at the time of the presentation of the risk (Mahli v Abbey Life Assurance Co Ltd [1996] L.R.L.R. 237).

An assured has no need to disclose any circumstance "as to which information is waived by the insurer". The waiver may be express or implied. An implied waiver might take the form of limited express questions by the insurer which exclude facts that might otherwise be material to him (see O'Kane v Jones (The Martin P) [2003] EWHC 3470 (Comm); [2004] 1 Lloyd's Rep. 389). Alternatively, an assured might provide a summary of the material facts, putting the insurer reasonably on notice of the possible existence of further material facts. If the insurer fails to ask for that further information this might amount to a waiver.
The key issue in these circumstances is whether the summary amounts to a "fair presentation of the risk".

Finally, any fact or circumstance which is the subject of a warranty in the insurance contract does not need to be disclosed, presumably on the rationale that since the breach of a warranty will discharge the insurer from liability under the policy from the moment of the breach, the lack of disclosure is unimportant.

Crucially, however, these exceptions to the duty of disclosure do not apply to active misrepresentations on the part of the assured during the placement of the risk.

Contracting Out: The assured and insurer may agree to contract out of or limit the assured's duty under the MIA to disclose material information. The permissible limits on clauses designed to vary the duty of disclosure or limit the insurer's remedy for breach were considered in two cases which arose out of the insurance of film financing arrangements: HIH Casualty & General Insurance Ltd v New Hampshire Insurance Co Ltd [2006] EWHC 1285 (Comm) (a decision of the Court of Appeal) and HIH Casualty & General Insurance Ltd v Chase Manhattan Bank [2003] UKHL 6; [2003] 1 All E.R. (Comm) 349 (a decision of the House of Lords). In the latter case, the Lords held that while an appropriately worded clause might exclude the consequences of innocent or negligent misrepresentation or non-disclosure, as a matter of public policy, a clause could not protect the assured from the consequences of its own fraudulent non-disclosure or misrepresentation.

The Remedy: Section 17 MIA states that if either party fails to observe utmost good faith, the other party may "avoid" the insurance contract from inception. In this context, "avoidance" means that the two parties are placed in the same position that they would have been in had the contract not existed. As a result, all premium paid is refunded to the assured and any previous paid claims are refunded to the underwriter. The only exception is in the case of a fraudulent misrepresentation or non-disclosure where the premium is not refunded to the assured. Avoidance is an all-or-nothing remedy and damages are not available for a breach of the duty of disclosure. The right to avoid is exercised by election and can be lost if the insurer, with knowledge of the breach, affirms the contract. For example, where the underwriter has actual (not constructive) knowledge of facts giving rise to the right to avoid and conducts himself in a way that unequivocally communicates to the assured that the contract remains in force (by,
for example, relying on a contract term accepting premium or a paying a claim), then this may amount to an affirmation of the contract. Mere silence, however, (even for an extended period of time) will not usually amount to an unequivocal communication.

Where a policy names more than one assured, it is necessary to distinguish between "joint" and "composite" policies. Joint policies insure two or more assureds whose interests are "inseparably connected so that a loss or gain necessarily affects" all the co-assureds in the same way (General Accident Fire and Life Assurance Corp Ltd v Midland Bank Ltd [1940] 2 K.B. 388): e.g. partners in a partnership. By contrast, composite policies insure the separate interests of more than one assured. Under a composite policy, a separate contract is entered into between the underwriter and each assured: for example, the owner and mortgagees of property or landlords and tenants. If the duty of disclosure is breached by an assured in a joint policy, then the underwriter can avoid the policy vis-à-vis all the assureds. If, however, the policy is composite, then the underwriter will only be able to avoid the contract vis-à-vis the party that breached the duty. One important caveat to this is that if the non-disclosure is made by an assured acting on behalf of the other assureds then the underwriter will be able to avoid the policy as against all the parties because the non-disclosure was effected by their agent (s.19 MIA).

The meaning of fraud

To defeat claims on grounds of fraud, insurers must show them to be 'wilfully false' in a 'substantial respect' (Britton v Royal Ins Co (1866) 4 F & F 905). Claims are wilfully false if the claimant knows that it is false, does not believe it to be true or makes it recklessly, not caring whether it is true or false (Lek v Mathews (1927) 29 LL L Rep 141, 145, HL), i.e. a case of common law fraud (Twinsectra Ltd v Yardley [2002] UKHL 12, [2002] 2 AC 164). Prima facie deliberate exaggeration is fraud; some cases suggest that exaggeration is not fraud but merely a bargaining position (Nsubuga v Commercial Union Assurance Co plc [1998] 2 Lloyd’s Rep 682, however, the balance of precedent confirms that it is fraud (Orakpo v Barclays Insurance Services [1995] LRLR 443, CA). Nonetheless, claimants usually get the benefit of any reasonable doubt. After all, claimants are human, ‘different views of values are common; memory is faulty’ (Soler v United Firemen’s Ins Co 299 US 45, 50 (1936)).

Whether a falsehood is substantial depends on the de minimis rule. More significant is the associated requirement that the falsehood be material. Until 2002 falsehood was not material unless it had a decisive effect on the readiness of the insurer to pay – whether to pay and to whom, or the amount
to be paid, thus, false evidence submitted to bolster a claim otherwise valid was not material (The Mercandian Continent [2001] EWCA Civ 1275; [2001] 2 Lloyd’s Rep 563, [35]).

The consequences of fraud

If fraud is discovered after a claim has been paid, insurers may recover the money as money paid by mistake. If fraud is established before any or all of the insurance money has been paid, insurers are not obliged to pay any of the amount claimed, even a genuine but exaggerated claim: courts apply the maxim fraus omnia corrumpit to discourage dishonesty (Galloway v Guardian Royal Exchange (UK) Ltd [1999] Lloyd’s Rep IR 209, CA). Further, insurers are usually entitled to terminate insurance contracts under a policy provision. Anyway, fraud being a breach of the duty of good faith, insurers are entitled to terminate by law (Orakpo, n 348)

THE UNIQUE POSITION UNDER INSURANCE CONTRACT LAW IN ENGLAND AND WALES

The “hold harmless” principle and insurance monies as damages

In England and Wales, by virtue of a legal fiction, a policyholder under an insurance contract is not able to claim, damages from an insurer who causes further loss as a result of wrongful, late or non-payment of an insurance claim. This is because the insurer’s obligation under a contract of indemnity insurance is not, as one may expect, to pay insurance claims in return for payment of the contract is underpinned by the legal fiction that an insurer’s primary obligation is to “hold the indemnified person harmless against a specified loss or expense”; that is, to prevent the event which is insured against from happening (Firma C-Trafe SA v Newcastle Protection and Indemnity Association (The Fanti); Secony Mobil Oil Inc v West of England Shipowners Mutual Insurance Association (The Padre Island) [1991] 2 AC 1 by Lord Goff at 35).

In other words, an insurer’s fundamental obligation is not to pay claims but to prevent the loss occurring in the first place. English law therefore regards an insurance contract as analogous to a contract with a security firm, in which the security firm undertakes to prevent a break-in. This is a surprising position. It is worth noting that the “hold harmless” analysis has not been applied to life insurance (Blackley v National Mutual Life Association Ltd (No 2) [1973] 1 NZLR 668, in which a claim was treated as a contract debt and the usual rules of contract law applied), or to the policies which provide for reinstatement (that is, repair or replacement of property) or where reinstatement is
selected as an alternative to financial compensation (see discussion in Part 5 of IP6. See also Colinvaux’s Law of Insurance (9th ed 2012) at 10-44, which refers to Ferruzzi France SA v Oceania Maritime Inc (The Palmea) [1988] 2 Lloyd’s Rep 261).

Importantly, in the case of most insurance policies, the “hold harmless” principle means that the law regards insurance payments not as debts due under the contract, but as damages for breach of contract. The significance of this analysis is that, while a claim can be made for damages for late payment of a debt (Sempra Metals (formerly Metalgesellschaft Limited) v Commissioners of Inland Revenue [2007] UKHL 34, [2008] 1 AC 561), English law does not recognise a claim for damages for the late payment of damages (The President of India v Lips Maritime Corporation (The Lips) [1988] AC 395, by Lord Brandon at 425). A policyholder therefore cannot claim damages for non-payment of insurance monies due (Apostolos Konstantine Ventouris v Trevor Rex Mountain (The Italia Express (No 3) [1992] 2 Lloyd’s Rep 281).

An illustration: the unenviable position of Mr Sprung

In Sprung v Royal Insurance (UK) Ltd ([1999] 1 Lloyd’s Rep IR 111), Mr Sprung owned a small family business that processed animal waste. He bought insurance to protect his factory against theft and “sudden and unforeseen damage”. When vandals broke into his premises, both his factory and his plant were badly damaged. Mr Sprung submitted a claim to his insurer under the policies, and his claim was rejected.

Mr Sprung’s insurers contended that no theft had occurred and that the policies did not provide cover for “wilful damage”. In difficult economic conditions, Mr Sprung lacked the finance to carry out repairs, and he was unable to raise a loan. Six months later he was out of business.

Mr Sprung started proceedings against his insurers. Four years later, the insurers abandoned their defence, and Mr Sprung was awarded an indemnity for his lost plant and machinery, plus simple interest and costs. The judge found that the claim should have been paid four years earlier. As a result of the insurer’s failure, Mr Sprung suffered a further loss of £75,000 on top of his initial insurance claim.
Mr Sprung was not, however, entitled to claim this further loss. The Court of Appeal with “undisguised reluctance”, considered itself bound by the principle that there could be no award for damages for late payment because there can be no damages on damages ([1999] 1 Lloyd’s Rep IR 118).

Lord Justice Beldam felt that indemnity plus simple interest was inadequate to compensate Mr Sprung or an insured in his position, and called for reform of the law ([1999] 1 Lloyd’s Rep IR 119).

In Sprung, Lord Justice Evans suggested that if the insurer could be found to have breached a separate obligation, then a claim for damages could arise (Sprung v Royal Insurance (UK) Ltd [1999] Lloyds Rep IP 111 at 116). However, in the cases discussed the courts have felt bound to reject arguments in favour of awarding damages for loss caused by late payment. They have not been prepared to find that the precise wording of the contract creates a contractual obligation to pay (Normhurst Ltd v Domoch Ltd [2004] EWHC 567 (Comm). [2005] Lloyd’s Rep IP 27, in which the insurance policy made reference to the insurers’ liability to make payment), or that the insurer had an implied term to pay within a reasonable time (Insurance Corporation of the Channel Islands Ltd v McHugh [1997] 1 Lloyds Rep IR 94).

Even where an insurance policy appears to include an express term to pay claims promptly, the courts have felt unable to accept it. In Tonkin v UK Insurance Ltd, a household policy contained the following term:

We will always try to be fair and reasonable whenever you have need of the protection of this Police. We will also act quickly to provide that protection ([2006] 2 All ER (Comm) 550. [2006] EWHC 1120 (TCC) at [34]).

The policyholders argued that the insurers had breached this term and tried to claim damages. Citing Sprung, the judge said that a claim for damages for delay would effectively amount to damages on damages. The judge identified this as “just the sort of claim which the authorities noted above hold to be invalid” ([2006] 2 All ER (Comm) 550. [2006] EWHC 1120 (TCC) at [38]) and considered that the general principle of no damages on damages was binding on him despite the wording of the clause. However, the judge did note Lord Justice Evans’ suggestion ([2006] 2 All ER (Comm) 550. [2006] EWHC 1120 (TCC) at [39]) that breach of a separate contractual obligation might allow a claim for damages. On the facts, the judge determined that the insurers had not been responsible for the delay.
Lord Mance has since commented on *Tonkin* (Lord Donaldson memorial lecture, ‘The 1906 Act, common law and contract clauses – all in harmony?’ delivered by Lord Mance to mark the Centenary of the Joint Hull Committee, in the Old Library at Lloyd’s on 10 November 2010; published [2011] *Lloyd’s maritime and Commercial Law Quarterly* p 346). He suggested that whilst the policy wording in that case may have been “insufficiently clear”, a more explicit requirement on the insurer to pay within a set time might be enforceable as a separate contractual obligation (Such as that in clause 46.7 of the International Hull Clauses 2003 which gives the leading underwriter 28 days to make a decision on a claim).

Although there may be some lack of clarity around the edges, the High Court and Court of Appeal have generally felt bound by the decision in *Sprung*. However, in 2005, Lord Justice Rix considered that if the issue was reviewed by the House of Lords it “may well lead to some clarification and amendment of the law” (*Mandrake v Countrywide Assured Group* [2005] EWCA Civ 840 at [25]).

**LIFE INSURANCE AND REINSTATEMENT CASES**

There are two significant exceptions to the prohibition on claiming damages for the failure to pay an insurance claim.

The first is for non-indemnity insurance such as life insurance: claims under life insurance policies have been characterised as contract debts so that the normal rules of contract apply (*Blackley v National Mutual Life Assn Ltd (No 2)* [1973] NZLR 668).

Secondly, the rule does not apply where the insurer has undertaken to reinstate property. Insurance policies often allow insurers to choose between payment or “reinstatement” (that is, repairing or replacing the damaged property). If an insurer elects to reinstate, it acquires obligations in relation to the quality of that reinstatement which are similar to the general obligations on suppliers of goods and services. In particular, the insurer may face liability in damages for the foreseeable loss caused to a policyholder if it fails to reinstate the property within a reasonable time (See IP6, paras 5.29 to 5.35.)