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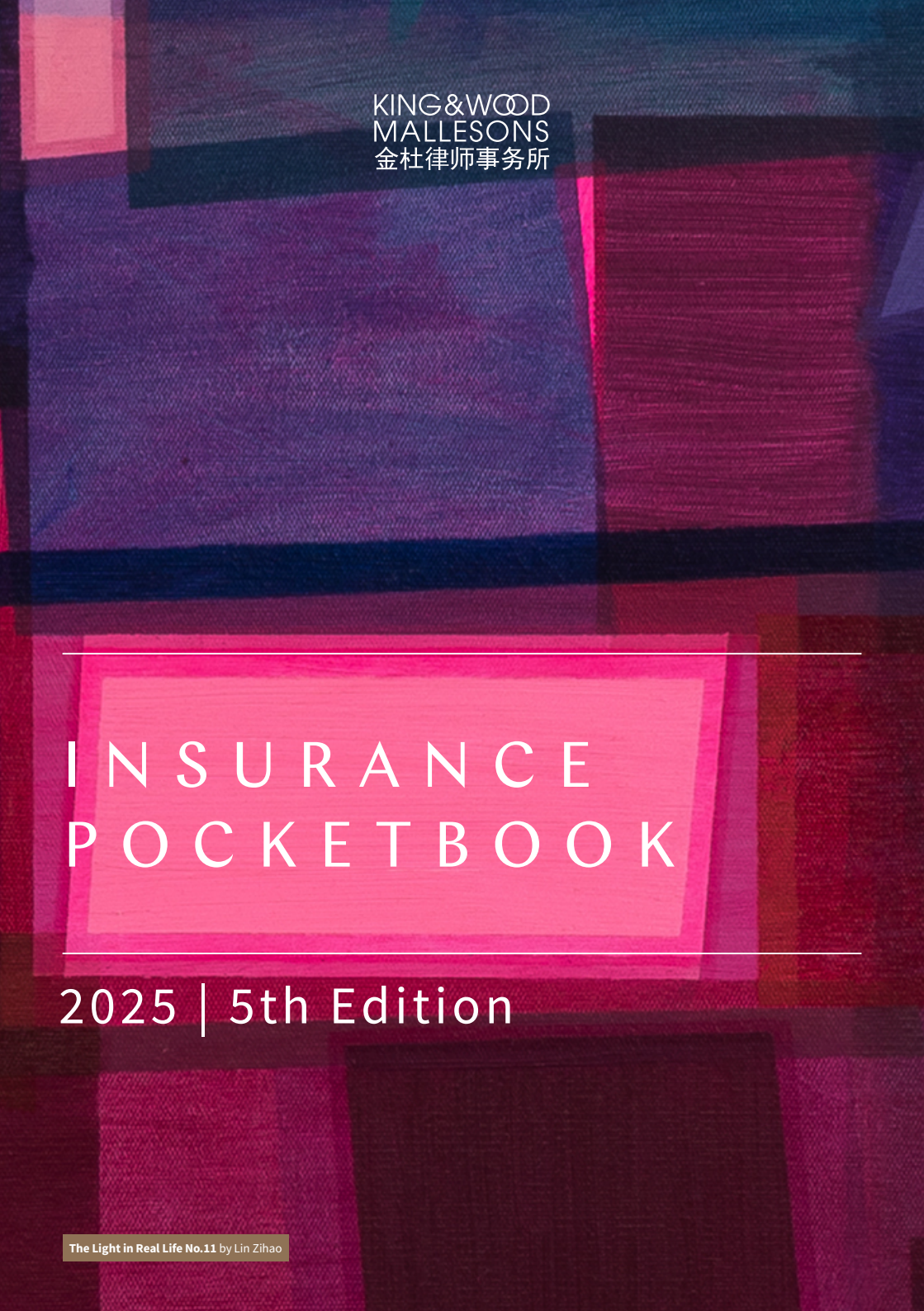
INSURANCE POCKETBOOK

2025 | 5th Edition



The Light in Real Life No.11 by Lin Zihao

FOREWORD

Australia has seen significant developments in the insurance sector over the last 12 months. These include regulatory matters such as DDO, FAR implementation, cases about good faith and unfair terms, enforcement trends in claims handling, renewal pricing and hardship, affordability of insurance and other impacts from extreme weather events.

In this edition you will find:

- Exclusive commentary on regulatory matters from Partner Mandy Tsang, as well as tips on navigating exclusions in warranty and indemnity insurance, and the emerging world of carbon credit insurance
- Exclusive interviews with:
  - Kerri Kohler-Saunders (Managing Principal, Pacific Cyber Practice at Marsh)
  - Professor Özlem Gürses (Professor of Commercial Law at the King's College London where she teaches insurance and reinsurance law)
- Short case notes on significant decisions from the past year and a spotlight on a handful of classic Australian insurance cases
- Our new column called 'Monument' which provides a snapshot on a historic issue in the insurance world, this year – fire marks!

HELPING YOU NAVIGATE THE INSURANCE LANDSCAPE

In the last year, we have engaged in thought leadership with the Life Insurance Council of Australia and Insurance Council of Australia. We have worked for insurers on significant transactions, product offerings and regulatory reform, and continued to advocate for policyholder clients regarding claims and underwriting of bespoke insurance products. Combined with our experience in warranty and indemnity claims, these experiences have provided us with a 360 degree view of the insurance market in Australia.

As a truly collaborative and cohesive full-service practice, acting for both policyholders and insurers, our team is at the coalface of these developments. In our fifth edition of the *Insurance Pocketbook*, we share some of our experience and insights into Australia's legislative and regulatory environment, and how the insurance sector is responding to these developments.

We are grateful to those who were involved in the production of this fifth edition, and also to our clients who are consistently encouraging of the publication. If anything in this *Insurance Pocketbook* is relevant to your business – please do not hesitate to contact a member of our team.

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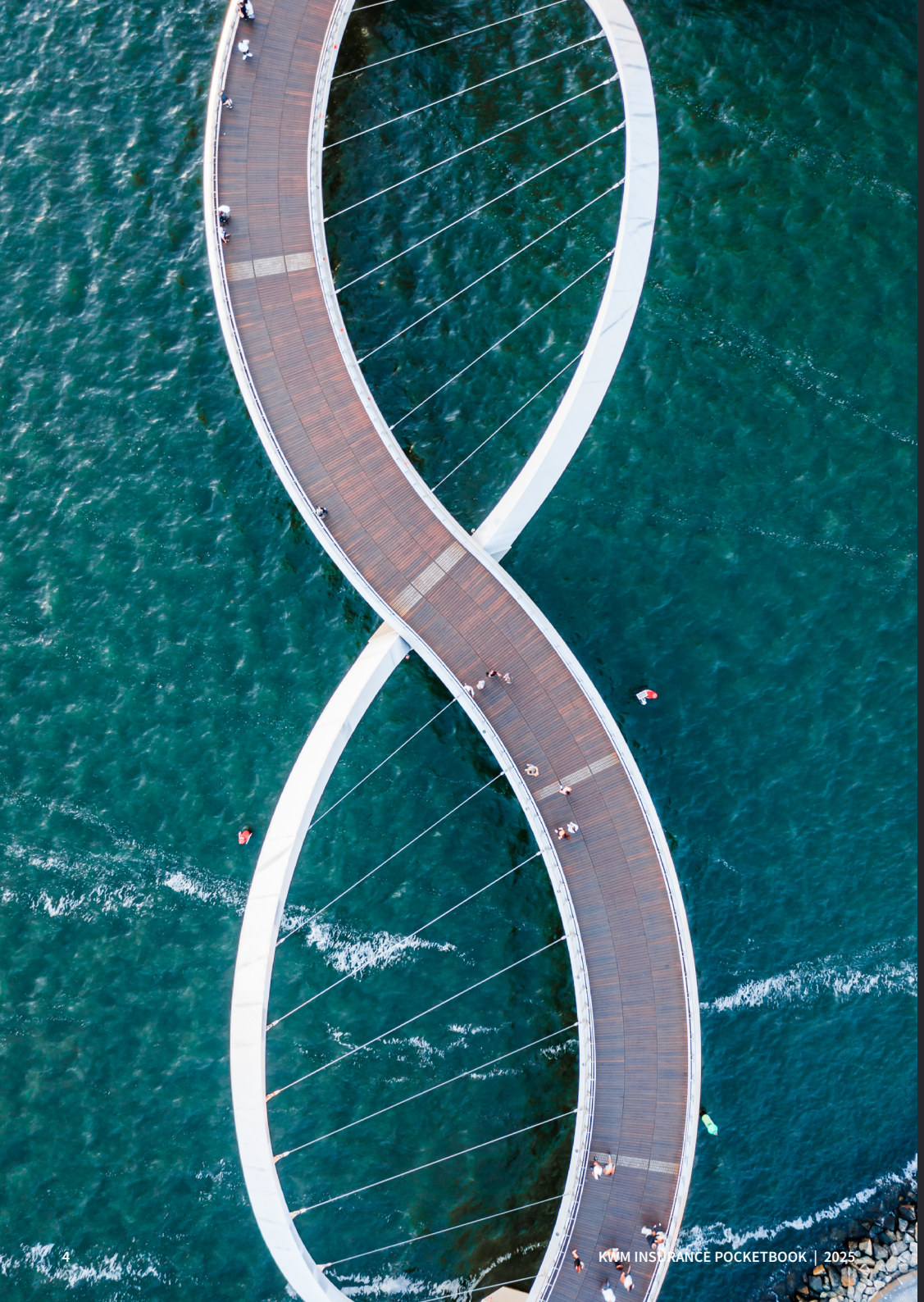

CONTENTS

ARTICLES & LEADERS

INTERVIEWS

CASE NOTES

MONUMENT

REGULATORY UPDATE

Introduction

As we look ahead to 2025, the insurance industry is gearing up for important changes, particularly with the Financial Accountability Regime (**FAR**) set to launch in March 2025. Both ASIC and APRA released their 2025 enforcement priorities, from claims handling misconduct to operational risk management. We explore what the regulators are sharpening their focus on below.

Overview / Timeline

11 July 2024
ASIC released 'Regulatory Guide RG 279 Financial Accountability Regime: Information for accountable entities'.

August 2024
APRA released its 2024-2025 Corporate Plan.

10 September 2024
ASIC released report 'REP 795 Design and distribution obligations: Compliance with the reasonable steps obligation'.

14 November 2024
ASIC Deputy Chair Sarah Court announced ASIC's 2025 enforcement priorities.

27 November 2024
ASIC-APRA released a joint letter: 'Observations from the implementation of the Financial Accountability Regime for the banking industry'.

15 March 2025
FAR Regime commences for insurance and superannuation industries.

1 July 2025
Prudential Standard CPS 230 Operational Risk Management commences.

Financial Accountability Regime (FAR)

The time has come, the *Financial Accountability Regime Act 2023* (Cth) (***FAR Act***) will commence for insurance entities, their licensed NOHCs and superannuation trustees from **15 March 2025.**

ASIC and APRA have released a joint information paper, 'Regulatory Guide Financial Accountability Regime: Information for accountable entities' (**RG 279**).[1] RG 279 aims to assist accountable entities and their accountable persons to understand and comply with their obligations under the *FAR Act*. It also provides an overview on how the Regulators will jointly administer the FAR and use their regulatory and enforcement powers.

ASIC and APRA also jointly released a letter on 27 November 2024, 'Observations from the implementation of the Financial Accountability Regime for the banking industry' (**Joint Letter**)[2] where they share observations on the registration and notification lodgements made by banking entities since the commencement of the FAR Act for the banking industry.

As the FAR approaches for insurers, key lessons from the banking sector's rollout are an important source of guidance. In their Joint Letter, ASIC and APRA have observed:

- possible gaps in the assignment and notification of prescribed responsibilities, including responsibilities associated with prescribed positions;
- possible gaps in the assignment and notification of accountable persons of significant related entities, and accountable persons with responsibility in respect of significant related entities;
- multiple accountable persons jointly holding prescribed responsibilities (noting that APRA and ASIC consider individual accountability to be the clearest form of accountability); and
- a need for accountable entities to more closely consider whether an individual holds general responsibilities that cause them to be an accountable person.

Unfair Contract Terms (UCT)

We expect UCT to remain an ongoing enforcement priority for ASIC.

In 2024, ASIC pursued several cases involving UCT. As discussed in our *2024 Insurance Pocketbook*, ASIC separately commenced proceedings against PayPal Australia (**PayPal**)[3] and Auto & General Insurance Company Limited (**Auto & General**),[4] alleging their standard form contracts contain UCT.

In the PayPal proceedings, the Federal Court found in favour of ASIC, declaring that the term was unfair because its effect was to allow PayPal to retain fees that it had erroneously charged if the small business failed to notify PayPal of the error within 60 days of the fee appearing on its account statement.

Conversely, in the proceedings against Auto & General, the Federal Court found that a term requiring policy holders to notify Auto & General of any changes to their home and contents was not unfair. See our case notes for further information.

Keeping it simple (or at least trying to)

At the 2024 ASIC Annual Forum, Chairman Joe Longo announced that ASIC will 'convene a Simplification Consultative Group made up of key consumer advocates, business leaders and directors and industry groups' so that ASIC can address the unnecessary complexity of corporate and financial services legislation.[5] The task of the Simplification Consultative Group will be to identify how 'ASIC can more efficiently and more effectively administer the law [and] how the levers and guidance available to ASIC can be more helpful'. It will be interesting to see how this initiative interacts with the ALRC reform of the *Corporations Act 2001* (Cth).[6]

Affordability

Amid the ongoing cost of living crisis and increased occurrence of extreme weather events, insurance affordability is a growing concern for consumers and regulators alike. During ASIC's 2024 Annual Forum, Deputy Chair Sarah Court noted that:

> *The ability to compare insurance products and pricing offers is critical for consumers… [e]qually important is being able to rely on promises made by insurers when they send renewal notices referencing discounts for loyalty or the number of policies held…We will continue our work in this area next year, with a focus on* ***failures by insurers to deal fairly and in good faith with their customers****.*[7]

Court's commentary emphasises the connection between the affordability of insurance products to ASIC's enforcement priority for insurers to deal fairly and in good faith with customers. This is something the insurance industry has focused on, particularly in relation to climate change. In their 2024 Submission to the inquiry on the Impact of Climate Risk on Insurance Premiums, the Insurance Council of Australia (**ICA**) highlighted that 'recent premium increases in Australia are being driven by many factors including the impact of extreme weather events, development and growing asset values in higher-risk areas, and higher inflation, particularly in the construction sector.'[8]

In addition to extreme weather events and climate change, the ICA have highlighted several other factors that are impacting the affordability of insurance costs in Australia including inflation (particularly in the building and motor repair sectors), rising reinsurance costs and increased value of our assets.[9]

In July 2023, APRA commenced the Insurance Climate Vulnerability Assessment which was designed and developed in collaboration with the five largest general insurers in Australia: IAG, Suncorp, Allianz, QBE and Hollard. This assessment explores how the affordability of general insurance may change between now and 2050.[10] APRA expects to receive the affordability metric results from the participants in the first half of 2025 and intends to publish a report based on the results later in 2025. This report will support an improved understanding of potential future general insurance affordability challenges.

Affordability is also one of APRA's 2025 enforcement priorities.[11]

ASIC Enforcement Priorities relevant for insurance

On 14 November 2024, ASIC Deputy Chair, Sarah Court announced ASIC's 2025 enforcement priorities.[12]

The enforcement priorities most relevant to the insurance industry include:

- claims handling misconduct (with a focus on home insurance claims);
- harmful product design and distribution practices; and
- failure by insurers to deal fairly and in good faith with customers.

ASIC will be monitoring general insurers' improvements to claims handling services and will be engaging with the independent review of the 2020 General Insurance Code of Practice.

Claim handling misconduct – ASIC 2025 priority

The catastrophic weather events that have occurred in Australia in the last few years have led to an influx of insurance claims. In our *2024 Insurance Pocketbook*, we highlighted 'Report 768: Navigating the storm: ASIC's review of home insurance claims' (**REP 768**) where ASIC stressed the need for insurers to handle claims consistently in good faith, and also highlighted areas for improvement. Since then, ASIC released a letter on 6 March 2024 reiterating that general insurers are obliged to 'resolv[e] claims in a timely manner, especially when responding to claims relating to severe weather events'.[13]

Additionally, in the recently released 'Report 802: Cause for Complaint: Complaints handling in general insurance' (**REP 802**) ASIC found that a delay in claims handling was one of the top categories of complaints to insurers.[14] ASIC also found that every insurer who participated in the report failed with one or more of their mandatory Internal Dispute Resolution (IDR) obligations.[15] Specifically, insurers failed to identify and record all complaints, failed to identify systemic issues and had immature systems for handling and reporting complaints.[16]

ASIC's recent action against Cbus will likely be followed by other enforcement actions for claims handling misconduct.[17]

Harmful product design and distribution practices – ASIC 2025 priority

In September 2024, ASIC released 'Report 795: Design and distribution obligations: Compliance with the reasonable steps obligation' (**REP 795**).[18]

'Regulatory Guide RG 274: Product design and distribution obligations' explains ASIC's interpretation of the design and distribution obligations.[19] Essentially, an issuer must take reasonable steps that will or are reasonably likely to result in distribution being consistent with the target market determination (**TMD**).

REP 795 asserts that issuers 'still need to do more do more to comply with the reasonable steps obligation', citing the following observations:

- 'limited due diligence arrangements to assess and monitor third-party distributors' ability to distribute a product in accordance with the TMD;
- some issuers of high-risk products relying on broad search terms in online marketing;
- reliance on poor-quality questionnaires that did not seek to understand a consumer's attributes and had poor design features such as prompts with 'correct' responses; and
- limited monitoring of consumer outcomes to inform product governance arrangements and future distribution practices'.

As at the date of the report, ASIC have issued four interim stop orders for concerns about compliance with the obligation to take reasonable steps and have also engaged in civil penalty proceedings. Notably, in *Australian Securities and Investments Commission v Firstmac Limited*[20] the court found that Firstmac contravened the reasonable steps obligation for cross-selling a high-risk financial product to consumers holding a guarantee-protected term deposit.

In REP 795, ASIC has said that it will continue to take regulatory action for contraventions of the design and distribution obligations, including where there is a high risk of consumer harm.

APRA's 2025 Insurance Priorities

In August 2024, APRA released its 2024-2025 Corporate Plan.[21] In their report, APRA identified that their 'focus is for insurers to be financially strong, with the financial capacity to pay all legitimate claims to Australian policyholders' and set out their insurance initiatives, which include:

Financial resilience

- **Crisis preparedness** (CPS 190 and CPS 900): Ensure insurers and APRA are ready to respond to significant crises in an orderly way.

Operational resilience

- **Operational resilience** (CPS 230): Ensure insurers understand and manage their operational risks to minimise the likelihood and impact of operational risk incidents. CPS 230 is set to commence on 1 July 2025. Insurers will be required to submit a register of material service providers on an annual basis and APRA will use this information to assess risks associated with these arrangements.[22]

- **Cyber resilience** (CPS 234): Ensure insurers have taken steps to be resilient and minimise the likelihood and impact of cyber incidents, as well as ensuring information security controls are effective across the supply chain.
- **Governance** (APRA to issue a discussion paper in first half of FY24/25): Simplify expectations of boards so they can be more effective and focus on important strategic issues, while ensuring expectations are aligned with international best practice.
- **Risk culture** (APRA to conduct a risk culture survey in first half of FY24/25): Ensure entities understand and foster a risk culture that supports effective risk management practices and behaviours and delivers sound prudential outcomes.
- **Accountability** (FAR): Ensure a clear, transparent, and common understanding of accountability, and that there are proportionate consequences to entities and individuals where poor outcomes occur.

Respond to significant emerging risks

- **Climate and nature risk** (CPS 220): Ensure insurers are well positioned to manage the financial risks associated with climate change and build insurers' awareness of the impact of nature risk on the resilience of entities, the financial system and the community. In 2024, APRA conducted a Climate Risk Self-Assessment Survey to understand the alignment of entities' practices with APRA's guidance on climate risk. The results from this survey will likely feed into the amendments to prudential standard CPS 220 to include climate risk.
- **Retirement outcomes**: To support life insurers to increase the availability of retirement products for retirees.
- **Protection gap for household insurance**: Support stakeholders in improving affordability and availability of household insurance to meet the needs of the community. APRA plans to consider the promotion of alternative reinsurance to improve the affordability and availability of household insurance.[23]

Address industry-specific challenges

- **Outsourced underwriting**: Strengthen the general insurance industry's management of risks related to outsourced underwriting.
- **Life Insurance sustainability**: Prevent deterioration of viability of certain life insurance products that may result in adverse consumer impacts.
- **Proportionality** (APRA to review asset thresholds for SFIs): Prudential requirements and supervisory approaches are commensurate to the systemic importance and risk profiles of regulated entities.
- **Transition D2A data collections to APRA Connect**: Remaining D2A data collections not related to policy priorities will be transitioned to APRA Connect to enable decommissioning of legacy systems.

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PRACTICAL TIPS TO NAVIGATE W&I POLICY EXCLUSIONS

In a W&I-insured transaction, the W&I policy is often the buyer's sole or primary recourse for warranty breaches. As such, it is important to understand the exclusions under the policy to ensure there is optimal cover. This article discusses some common exclusions in W&I policies, provides insights on negotiating them and offers strategies to get cover under other arrangements. As W&I insurance is a brokered product in Australia, W&I insurance brokers play a significant role in this process and are able to leverage their industry knowledge to assist prospective insureds and their lawyers. Of course, the input of legal and other diligence advisors is also critical.

The focus of this article will be on the warranty-agnostic general exclusions. These exclusions trump the coverage provided in the warranty schedule at the back of the policy. The recent case of *Project Angel Bidco Limited v Axis Managing Agency Limited* [2024] EWCA Civ 446 illustrates this, where a general anti-bribery and corruption (**ABC**) exclusion excluded cover for specific ABC warranties notwithstanding that they were marked as covered in the warranty schedule (decided on whether there was a drafting error in the general exclusion and whether it could be cured). Further, this article will not focus on standard exclusions, which are excluded as a matter of custom or insurer appetite, or those which can be resolved by way of additional diligence.

Failure to establish breach – seller knowledge qualifiers

Whilst not an actual exclusion, failure to establish breach makes for a swift declinature by the insurer and, in fact, this was the most common reason for Liberty declining claims in 2024.[24] Liberty provides the example of a warranty which is qualified by seller knowledge but the insured, alleging a breach, fails to demonstrate that the seller knew the warranty was untrue. Given Liberty's emphasis on this particular manner of exclusion, this section will consider how buyers can deal with seller knowledge qualifiers to maximise coverage under their policies.

Background to seller knowledge qualifiers

By way of a refresher, seller knowledge qualifiers are statements to the effect that a warranty is true only so far as the seller is aware, which the sale agreement would usually define as the knowledge of specific individuals in management of the target. From the seller's perspective, using seller knowledge qualifiers is sensible. A risk-conscious seller should include (and a prudent W&I insurer would require) knowledge qualifiers if the seller itself may not be in a position to confidently or verifiably warrant a matter. The buyer, however, should be careful when accepting such qualified warranties because to prove a breach and recover loss under the policy, it must prove not just the falsehood of the subject matter of the warranty but also that the seller had knowledge of it. This would be an ineffectual task if the warrantor had inadequate visibility over the subject matter, for example, in larger deals with institutional or corporate principal sellers, deals where the warrantors are not involved in the day-to-day management of the business or distressed targets having newly-appointed administrators.

The first question for the buyer is whether the warrantor should be able to give the warranty without a knowledge qualifier. For example, a warranty regarding title and capacity of the seller or the corporate affairs or core operations of the target are usually not knowledge-qualified, as these are matters the sellers should be able to stand behind. However, seller knowledge qualifiers do not inherently make for weak representations and could in fact strengthen a warranty if formulated correctly and for the appropriate warranty. Technical or niche warranties for example, such as those relating to information technology, may be qualified by reference to the knowledge of a specific person, in this example, the head of IT or the chief information officer. In some situations, the seller may be open to giving unqualified warranties, but coverage may be resisted by the W&I insurer. Whilst this is ultimately a matter for the insurer's risk appetite and underwriting guidelines, a possible solution is proving the existence of adequate buyer diligence in the area of concern.

One case in which this point did not go the insurers' way (although the insurers were ultimately successful) was the recent case of *DTZ Worldwide Limited v AIG Australia Limited* [2025] NSWSC 12. In that case, the Court, having found that a knowledge-qualified disclosure warranty had been breached because the disclosure materials were misleading, also inferred that the Chief Executive, Mr A, had the requisite knowledge. The Court noted that it was reasonable to infer that Mr A had been involved in preparing responses in relation to the Q&A or was at least aware of the answers, and would have known that the answers were misleading after correspondence with the Chief Executive of one of the target companies.

Tax-related exclusions

Difficulties in insuring tax risks

Tax exclusions are also usual in W&I policies, forebodingly presenting in square brackets even before underwriting is complete as the trifecta of secondary tax liabilities, transfer pricing and non-availability of tax losses. Transactions with a higher tax risk or those lacking adequate tax due diligence may see broader exclusions, such as a broad-brush 'any matter relating to tax' carve-out.

It is understandable that insurers are cautious. As Aon has aptly observed, the difficulty with tax is that larger acquisitions usually involve complex tax structures, attracting the attention of tax authorities in the deal's home jurisdiction as well as other jurisdictions in which the target operates.[25] Tax is also subject to complex and evolving regulation and proactive enforcement activity, often resulting in lengthy investigations, enforcement action and, by extension, increased defence costs and further

pressure on insurers. To illustrate, Liberty for example has noted that 17% of its paid or reserved amounts on tax-related notifications relate to third-party claims but defence costs in particular.[26]

Tax due diligence is key

Notwithstanding these difficulties, we find that W&I insurers and their tax advisors are commercial in dealing with tax issues. Perhaps one reason is that, whilst notifications are numerous, losses tend to be low (at least compared to other breach types). For example, whilst tax-related matters constituted 23% of notifications to Liberty (top of the list by breach type), they constituted only 2% of the payouts.[27] Liberty has noted that many of the tax notifications, especially those in APAC, related to the commencement of a routine tax audit which never resulted in a formal claim.

Ultimately, as with most other areas of underwriting focus for insurers, tax due diligence is the key to obtaining coverage for tax matters. To satisfy the insurer that all relevant risks have been properly identified, analysed and assessed, the diligence report should clearly explain the scope, set out the materiality threshold and explain the issues and the insured's exposure to the risks. Given the no- or low-recourse regime in a W&I-insured deal, the authors should provide a clear and fair overview of the tax affairs rather than a generic warning.[28] The W&I insurer will likely only step in if it is satisfied that the insured has satisfied itself that there are no known and unmanaged tax risks, any possible tax risk is low-likelihood or low-impact and any residual tax risk is within the insurer's risk appetite.

Tax in focus and alternative products

Notably, Liberty has also observed an increase in the number of adverse tax findings, which it considers suggests a more aggressive tax regulatory approach.[29] Further, Aon has made the interesting connection that in the current high-interest and high-inflation environment, governments may be looking for ways to boost tax revenue.[30] It will be interesting to see if W&I insurer's approach to tax issues will change in light of such developments. To address such risks, as an alternative or complementary insurance solution for tax matters, buyers may also consider a tax liability insurance policy. Like other specific transaction liability policies, tax policies often cover specific tax concerns, subject to the availability of a favourable prospects or compliance advice from the insured's tax counsel and the insurer and its counsel's review and comfort. The use of such policies is on the rise, with Marsh observing a 5-fold increase in notifications made under them in the Asia Pacific region.[31]

Employment

Any business which employs people or uses independent contractors has employment and social security compliance risk which will be excluded if not diligenced to the insurer's satisfaction. The insurers' lack of appetite for such risks is not helped by a not-insignificant number of private and class-led wage underpayment proceedings, government action to recover undue support payments, the evolving regulatory framework, increasing penalties for breaches of employment laws and modern awards due to misclassification and underfunding of pensions and superannuation accounts.

To obtain cover for such risks, buyers must conduct extensive due diligence and payroll sampling, with many brokers and consultancy firms now offering bespoke diligence services in this area. Engaging with this process at the get-go is important, in particular given it can be costly and time consuming.

Pollution

Pollution is another usual exclusion in a W&I policy. A pollution exclusion is likely in any transaction involving property (even if the core business is not property or the business does not use property) and especially in transactions where the business has a predisposition to pollute (for example, logistics, energy and waste management).

If pollution is a concern, obtaining a standalone environmental risk insurance policy providing comprehensive coverage could be the best course of action. However, the pollution exclusion may be able to be managed by utilising some W&I insurers' offer to underwrite excess or 'top-up' pollution liability cover. This involves satisfying the W&I insurer of the adequacy of the target's existing pollution cover (like a standalone pollution or environmental liability policy), backed by 'clean' due diligence of the target's pollution risk. In response, the W&I insurer may agree to sit excess of that underlying cover for breach of pollution warranties. In our experience, some insurers can get comfortable with small, contained incidents not reflecting systemic issues or inherent deficiencies. However, significant, systemic or recurring issues will work against the buyer. Excess liability cover was discussed in more depth in the *2024 Insurance Pocketbook*. As a reminder, notwithstanding that excess pollution liability cover may be available under a W&I policy, the cover provided under it is limited and requires the buyer to be able to successfully claim under the underlying pollution liability policy (but for having exhausted the limit of liability) and then formulate its claim as a warranty breach and claim under the W&I policy. Buyers should be mindful that most insurance policies in Australia, including W&I policies which offer the abovementioned pollution cover, will exclude asbestos and certain other high-impact pollutants. If required, coverage for such matters should be discussed with the insurance broker at the outset of the transaction to ensure that alternative cover can be arranged.

Cyber

W&I policies typically also exclude cyber risk, primarily due to the increasing frequency and severity of ransomware attacks, hefty penalties for non-compliance with data protection laws, the continuous evolution of data risks and inherent vulnerabilities of IT businesses and global supply chains reliant on IT infrastructure. This situation has been exacerbated by significant cyber attacks on several Australian companies in 2022 and 2023, along with other lower-profile incidents and a global IT outage in 2024.

Similar to pollution above, buyers can consider undertaking due diligence to support top-up cyber cover (if offered). However this could be challenging given the difficulty in securing standalone cyber insurance solutions for targets at a commercial premium.

At a minimum, to manage the insurer's risk appetite, buyers and their advisors should undertake adequate due diligence so that they can paint a true but realistic and firm picture of the actual cyber risks. Depending on the nature of the target business, this can include reviewing any data-related business services provider (e.g., hosting services, IT support and data security services), historical cyber claims, customer contracts, IT equipment and equipment housing and in-development or under-construction projects.

Known issues

Finally, W&I policies will exclude known issues, including any issues revealed during due diligence. Whilst this may mean that due diligence is a double-edged sword, the answer is that W&I insurance, as with any other insurance, simply will not respond to matters which are known before the insured takes out the policy. Such issues should be dealt with between the parties before signing the sale agreement, either by seeking a specific indemnity or adjusting the purchase price. The insurer's inability to cover such issues, which would have been breaches but for the fact that they are known, may help move these negotiations forward.

Where an issue is known and carries the risk of a contingent liability, buyers may also consider contingent risk insurance, a standalone insurance policy typically covering known, contingent legal risks such as litigation (including the risk of a counterparty appealing a favourable outcome), liquidation or administration and title risks. Contingent risk insurance can also cover the subject matter of

specific indemnities in the sale agreement. With WTW reporting that 17% of global claims are declined due to known issues,[32] this could be the useful strategy if supported by a legal prospects advice.

Concluding remarks

Understanding W&I policy exclusions and how to navigate them is essential for buyers seeking to optimise coverage in W&I-insured transactions. Familiarity with common exclusions and being aware of common pitfalls of warranty drafting can significantly influence the buyer's risk transfer arrangements. By conducting thorough due diligence and engaging with lawyers, brokers and other advisors who are knowledgeable in this space, buyers can enhance their negotiating position and potentially secure additional coverage options. Ultimately, a proactive approach to diligence and identifying and addressing these exclusions will not only safeguard buyers' interests but also facilitate smoother negotiations and lead to a more successful transaction outcome.

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A NEW FRONTIER: CARBON CREDIT INSURANCE

The issue at hand

There's no denying that human activities, namely the emission of greenhouse gases (GHGs), have caused global warming.[33] In 2023 the Intergovernmental Panel on Climate Change (**IPCC**) reported that the global surface temperature reached 1.1°C above 1850-1900 in 2011-2020 and that global warming is more likely than not to reach 1.5°C.[34] We've been able to observe the impact of climate change in our own backyards with the devastating 2019/2020 bushfires and 2022 major floods. Insurance has a role not only to mitigate the consequences of climate change but also to provide financial certainty for measures which combat climate change (i.e. carbon credits).

One of the ways in which countries have attempted to mitigate global warming is through the implementation of emission trading schemes or carbon markets. At a high level, carbon markets are mechanisms for pricing carbon that facilitates the trading of GHG emission credits by governments and non-state actors.[35] There are two types of carbon markets, compliance (**CCM**) and voluntary (**VCM**). Compliance markets are regulated by state or international regulatory authorities and are usually aimed at energy intensive emitters such as energy generators - think the European Union Emissions Trading Scheme or the Australian Carbon Credit Unit (**ACCU**) Scheme.[36] In voluntary markets, non-state actors such as companies seek to voluntarily offset their emissions to achieve mitigation targets, for example net zero emissions.[37]

The value of the VCM has been forecasted to reach over $1.1 trillion annually by 2050, however this can only come to fruition if the credibility issues surrounding the VCM are resolved.[38]

In the early 2020s the scientific community published a number of articles calling into question the integrity of carbon credits traded in carbon markets, particularly those traded in VCMs as these (unlike CCMs) are subject to little regulation.[39] At a high level, it was found that the carbon credits did not actually represent the GHG emission reductions claimed. This was picked up by the press and prompted headlines such as 'Australia's carbon credits system a failure on global scale, study finds'[40] and 'Critical or concerning? Cop28 debates role of carbon markets in climate crisis'.[41] These findings and headlines shook stakeholder confidence in the VCM. Despite these shortcomings, leading authorities such as the UN have faith that VCMs and carbon markets more broadly have an important role in the decarbonisation journey.[42] So, the race to a high integrity carbon credits and increased participation in carbon markets is on, and insurance has a key role to play.

Insuring carbon markets

Defining the risks

Some of the risks associated with carbon credits will be familiar, for example geopolitical risk. Others such as reversal or invalidation may be new concepts. Defining the risks is not an exact science, but broadly speaking the risks that can impact the credibility of carbon credits are:[43]

Non-Delivery: occurs when the credits from a project are not delivered in part or in full, this could be the result of theft, loss or even cyber attacks on the project;

- **Reversal**: occurs when carbon captured by a project is re-released into the atmosphere, for example due to bushfires or disease destroying an afforestation project;
- **Counterparty**: occurs when transaction parties default on their contractual obligations;
- **Invalidation**: occurs when credits or an entire project are invalidated, for example due to fraudulent misrepresentations of the emissions reductions achieved or a significant shift in emission reduction accounting methodology;
- **Geopolitical**: occurs when the political climate of the host country to a carbon credit project negatively impacts a carbon credit project, for example when the host country amends its laws and regulations in a way that impacts the project or the trading of carbon credits;
- **Reputational**: the reputational harm associated with purchasing or issuing faulty carbon credits, for example dealing with accusations of greenwashing;
- **Price**: occurs when a company has to purchase additional carbon credits at unknown future prices to replace previously purchased faulty credits.
- It's important to note that the risks associated with a particular carbon credit depend on several variables. For example, the type of carbon credit project is important. An afforestation project (establishment of new forests) faces reversal risks due to bushfires whereas this would clearly not be so much of an issue for a blue carbon project (carbon captured from the atmosphere and stored in marine ecosystems).[44] The carbon credit lifecycle is also a key variable. For example, the risk of non-delivery drops to zero at the point of issuance, but this is where the risk of reversal comes into play.[45]
  Finally the role a party plays is also important to keep in mind. Although there is overlap, the key risks faced by carbon project investors, differ from those faced by carbon project developers, which differ again from those who purchase the carbon credits.

2.2 Who's insuring what and where?

Carbon credit insurance is a new product offered by insurers aimed at safeguarding against the risks described above. Early adopters of this novel product came about in 2022, with Howden's (in partnership with Respira International and Nephila Capital) invalidation risk insurance solution.[46] Since then, several existing insurers and some new carbon credit insurance specialists (Kita & Oka) have made offerings primarily in the US, EU and UK markets. In fact, the market has expanded so rapidly that it's been estimated that gross written premium could be up to $1 billion annually by 2030.[47] So who's contributed to this boom and what are they offering? Below is a summary of some of the key carbon credit insurance players and examples of the products they offer.

EXAMPLE CARRIERS	CARBON CREDIT INSURANCE PRODUCT[48]
AXA	**Excess Emissions Insurance:** covers the GHG emissions from marine vessels in the event of a fortuity covered by their Marine Hull policy. AXA contributes to carbon removal and avoidance projects to offset the additional emissions impact caused by course deviations.[49]
CarbonPool, Oka, CFC	**Carbon Cancellation Insurance:** ensures the long-term integrity of carbon credits by replacing sequestered carbon lost due to reversal or invalidation events. CarbonPool compensates its insureds with carbon credits rather than cash.[50]
Descartes, Swiss Re, Beazley, Nephila Capital, Allianz, Liberty	**Parametric solutions:** provides cover for climatic perils facing carbon credit projects for example, Parametric Wildfire Insurance for afforestation projects.[51]
Howden, Oka, CFC, CarbonPool	**Invalidation risk insurance solution**: this product is wrapped around independently verified, high-quality carbon credits and provides cover for third-party negligence and fraud.[52]
Kita	**Buffer Depletion Protection Cover:** a buffer is a central pool of carbon credits to which can be drawn upon to replace carbon credits that have been reversed.[53] This cover provides a protective wrap against depletion of buffer pools, a backstop against unexpected loss and security to counterparties, and clarity as to how losses are addressed and compensated.[54]
Oka, CFC	**Corresponding Adjustment Protect**: corresponding adjustments must be made for a VCM credit to be eligible for use in CCMs (like CORSIA). This policy pays out in the event that a corresponding adjustment is not applied to a credit and allows the insured to replace it with an Article 6 authorised credit.[55]
Marsh/We2Sure	**Fraud insurance:** this product is an insurance facility that enables businesses to insure against the risk of purchasing counterfeit certificates, the sale of certificates for non-existence projects, and theft.[56]

Where does Australia fit into all of this?

KWM has had conversations with Marsh who is one of the leading insurance brokers in the carbon credit insurance space. Marsh has indicated that at the moment there is limited demand for insuring carbon credits in Australia. This can largely be attributed to two things, firstly Australia's track record of slow implementation and secondly the presence of the ACCU Scheme.

With respect to the former, the lack of uptake in Australia is somewhat expected. It's not uncommon for the Australian market to use the UK and US as testing grounds before bringing in novel insurance products.

Regarding the latter and although this is a contested view, the ACCU Scheme is comparatively robust. The 2022 Independent Review of ACCUs (**Chubb Review**) found despite the integrity of the Scheme being called into question, the Scheme was fundamentally well designed when introduced.[57] It should be noted however that the Chubb Review does go on to make a number of recommendations to improve the Scheme.[58] Regardless, the generally held view that the ACCU Scheme is robust, in addition to the fact that ACCUs can be traded in VCMs,[59] means that it is perceived that the risks surrounding carbon markets are better mitigated in Australia and therefore insurance is not required.

This slow uptake doesn't mean that there isn't space for carbon credit insurance in Australia. It's important to note that the Chubb Review was an analysis on the ACCU Scheme, not the underlying projects generating the carbon credits. A 2024 research article published in the nature journal *Communications Earth & Environment* analysed 182 Australian afforestation carbon credit projects and found limited evidence of regeneration in credited areas.[60] More recently, there has been an exodus by some of Australia's largest companies from the Federal government's carbon offset scheme, Climate Active.[61] The scheme aims to encourage Australian businesses to voluntarily reduce and offset emissions by awarding Climate Active certification to those that have achieved carbon neutrality.[62] Climate Active certification is intended to help consumers identify carbon neutral brands enabling them to make informed climate conscious decisions.[63] However, concerns have been raised about the integrity of Climate Active's accounting standards and this in turn has prompted more than 100 companies to depart from the scheme.[64] Given this, there is certainty opportunity to develop carbon credit insurance products for the Australian CCM and VCM.

The spectrum of participants in the Australian carbon markets is broad and not limited to high GHG emitters. These can include banks and developers who invest in carbon projects, projects with carbon credit components, or trade carbon credits, and businesses of all sizes who offset their emissions though purchasing and surrendering credits. These entities should consider how carbon credit insurance might help them mitigate the risks associated with participating in the carbon market and enable them to achieve their net zero goals, financial certainty, and ESG objectives.

Moreover, there are international industry specific carbon markets such as the previously mentioned CORSIA (Carbon Offsetting and Reduction Scheme for International Aviation). Although currently voluntary, CORSIA will implement mandatory offsetting requirements starting in 2027.[65] This will capture major Australian airlines and we anticipate that CORSIA specific insurance products, such as the Corresponding Adjustment Protect offering from Oka may have utility for the Australian international airlines.

So although carbon credit insurance has not yet become a common product in Australia, it's definitely something to watch out for on the horizon. We'll keep monitoring the situation and keep you informed.

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INTERVIEW WITH KERRI KOHLER-SAUNDERS

Kerri Kohler-Saunders is Managing Principal, Cyber Practice – Pacific at Marsh (a member of Marsh & McLennan Companies, Inc).

We recently caught up with Kerri to discuss his role at Marsh and glean some valuable insights from his extensive experience working in cyber insurance.

About Kerri

Tell us about your role at Marsh and what it's like to work in cyber risk.

As Managing Principal for Marsh Pacific's Cyber Practice, I deliver cyber insurance broking placement services and incident response planning to large and medium enterprise clients across a breadth of industries and sectors. We take a holistic approach to managing risk, versus that of a transactional insurance broker who simply places insurance, as every business is unique.

Cyber placement is an involved process with multiple continuous touchpoints. It includes discussing and executing program placement strategy, supporting clients involved in cyber incidents, and collaborating on advisory and incident response preparedness projects.

Cyber is one of the fastest-changing risk areas. So to deliver real-time expertise to my clients, this means staying up-to-date and ahead of market trends and shifts in the cyber risk landscape, from claims activity trends, threat actor groups and AI threat, as well as regulatory changes and their implications for our clients.

Because technology is central to most organisations, it is essential for me to understand how a client uses technology – and the associated risks.

Today's sobering reality is that businesses' ability to operate is at the mercy of internal IT systems as well as third-party technology suppliers. A majority of firms outsource critical IT functions such as cloud-based data storage and virus-scanning software that require profound access privileges across an organisation's systems in order to operate. As a broker this means that I need to continuously review clients' cyber risk and technical control environments.

A quick refresher on cyber insurance

What are the key risks / cyber incidents that cyber insurance typically provides cover for? How does cyber insurance help businesses recover from a cyber attack or data breach?

Cyber risk encompasses malicious cybercrime, such as ransomware attacks, as well as non-malicious human error, such as inadvertent disclosure of information, loss of confidential data and outages caused by human error. Last year's CrowdStrike outage helped to highlight the latter in particular – cyber insurance coverage isn't there only to mitigate impact of incidents caused by 'bad actors' – business disruption can also arise from non-malicious errors.

Comprehensive cyber insurance serves as a risk transfer mechanism to help mitigate the significant financial costs that can affect an organisation and its customers. However, the client's own in-house organisation-wide measures are equally vital to managing its risk and mitigate loss.

From an insurance perspective, cyber events can also have consequences for multiple policies in a business's insurance portfolio – beyond cyber – such as Professional Indemnity, Directors' & Officers' Liability and Industrial Specialty Risk. For this reason, it is important to consider protection against events such as professional negligence claims, securities class actions, or physical damage loss.

Are there any additional services or resources that cyber insurance providers offer to businesses?

The very process of a firm obtaining a cyber policy is a beneficial exercise due to the information underwriters require from businesses about their current cyber risk management measures. Organisations answer 230+ questions in order to apply for it. In this sense, seeking cyber insurance is essentially a top-down self-audit for a business on

every aspect of its cyber vulnerabilities and strengths, helping them identify any blind spots as well as the robustness of its incident response processes.

While some organisations only buy cyber insurance for incident response, many underwriters also support risk management procedures for their clients as part of their premium spent. Clients can benefit from these without them having to make a claim under their policy, such as management funds or discounted incident tabletop exercises. Clients who have experienced breaches tell us how invaluable these exercises were.

This is because employees were already well-versed in immediate first steps when an incident occurred, and knew their roles and responsibilities. This meant they could act faster in the critical first 48-72 hours, minimising the financial and business disruption impact, as well as reputational impact with a well-rehearsed communication plan to customers and the media.

Cyber incidents are becoming inevitable, even for the best prepared and defended organisations. It is not a matter of if, but when and how well your organisation responds. A business's ability to respond quickly and effectively has the most significant impact in stemming business interruption, and financial and reputational damage.

What are the common exclusions or limitations in cyber insurance policies that insureds should be aware of?

It varies between industry and insurer. However, some common exclusions include catastrophic risk exclusions related to war, critical infrastructure, natural perils and government actions. Several of these issues are top of mind for clients for 2025. The latest Global Risk Report 2025 from the World Economic Forum ranks cyber espionage and warfare in the top five short-term threats for organisations globally.[66]

Other market exclusions can include sub-limits or co-insurance for systemic or widespread events such as a breach suffered by a third-party cloud or data-host supplier, or high-severity events such as ransomware.

What steps should a business take before seeking cyber insurance quotes? Are there any best practices, specific cybersecurity measures or protocols which businesses should adopt to minimise cyber risks?

Clients must present a mature cybersecurity risk preparedness to insurers and demonstrate its effectiveness in key areas. Marsh recommends 12 cybersecurity controls to strengthen cyber resiliency (which can be found on our website). As part of supporting clients, we help them to identify and demonstrate their effective risk management against these 12 cybersecurity controls – as well as address any blind spots or vulnerabilities.

We also recommend that businesses educate themselves about their unique vulnerabilities at every touchpoint. It is essential that employees understand their unique roles and responsibilities should a cybersecurity incident occur.

What factors affect the cost of cyber insurance premiums?

Cyber insurance is largely underwritten based on cybersecurity risk controls. Clients must have a certain level of baseline controls in place to access the market - a 'ticket to play'. Therefore, the market incentivises businesses to implement advanced cybersecurity risk controls and increase their cyber resilience. These clients have greater insurer options available and may receive preferential terms and conditions. Other factors include past claims and loss experience, and the nature of risk within the client's industry segment.

We are currently operating in a relatively 'buyer-friendly' insurance market, with premiums trending downwards. This means that the financial cost of cybersecurity risk transfer is becoming more affordable. By using Marsh's expertise and understanding of underwriters' pain points for particular risk exposures, we can prepare clients and demonstrate mature cybersecurity risk preparedness to achieve 'better-than-market results' in terms of premium and coverage.

Observations

What are some of the most common mistakes you see businesses making when it comes to cybersecurity?

The biggest mistake we observe is when businesses take a short-term approach to cybersecurity. They tend to treat cyber resilience measures as quick fixes, rather than integrating them into a comprehensive, ongoing risk management strategy. This mindset can leave organisations vulnerable over time.

Another common pitfall is thinking that cyber risk and cyber insurance is a set-and-forget exercise. Cyber threat is constantly evolving, and when businesses fail to keep a vigilant eye on their IT systems, they essentially leave the door wide open for attackers. Many organisations believe that once they've established their cyber resilience measures, their job is done. In reality, it is about creating a continuous cycle of implementation, monitoring and review. For instance, a company might install a firewall but forget to regularly install software patches or monitor email traffic regularly.

Lastly, businesses can fail to understand that they must adopt a cyber resilience culture across the entire organisation involving all employees. The majority of cybersecurity breaches – around 75% – occur due to human error, so regular employee training and awareness campaigns can significantly reduce risks for all employees.

What are the most cost-effective ways for a business to protect itself against the impact of cybersecurity threats?

Businesses who prepare for a cyber incident and regularly practise their response recover much faster. Those who plan, rehearse responding to supply chain and extreme cyber events, and who leave as little as possible to chance are the best placed to manage a cyber attack.

Other effective strategies include limiting employee data access via role-based access control (RBAC), which means they only have access to data they need, significantly reducing the risk of data breaches and helping to safeguard sensitive information. Regular monitoring by leveraging automated monitoring tools can provide real-time insights without a hefty resource investment.

Also, investing in employee training and awareness programmes is a cost-effective way to enhance overall cybersecurity posture. Educated employees are the first line of defence against cyber threats.

What are the emerging trends or changes in cybersecurity risk and the cyber insurance market that organisations should be aware of?

There is an increased requirement on Australian businesses to update their privacy governance (and demonstrate compliance with privacy regulations), and commit to maintaining the security of customer data.

Overall, the cyber insurance market remains in a positive state, with increased insurer capacity likely to continue in 2025. However, any increase in long-tail cyber claims, arising from third-party class actions and regulatory matters, may impact the market.

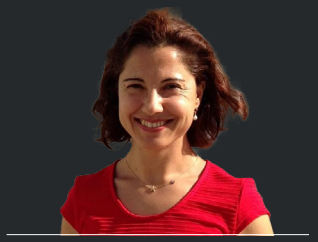
Factors outside of the Australian market can also have an influence, including competition driven by global market conditions. If the US market were to harden in the future, this could impact pricing and underwriting practices in the Australian market.

Consequently, Marsh makes it a priority to keep our clients informed about global market trends and potential implications for their cyber insurance strategies so they can make informed decisions.

In terms of emerging risks, securing vulnerabilities associated with the Internet of Things (IoT) is already a focus in the Australian government's cybersecurity strategy, with the proliferation of IoT devices creating new attack vectors which could compromise personal and corporate data.

Quantum computing could also compromise current cybersecurity protections. As warned in our last two Global Risks Reports, quantum computing may soon have the capability to break traditional encryption methods within seconds. Business must start considering quantum-resistant algorithms now in order to stay ahead.

INTERVIEW WITH PROFESSOR ÖZLEM GÜRSES



Professor Özlem Gürses is a Professor of Law at King's College London.

KWM spoke with Professor Gürses in February 2025 about all things insurance, including some predictions for the next few years in this space.

About Özlem

Tell us about current role and what you like about it.

I am a Professor of Law at King's College London, and a visiting lecturer at various universities across the world. I am very fortunate; I'm doing a job that suits my character and I enjoy every aspect of it – teaching, researching, learning more about the law (in detail!).

Part of what I enjoy so much about my role is that in order to write about the law I have to make sure I know about it. My teaching complements my research and vice versa. I always feel like I'm putting together the pieces of a puzzle. It is also a luxury to have the freedom I do, to write about what I want.

What is your origin story in insurance?

Everything has been unplanned.

I was not planning to study law, I was going to be a nurse. I actually trained as a nurse and was working a nurse in a hospital, but it became clear to me that I did not want to do that for the rest of my life. My sister pushed me to do a university degree. The sliding doors moment came for me when my history teacher suggested that I do law (and not to do history).

I then practiced law for a year and I was not happy [*Editor's Note – not at KWM*], I wanted to become an academic. Istanbul University opened positions for all their departments. On the advice of a friend, I took the maritime law department exam (you had to take an exam to be considered for an interview for a research assistant position).

I wanted to improve my English speaking skills and the way to do that was to go to England. I was very fortunate to study an LLM in Maritime Law at Southampton University. When I was offered a PhD candidature at Southampton, I was told the only professor available was Rob Merkin KC, the legend, and so then I did it in Reinsurance Law. He was such an inspiration.

You have taught insurance at universities across Europe, Asia and Australia. Is there much similarity in insurance law across those jurisdictions?

One of the fantastic aspects about working in English insurance law is that there is interest anywhere you go. In different countries, I have different audiences with different interests. Sometimes it is marine insurance, other times universities want to learn more generally about insurance and reinsurance law. At the University of Melbourne I taught International Commercial Insurance Law, focusing on the general principles. At a number of conferences I attended in Australia in the past, I have presented papers on general insurance law principles.

I think that there are a number of jurisdictions which look to English cases and authority as they do not have relevant precedent. That is not always the case though - Australia has its own body of case and statutory law on insurance. However, in marine insurance law, English law is still relevant, and in some areas such as brokers' duties and reinsurance, we also see the Australian courts referring to English cases.

There is also the challenge of teaching in jurisdictions that are not common law-based. Students have to grapple with stark differences between their jurisdiction and a common law system. I see that the contractual certainty and the objectivity principle governing insurance contracts may result in consequences that may be considered unusual or surprising in some foreign jurisdictions.

Can you tell us about anything you are currently researching and why it has piqued your interest?

I always have a few projects that I am working on. Top of mind for me at the moment is a case on appeal in England at the moment, *Delos Shipholding S.A. others -v- Allianz Global Corporate and Specialty S.E. & Ors* [2024] EWHC 719 (Comm) (the ***WIN WIN*** case). I am struggling to reconcile the Court's assessment of 'materiality of criminal charges against the assured company's director' with the principles and law, so I would like to write a critical piece.

Presently, I am updating my first book, *Reinsuring Clauses* (the first edition was published in 2010). I have recently finished writing a chapter on aggregation which was not included in the first edition.

A decision was recently handed down by our Court of Appeal, *Norman Hay Plc v Marsh Ltd* [2025] EWCA Civ 58, which discussed whether a broker's liability for their negligence to their clients could be assessed on a loss of chance basis. I am in the process of writing an article, with an expert from Singapore, on this matter.

We are about ten years on from the *Insurance Act 2015* in the UK – what are your reflections on its success? Has it worked?

It is hard to measure the success of any piece of legislation, especially in the first ten years.

Consider this - there was a period of time when the *Insurance Act* was in force, but we were waiting for cases to head to the courts and for decisions on the application of the *Insurance Act* to be made. As time has passed, there are more decisions being published, and being analysed.

Did it work? The assureds' claims for damages for late payment under section 13A of the *Insurance Act* have all been rejected. These cases focused on the 'reasonableness' of the insurer's investigation of the claim and how long it took. Some commentators expressed their doubts as to whether there will ever be damages awarded under this section. This may well be the case given that insurers might prefer to settle such claims.

The *Win Win* case I mentioned addressed for the first time in the *Insurance Act's* history 'attribution of knowledge' when the assured is a company and decided that the nominal director's knowledge of a criminal charge against him was not to be attributed to the company assured. This was an interesting development.

What does an Australian lawyer need to know about section 11 of the *Insurance Act* 2015 and how it compares with section 54 of the *Insurance Contracts Act 1984*?

Section 11 is similar to your section 54 as the purpose is the same, and insurers should determine claims based on the substance not the form. That is what the provisions appear aimed at achieving.

The expression of the sections is different. At first sight the most controversial part of section 11 seems to be its first sentence which provides that if a term is one 'defining the risk as a whole', section 11 does not apply to it. The ***Insurance Act*** does not set any guidance on what terms define the risk as a whole – the matter was left to the courts. However, none of the decisions that have been concerned with section 11 thus far have analysed whether the term being considered was *risk defining*; they moved straight to the remainder of section 11(1) and assessed the matter as the term was *risk mitigating*.

Also, the threshold that the assured must satisfy under section 11(3) appears to be higher than the standard provided for in section 54 of *Australia's Insurance Contracts Act*. In the former, the assured bears the burden of proof in order to prove that non-compliance with the term could not have *increased* the risk of the loss in the way the risk has occurred.

Utmost good faith – what does that mean to you? What should it mean to the industry?

How long have you got?

Some suggest that the concept of utmost good faith is an interpretive provision that applies when you have a contractual obligation and applies to the performance of these obligations, and it is done in a businesslike and fair way. They reject that it is an overreaching principle applying to the life cycle of a policy. I disagree, I think it is an overarching principle that applies pre-contractually and post-contractually. Parties should be acting in a business-like, fair way.

What are your thoughts are on how reinsurance contributes to financial stability, particularly given reinsurers' performance is impacted by catastrophic events which have been on the rise?

If reinsurers withdraw their support, there is no insurance. Reinsurers are crucial and an integral part of insuring any risk.

It is becoming more and more visible for many now - the protection gap for all those risks that are considered 'uninsurable' or 'uninsurably expensive'.

The solution appears to be collaboration between governments and reinsurers (an example is the *Terrorism Pool* which operates in Australia). This is something the Australian Government seems to be cognisant of, whilst recognising that government is not best placed to step in and bear all the risk. Reinsurers need to do this, with the backing of the government.

Any predictions on the next battlegrounds in the Courts for insurance?

I can only talk to English courts. COVID cases – especially about reinsurance - will keep our courts busy. Mr Justice Jacobs observed in *Gatwick Investment Limited & Others v Liberty Mutual Insurance Europe Se* [2024] EWHC 124 (Comm) at [113] that '*There are now well over a hundred claims which have been issued in the Commercial Court, and which are being managed in a Covid-19 BI sub-list.*'

We have also started to see the cases come through for the aircraft that have been stranded in Russia. The hearings which lasted a number of weeks have just ended. Initially there were jurisdiction issues and a dispute over the exclusive jurisdiction clause in favour of Russia, they accepted this was an exceptional circumstance and the case can be tried in England. I am very interested in the arguments to be made in these cases about the concept of 'total constructive loss' (which is a marine insurance concept).

What is next for insurance? If we did this interview again in five years – what will we be talking about?

Of course I have to say AI because insurers are using AI in their businesses. In five years time, I would expect that to be a topic – looking at the liability of institutions who use AI and exploring the liability where AI has made a decision.

In terms of insurtech, I am intrigued as to whether it has transformed the insurance industry, and what role the duty of good faith will play. There is both a client service piece to this and a disclosure one.

I think the other major issue will be the matter of the protection gap – how we will fill that in. I do not think governments will ignore that; I want to be optimistic on that.

Professor Gürses is a visiting Professor at the University of New South Wales in 2025.

CASE NOTE

A FEE-NOMENAL RESULT

***Birketu Pty Ltd v Atanaskovic* [2025] HCA 2**

SNAPSHOT

- By majority (Steward and Jagot JJ dissenting, in separate judgments), the High Court of Australia ruled that a self-represented unincorporated law firm can claim the costs of legal work performed by its own employed solicitors.
- This decision does not mean that such firms are able to recover the costs of legal work performed by its own partners.

ISSUES CONSIDERED BY THE COURT

- Whether the general common law principle (that costs are awarded only for professional costs actually incurred) is engaged where an unincorporated law firm represents itself in litigation and incurs costs for legal work performed by its employed solicitors.
- Quantification of costs incurred.

Facts

- The sole two partners of an unincorporated legal practice, Atanaskovic Hartnell, commenced proceedings in the Supreme Court of New South Wales to recover fees and disbursements for legal services provided to its former clients, Birketu Pty Ltd and WIN Corporation Pty Ltd (together, **Birketu**). Mr Atanaskovic, one of two partners of Atanaskovic Hartnell, represented the firm in those proceedings.[67]
- The Supreme Court of New South Wales had awarded Atanaskovic Hartnell $943,912.15, plus interest and its '*costs of the proceedings… assessed on the ordinary basis*'.
- Atanaskovic Hartnell filed an application for assessment of its costs, which included a claim for professional fees for work performed by its employed solicitors. It did not claim for work performed by Mr Atanaskovic. The costs assessor, Mr Castagnet, declined Birketu's request to determine as a preliminary issue whether Atanaskovic Hartnell was entitled to recover professional fees for work done by its employed solicitors.[68]
- Birketu commenced proceedings against Atanaskovic Hartnell and Mr Castagnet in the Supreme Court of New South Wales. Birketu obtained a declaration that the partners of Atanaskovic Hartnell were not entitled to recover the professional fees for work performed by their employed solicitors.[69]
- The first instance decision in respect of the costs incurred was overturned on appeal by the majority of the Court of Appeal of New South Wales (Kirk JA and Simpson AJA, Ward P dissenting).[70]
- Birketu appealed to the High Court of Australia.

Key principles for costs recovery for self-represented litigants

PRINCIPLE / CASE	EXPLANATION
General common law principle	The general common law principle is that costs are awarded only by way of indemnity or partial indemnity '*for professional legal costs actually incurred in the conduct of litigation*'.[71]
General rule	The (uncontroversial) general rule is that a self-represented litigant is not entitled to recover costs for their own time spent in litigation. Until the High Court decision of *Bell Lawyers Pty Ltd v Pentelow*[72] in 2019, this general rule was subject to two exceptions (which are explained further below): 1. the '*Chorley* exception' (rejected by *Bell Lawyers*); and 2. 'in-house solicitor rule' (affirmed by *Bell Lawyers*).[73]

PRINCIPLE / CASE	EXPLANATION
'*Chorley* exception'[74]	A self-represented solicitor could obtain recompense for legal work performed by the solicitor on their own behalf.[75] The *Chorley* exception was rejected by the High Court in *Bell Lawyers*.[76]
'**In-house solicitor rule**' (or the 'employed solicitor exception'[77])	The 'in-house solicitor rule' is that a litigant could obtain recompense for legal work performed by a lawyer employed by the litigant, on behalf of the litigant.[78] The 'in-house solicitor rule' was affirmed by the High Court in *Bell Lawyers*.[79]
Bell Lawyers	In *Bell Lawyers*, the High Court held that the *Chorley* exception was not part of 'the common law in Australia, calling it '*an affront to the fundamental value of equality of all persons before the law*'.[80]

The scene set by the High Court in Bell Lawyers

- Like *Birketu v Atanaskovic*, *Bell Lawyers* concerned costs orders made in New South Wales. The power and discretion to award costs in New South Wales is provided in section 98(1) of the *Civil Procedure Act 2005* (NSW) (***NSW Civil Procedure Act***). Section 3(1) of the *NSW Civil Procedure Act* provides that, '*costs, in relation to proceedings, means* ***costs payable*** *in or in relation to the proceedings, and includes fees, disbursements, expenses and* ***remuneration***' (emphasis added).
- The High Court in *Bell Lawyers* held that the reference to '*costs payable*' in this definition is a restatement of the general common law principle that costs are awarded only for professional costs actually incurred. The High Court concluded that the word '*remuneration*' in this definition did not include the notion of a person paying themselves for work they performed themselves.[81]
- The High Court in *Bell Lawyers* accepted that the recovery of the professional costs of in-house solicitors is available by way of indemnity to the employer, and stated that its rejection of the *Chorley* exception does not disturb the in-house solicitor rule.[82] Gageler J (as his Honour the Chief Justice then was) described the in-house solicitor rule as an *application* of (not an *exception to*) the common law principle that professional legal costs are confined to those *actually incurred* in the conduct of litigation.[83]

Issue to be determined

- The High Court in *Bell Lawyers* did not decide the question of whether the in-house solicitor rule applies to employees of litigant law firms.
- In a later case, the Court of Appeal of the Supreme Court of Victoria in *United Petroleum Australia Pty Ltd v Herbert Smith Freehills* ('***United Petroleum***')[84] unanimously held that litigant law firms are not entitled to recover costs of legal work performed by their employed solicitors. Key reasons for the decision in *United Petroleum*, included:
  - a salaried in-house solicitor is independent of their employer, whereas a solicitor employed by a law firm is not independent such that they *represent* their employer and are therefore akin to self-representatives; and
  - the policy of equality of all persons before the law, which underlies the decision in *Bell Lawyers*, means a firm of solicitors should not be permitted to recover such costs when an individual solicitor cannot.[85]
- Although the statute providing the power to award costs in Victoria is different to that in New South Wales, it was accepted by the Victorian Court of Appeal in *United Petroleum* and by the majority in *Birketu v Atanaskovic* (Gageler CJ, Gordon, Edelman, Gleeson and Beech-Jones JJ) (the **Majority**) that those statutory differences are not determinative for the question as to whether a litigant law firm is entitled to recover for the costs of work performed by employed solicitors. The common law principle that costs are awarded only for professional costs *actually incurred* applies in both jurisdictions, and so it was a question of application of the common law principle.[86]
- The critical question for the High Court to determine in *Birketu v Atanaskovic* was whether the common law principle (embodied in the reference to '*costs payable*' in the definition of 'costs' in section 3(1) of the *NSW Civil Procedure Act*) was engaged where an unincorporated law firm acts for itself in litigation.[87] The Majority found it was.

Analysis by the High Court

- The Majority, writing in a single decision, concluded that litigant solicitors or unincorporated law firms can be compensated for their legal work on the basis that the expenses of the salaries and overheads associated with having that work done by employees constitutes legal professional costs *actually incurred*.[88]
- The Majority view was that such an approach aligned with the fundamental principle of equality before the law emphasised in *Bell Lawyers*.[89]
- In addition, the Majority said that denying a litigant solicitor or unincorporated law firm compensation for the costs of work performed by employed solicitors would depart from the application of the general common law principle.[90]
- As to arguments relating to the difference between in-house solicitors and solicitors employed by a law firm, the Majority acknowledged that employed solicitors are directly supervised by their employers, that there is a lack of objectivity and professional detachment when firms represent themselves, as well as a potential incentive for self-representation. That said, the Majority concluded that those factors do not affect the general common law principle that costs are awarded to cover professional legal costs *actually incurred*.[91]
- In separate and detailed dissenting judgments, Steward and Jagot JJ each agreed with the decision of Victorian Court of Appeal in *United Petroleum*.[92] Steward and Jagot JJ each considered that the substantive effect of the Court of Appeal's decision below was to restore (in part) the *Chorley* exception, and for their Honours such a result would undermine the decision of the High Court in *Bell Lawyers*.[93]
  - For Steward J (in dissent), the recovery of costs would '*make a mockery of what was decided in Bell Lawyers, and would, in substance, resurrect the Chorley exception*.'[94]
  - Jagot J (in dissent) likewise equated allowing recovery of the costs to a '*partial reinstatement of the Chorley exception in Australia*' which '*would therefore restore the very affront to the equality of all persons before the law which motivated the decision in Bell Lawyers*.'[95]

Quantification of costs

- The Majority in *Birketu v Atanaskovic* also addressed the argument that allowing litigant solicitors and unincorporated law firms to recover costs of legal work performed by their employed solicitors would violate the general common law principle by enabling them to profit from their own litigation. The Majority described this concern as one of '*quantification by way of assessment*'.[96]
- The Majority noted this matter has been repeatedly raised in the broader context of the general common law principle and the in-house solicitor rule.[97]
    - The '*traditional approach*' to award costs on a basis comparable to the cost which would have been incurred and allowed had an independent solicitor been engaged, would not ordinarily result in an employer-litigant obtaining more than an indemnity for expenses *actually incurred*.[98]
    - The Majority emphasised that an objecting party can challenge this if it results in more than indemnity for expenses.[99]

Result

- The High Court overturned the decision of the Victorian Court of Appeal in *Uniting Petroleum* and dismissed the appeal with costs.[100]
- As the general common law principle is that costs are awarded to cover professional legal costs *actually incurred*, self-represented unincorporated law firms awarded costs orders are entitled to claim the cost of professional fees for work performed by employed solicitors.

CASE NOTE

UNFAIR OR NOT UNFAIR: THAT IS THE QUESTION

***ASIC v Auto & General Insurance Company Ltd* [2024] FCA 272**

SNAPSHOT

- This case was about whether a term regarding notification in contracts of home and/or contents insurance was an unfair contract term.
- Jackman J concluded that the term was ultimately not unfair and dismissed the proceedings brought by ASIC against Auto & General Insurance Company Ltd (**AGI**) (an insurer).
- Notwithstanding that AGI's reliance on the term would cause detriment to insured customers and the term lacked sufficient clarity, the term did not cause a significant imbalance of rights between AGI and insured customers and was reasonably necessary to protect AGI's legitimate interests.
- This is the first case to consider the application of the unfair contract terms regime in section 12BF of the *Australian Securities and Investments Commission Act 2001* (Cth) (**ASIC Act**) to an insurance contract.
- Although ASIC was not successful, Jackman J accepted that the Notification Clause would cause a detriment to insureds and was not sufficiently transparent.

INSURANCE ISSUES CONSIDERED BY THE COURT

- Whether an insured's obligation to notify an insurer of changes in a contract for home and/or contents insurance was 'unfair' within the meaning of section 12BF of the ASIC Act.
- Explores the interaction between the unfair contract terms regime and the *Insurance Contracts Act 1984* (Cth), particularly section 13, which provides a duty of utmost good faith and section 54, which provides that in certain circumstances an insurer may not refuse to pay a claim.

Facts

- ASIC commenced proceedings against AGI alleging that a contractual term in a product offered by AGI was unfair within the meaning of section 12BF of the ASIC Act.[101]
- AGI entered into (including by renewal) approximately 1,377,900 contracts of home and/or contents insurance, between 5 April 2021 and 4 May 2023 by way of, among other things, Product Disclosure Statements (**PDSs**) and supplementary PDSs on substantially identical terms.[102]
- Relevantly, the PDSs[103] included a section that read:[104]

  Tell us if anything changes while you're insured with us

  While you're insured with us, you need to tell us if anything changes about your home or contents.

  If you don't tell us about changes, we may:

  - *refuse to pay a claim*
  - *reduce the amount we pay*
  - *cancel your contract*
  - *not offer to renew your contract.*

  Examples of changes we want you to tell us about are:

  - *Your insured property or address for contents changes*
  - *Paying guests stay in your home, for example, Airbnb, Homestayz*
  - *You are moving out and rent your home to tenants*
  - *Any construction, alteration, or renovation work will start or finish*
  - *Your home will be demolished, by you or a government authority*
  - *Your property will be unoccupied for more than 60 days, or is occupied by trespassers*
  - *You find out your home is heritage listed or has a heritage overlay*
  - *Your home is no longer in good condition*
  - *You will start earning an income at your insured address*
  - *Security devices are removed, or broken*
  - *You find out the building materials contain asbestos.*

- This section was referred to in the judgment and in this case note as the '**Notification Clause'.**[105]

Analysis by the Court

Issue 1: The Proper Construction of the Notification Clause

- The first issue Jackman J considered was the proper construction of the Notification Clause.
- Jackman J relied on orthodox principles of construction of commercial contracts.[106] Specifically, the meaning of a contract is determined objectively, by asking what a reasonable businessperson would have understood those terms to have meant and having regard to the commercial purpose of the contract.[107] The purpose of an insurance contract is to share the risk of a contingency, which involves identifying the risks that the insurer has, or has not, agreed to cover.[108]
- Jackman J concluded that, on its proper construction, the Notification Clause provided that:

  a) the insured must notify AGI during the policy period if there was any change to the information about the insured's home and/or contents insurance that the insured had previously disclosed prior to entry into that contract (including prior to renewal); and

  b) if an insured failed to notify of any such change, AGI had the discretionary right to refuse to pay the claim, reduce the amount paid, cancel the contract or not offer to renew the contract, to the extent that it would be consistent with the commercial standards or decency and fairness to do so (**AGI Discretion**).[109]

Insured's Obligation to Notify

- Jackman J rejected ASIC's submission that the word 'anything' in the expressions '*Tell us if* anything *changes while you're insured with us*' and '*While you're insured with us, you need to tell us if anything changes about your home or contents*' should bear its literal meaning.[110] This is because its literal meaning would require the insured to notify AGI of everyday changes to home and contents, such as the purchase of groceries, which was an absurd construction.[111]
- Instead, Jackman J accepted AGI's submission that the Notification Clause required the insured to disclose '*any change to the information about the insured's home or contents that the insured customer provided to AGI prior to entry into the contract*.'[112] This is because the word 'change' was consistently used throughout the PDS and elsewhere in the insurance contract to refer to information already provided to AGI.[113]

AGI's Rights Upon Breach

- Jackman J concluded that AGI's exercise of the Insurer Discretion is subject to section 13 of the Insurance *Contracts Act 1984* (Cth) (**ICA**) (**Duty of Utmost Good Faith**), which requires each party to an insurance contract:

  a) 'to act towards the other party, in respect of any matter arising under or in relation to it, with the utmost good faith';[114] and

  b) behave consistently with commercial standards of decency and fairness.[115]

- As such, if an insured fails to notify AGI of a relevant change in breach of the Notification Clause, AGI has the right to exercise the AGI Discretion '*if and to the extent that it would be consistent with commercial standards of decency and fairness for the defendant to do so.*'[116]

Issue 2: Was the Notification Clause 'unfair'?

- The key issue in the proceeding was whether the Notification Clause was 'unfair' within the meaning of section 12BF(1) of the ASIC Act.[117]
- The criteria to determine whether a term in a consumer contract is 'unfair', within the meaning of section 12BF of the ASIC Act, are outlined in section 12BG of the ASIC Act. Specifically, a term of a consumer contract or small business contract is unfair if:

  a) it would cause a significant imbalance in the parties' rights and obligations arising under the contract;[118]

  b) it is not reasonably necessary to protect the legitimate interests of the party who would be advantaged by the term;[119] and

  c) it would cause detriment (whether financial or otherwise) to a party if it were to be applied or relied on.[120]

- In considering those three criteria of unfairness, Jackman J was also required to consider the extent to which the Notification Clause is transparent.[121]
- Jackman J observed that whether a term is unfair must be assessed against the context of its legal environment, which, in the case of an insurance contract, includes the ICA's purpose to strike *'a fair balance between insurers, insureds and other members of the public'*.[122]

Does the Notification Clause cause a 'significant imbalance'?

- Jackman J concluded that the Notification Clause did not cause a '*significant imbalance*', meaning section 12BF(1)(a) of the ASIC Act was not satisfied.
- Jackman J observed that the term '*significant imbalance*' refers to the substantive unfairness of the contract.[123] Whether a term causes a '*significant imbalance*' requires a consideration of the relevant term compared with the parties' rights and obligations under the contract.[124]
- ASIC made three submissions that the Notification Clause caused a significant imbalance:

  1) First, absent the Notification Clause, the insured would have no obligation to notify AGI of changes to its home and/or contents, as this obligation does not exist at common law. At common law, the parties' disclosure obligations cease once they enter into the relevant contract.[125]

  Jackman J concluded that the Notification Clause did not cause a '*significant imbalance*' by *creating* rights and obligations which would not have otherwise existed. Further, comparing the effect of the contract with and without the Notification Clause is only one factor in the overall analysis and the contract as a whole should be taken into account. Jackman J also determined that there was a meaningful relationship between the notification obligation provided by the Notification Clause and the protection of AGI's interests.[126]

  2) Second, the Notification Clause gave rights to AGI but no corresponding rights to the insured.[127]

  Jackman J concluded that the Notification Clause *did* confer reciprocal rights on the insured *because*, in exchange for notifying AGI of changes, the insured received ongoing insurance cover.[128] Further, the existence of a unilateral obligation did not create an imbalance; it simply reflected the nature of the contract.[129]

  3) Third, if an insured breached the Notification Clause, AGI had broad discretionary rights, such as to deny a claim in its entirety, which gave rise to an imbalance. This submission turned on the interaction between section 54 of the ICA and section 12BG(1) of the ASIC Act.[130]

Jackman J concluded that AGI's rights following a breach of the Notification Clause were qualified by the Duty of Utmost Good Faith.[131] For Jackman J, the Duty of Utmost Good Faith prevented AGI from relying on the Notification Clause to an insured's prejudice, unless AGI itself would suffer prejudice because an insured failed to notify AGI of changes. As such, the substantive effect of section 54 of the ICA was consistent with the proper construction of the Notification Clause, and on that basis there was no reason to consider the relationship between section 12BG(1) of the ASIC Act and section 54 of the ICA.[132]

Was the Notification Clause 'reasonably necessary' to protect AGI's 'legitimate interests'?

- Jackman J found that the Notification Clause was reasonably necessary to protect AGI's legitimate interests, meaning section 12BF(1)(b) of the ASIC Act was not satisfied.
- Jackman J observed that authorities relating to section 24 of the Australian Consumer Law (**ACL**) are relevant, as section 24 of the ACL is analogous to section 12BG of the ASIC Act. Such authorities establish that the term:
  a) '*legitimate interests*' depends on the particular business and the legal context of the contract; and
  b) '*reasonably necessary*' requires a proportionality analysis between the term and the loss/risk the term seeks to prevent.[133]
- The onus was on AGI, as the defendant, to prove that the clause was reasonably necessary to protect its legitimate interests.[134]
- Jackman J concluded that:
  a) '*reasonably necessary*' did not include a '*requirement of absolute necessity*';[135]
  b) AGI's legitimate business interests included choosing the particular risks it provided coverage for, and that it had a legitimate interest in cancelling or otherwise varying contracts of insurance if it became aware of information that changed that risk-profile;[136]
  c) AGI had a legitimate interest in not being liable for claims it did not insure against;[137] and
  d) the obligation in the Notification Clause for insureds to disclose relevant changes was proportionate to protecting those legitimate interests.[138]

Would the Notification Clause cause 'detriment' to the insured customers?

- Jackman J found that AGI's reliance on the Notification Clause would cause a 'detriment' to the insured, triggering section 12BF(1)(c) of the ASIC Act.[139]
- Jackman J relevantly observed that:
  a) a 'detriment' will exist if the term is disadvantageous to the insured[140] and that a 'significant' detriment is not required;[141] and
  b) even if a disadvantage represents a '*fair outcome*', it is nevertheless a disadvantage and can still cause a detriment to the insured.[142]

Transparency

- Jackman J accepted that the Notification Clause lacked clarity, partly because an insured may not have been able to properly construe its meaning.[143]
- Jackman J observed that, while a lack of clarity is relevant to considering whether a detriment was caused,[144] it is not an '*independent element of unfairness*'.[145] Rather, transparency may influence the analysis of the three elements in section 12BG(1)(a) to (c).[146]
- In applying transparency to those three elements, Jackman J concluded that because the Notification Clause did not cause a '*significant imbalance*' and was reasonably necessary to protect AGI's legitimate interests, a lack of transparency did not change those conclusions.[147]

Result

- This decision provides an illuminating application of the unfair terms regime to an insurance contract. It highlights that the unfair terms regime is to be applied with regard to the impact of the ICA, particularly the Duty of Utmost Good Faith and section 54 of the ICA.
- Furthermore, even though ASIC failed to make its case, Jackman J accepted that the Notification Clause would cause a detriment to insureds and was not sufficiently transparent.
- An appeal from ASIC was heard before the Full Federal Court on 28 August 2024 and as at the date of publication of this *Insurance Pocketbook*, the decision remains reserved. The online version of the *Insurance Pocketbook* will be updated once judgment is handed down.

CASE NOTE

UNFAIR TERMS OR JUST A PEC-TACULAR MISSTEP?

***Australian Securities and Investments Commission v HCF Life Insurance Company Pty Ltd* [2024] FCA 1240**

SNAPSHOT

- Where a pre-existing condition (**PEC**) exclusion in a life insurance policy is inconsistent with section 47 of the *Insurance Contracts Act 1984* (Cth) (**ICA**), a Court may deem the exclusion as being unenforceable to the extent of the inconsistency, and make a finding of misleading conduct within the meaning of section 12DF of the *Australian Securities and Investments Commission Act 2001* (Cth) (**ASIC Act**).
- When considering whether a term is unfair, a Court will have regard to the overall legal environment in which the term operates, including the ICA.
- A consumer being left confused about their rights and obligations under a product does not necessarily mean that the terms of the product are unfair.

INSURANCE ISSUES CONSIDERED BY THE COURT

- Does inconsistency between a life insurance PEC exclusion and section 47 of the ICA render the PEC term partially unenforceable, or give rise to misleading conduct within the meaning of section 12DF of the ASIC Act?
- Does a policy term's inconsistence with section 47 of the ICA make it an unfair contract term within the meaning of section 12BF of the ASIC Act?

Facts

- Section 47 of the ICA provides that an insurer may not rely upon an exclusion in respect of a PEC where '*at the time when the contract was entered into, the insured was not aware of, and a reasonable person in the circumstances could not be expected to have been aware of, the sickness or disability*'.
- Published in August 2019, ASIC's Report 587 on 'The Sale of Direct Life Insurance' stated, '*Pre-existing condition exclusions … should be clearly explained to the consumer*'.
- HCF Life Insurance Company Pty Ltd (**HCF**) subsequently made changes to its PEC exclusion to make it clearer for policyholders to understand. In policies issued between 1 April 2021 and 25 March 2024, PEC was relevantly defined as:

  > *any condition, illness or ailment where the signs or symptoms of which in the opinion of a registered medical practitioner, existed at any time before the Cover Commencement Date, even if a diagnosis had not been made*[148] (**2021 PEC Clause**).

- Proximate versions of the PEC definition were similar to the 2021 PEC Clause and received similar court commentary (together, forming the **PEC Terms**).[149]
- ASIC commenced proceedings against HCF Life alleging that HCF Life issued life insurance products containing exclusions in respect of PECs which were:[150]
  - rendered partially unenforceable by virtue of section 47 of the ICA;
  - misleading in contravention of section 12DF of the ASIC Act; and
  - unfair within the meaning of section 12BF of the ASIC Act.

Analysis by the Court

Issue 1: Does section 47 of the ICA render the PEC Terms partially unenforceable?

- The Court agreed that the PEC Terms were rendered partially unenforceable as the inquiries mandated by the PEC Terms and section 47 of the ICA concern questions upon which reasonable minds would differ.[151]

Construction of section 47 of the ICA

- In construing section 47 of the ICA, HCF Life submitted that the second limb of section 47(2) necessarily includes the awareness that would have been obtained had the insured consulted their doctor prior to entry into the insurance contract. This submission was rejected by the Court.

- Jackman J concluded that section 47(2) requires an objective test of awareness and that potential medical tests were irrelevant unless a reasonable person in the circumstances would be expected to take them.[152] Jackman J noted that the fact that medical tests could have been taken and would have disclosed the insured's condition is irrelevant if a reasonable person in the circumstances could not be expected to have taken such tests.[153]
- In addition, HCF Life adopted a position that there is no temporal limit on the relevant subjective or objective awareness which must have existed prior to contracting. This submission was rejected by the Court. Jackman J noted section 47(2) requires that the subjective or objective awareness of the insured be assessed 'at the time when the contract was entered into'.[154]
- Jackman J observed that section 47 of the ICA does not vary the terms of a contract of insurance but creates a conditional statutory prohibition that precludes the insurer from relying upon exclusions for PECs in specified circumstances.[155]

Construction of the PEC Terms

- Jackman J observed that the PEC Terms rely on a medical practitioner's subjective opinion, which is limited to assessing signs or symptoms before the cover commencement date. The terms '*signs or symptoms*' carry their medical meanings, as established in case law, and '*sickness or disability*' in section 47 of the ICA is equivalent to '*condition, illness, or ailment*' in the PEC Terms.[156]

Were the PEC Terms partially unenforceable?

- The questions asked under the PEC Terms and section 47 of the ICA are quite different and can lead to different results as:
  - there is a difference between having signs and symptoms (which is what the PEC Terms refer to) and actually knowing about the underlying condition, illness or ailment to which they relate (which is what section 47 of the ICA refers to)[157]; and
  - even if the questions under the PEC Terms and section 47 of the ICA were the same, the PEC Terms turn on the subjective opinion of a registered medical practitioner, unlike section 47,

  leading to the conclusion that PEC Terms were partially unenforceable.
- The Court reached this finding despite the PEC Terms being administered consistently with section 47 of the ICA.[158]

Issue 2: Do the PEC Terms give rise to misleading conduct?

- ASIC's position was that HCF Life's policies were misleading, as a reasonable consumer would view the PEC Terms as a complete statement of benefit exclusions, despite section 47(2) making them partially unenforceable. The Court agreed, finding a breach of section 12DF of the ASIC Act.[159]

The first and second steps – impugned conduct in trade or commerce

- HCF Life did not dispute that it engaged in the 'impugned conduct' in trade or commerce.[160]

The third step – meaning conveyed

- ASIC submitted that an ordinary and reasonable member of the public would read and understand the PEC Terms within the PDS as being an accurate and complete statement of when benefits will not be payable under a policy by reason of a PEC.[161]
- HCF Life submitted that all that is conveyed to readers of the PDS is that HCF Life is willing to treat with members of the public on the terms of the contract, including the PEC Terms.[162]
- The Court accepted ASIC's submissions as the PDSs:[163]
  (a) were not mere recitations of contractual terms as each PDS was designed to help insureds decide whether the product is right for them; and
  (b) did not refer at all to the possibility that any of their terms may be unenforceable or may be subject to the application of other laws.
- Jackman J noted an ordinary and reasonable reader would be ignorant of the potential effect of section 47 of the ICA and nothing in the PDSs adverts to the possibility that it may preclude HCF Life from relying upon the PEC Terms in particular circumstances.[164]

The fourth step – liable to mislead

- ASIC submitted that the meaning conveyed by the impugned conduct is misleading as it presents as an accurate, complete and unqualified statement of the circumstances in which benefits will not be payable to a consumer by reason of a PEC, despite section 47(2) of the ICA rendering the PEC Terms partially unenforceable.[165]
- HCF Life submitted that ASIC failed to demonstrate that the mismatch between section 47 of the ICA and the PEC Terms is anything more than speculative and does not give rise to the sufficient likelihood of an outcome that its failure to advert to section 47 is liable to mislead.[166]
- The Court accepted ASIC's submission and rejected HCF Life's submission as:[167]
  (a) HCF Life's submission erroneously treats the requirement in section 12DF that conduct be liable to mislead the public as a requirement that the public be misled to their detriment; and
  (b) the probability of mismatch between section 47 of the ICA and the PEC Terms is real and not speculative.
- Notably, the Court reached this conclusion despite ASIC having not adduced any evidence of a policyholder actually having been misled, as the critical question is whether HCF Life's conduct was liable to mislead the public.

The nature, characteristics or suitability of financial services

- HCF Life argued that ASIC's complaint focused on the failure to disclose section 47 of the ICA rather than the nature, characteristics, or suitability of the contracts.[168] The Court rejected this, concluding that HCF Life misinterpreted 'any financial services' in section 12DF, as the relevant service is the provision of insurance itself.[169]

Issue 3: Are the PEC Terms an unfair contract term?

- Section 12BG(1) of the ASIC Act states that a term of a contract will be '*unfair*' if:
  (a) it would cause a significant imbalance in the parties' rights and obligations arising under the contract; and
  (b) it is not reasonably necessary in order to protect the legitimate interests of the party who would be advantaged by the term; and
  (c) it would cause detriment (whether financial or otherwise) to a party if it were to be applied or relied on.

- Jackman J noted that to make out a contravention of section 12BF of the ASIC Act, all three criteria in section 12BG need to be satisfied to deem a term as '*unfair*'. Also, although the criterion in section 12BG(1)(c) was satisfied, the criteria in sections 12BG(1)(a) and (b) were not satisfied.
- Jackman J found that HCF Life did not contravene section 12BF and the PEC terms were not unfair.

Construction of section 12BG

- Jackman J noted there are two points concerning the proper construction of section 12BG namely:

  (a) when assessing the three criteria of unfairness in section 12BG(1), the Court must take into account the context of the overall legal environment in which the terms of the contract operate, including section 47 of the ICA;[170] and

  (b) it is the time of entry into the contract that is the relevant time of assessment of the criteria set out in section 12BG(1).[171]

Section 12BG(1)(a) – causing a significant imbalance in the parties' rights and obligations

- Jackman J noted that if the focus were solely on the contracts, then the PEC Terms may well be unfair. However, the exercise must also take into account the ameliorative effect of section 47 of the ICA.[172]
- Once section 47 is taken into account, Jackman J noted the PEC Terms do not cause a significant imbalance in the parties' rights and obligations as:

  (a) the fact that a consumer is left confused about his or her rights and obligations does not mean those rights and obligations are imbalanced;[173] and

  (b) there is no suggestion that the PEC Terms are not transparent as the inquiry mandated in section 12BG is the extent to which the term is transparent, and not the extent to which the parties' rights and obligations are transparent.[174]

Section 12BG(1)(b) – reasonably necessary to protect the legitimate interests of the party advantaged

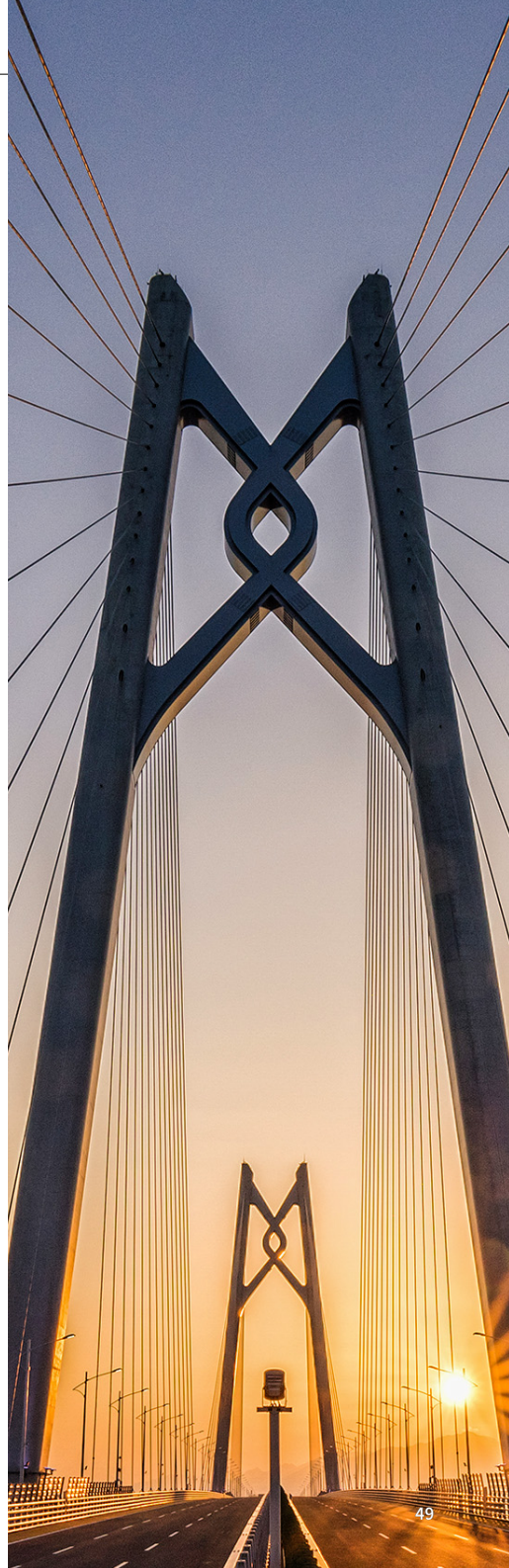
- In considering what is reasonably necessary to protect legitimate interests, Jackman J noted that a determination of what is '*reasonably necessary*' may take into account other options that might be available to the party in terms of protecting its business and which are less restrictive to the other party to the contract.[175]
- For that reason, Jackman J considered the relevant comparison should be between a contract that contains the PEC Terms and a contract that contains a similar term that protects HCF Life's business but which is less restrictive to consumers.[176]
- Jackman J accepted HCF Life's submission that the PEC Terms were reasonably necessary to protect its legitimate interests.

Section 12BG(1)(c) – causing detriment to a party

- HCF Life did not dispute that detriment for the purposes of section 12BG(1)(c) includes uncertainty as to whether a consumer can make a claim. Instead, HCF Life submitted that any uncertainty in the present case only exists to the extent that the PEC Terms are liable to mislead.[177]
- The Court accepted that the PEC Terms are liable to mislead and therefore that those terms would cause detriment.

Result

- The PEC Terms were rendered partially unenforceable by virtue of section 47 of the ICA.
- HCF Life contravened section 12DF of the ASIC Act insofar as HCF Life engaged in misleading conduct in connection with the PEC Terms, but not section 12BF insofar as the PEC Terms were not 'unfair' in accordance with the criteria in section 12BG(1) of the ASIC Act.
- This case underscores the critical importance for insurers to align their policy terms with the exact requirements of the ICA. Failure to do so not only exposes insurers to the risk of having their terms deemed unenforceable but also increases the likelihood of facing ASIC action for misleading conduct and unfair contract terms.



CASE NOTE

BETWEEN A ROCK AND A HARD PLACE SUBSTANTIAL CHANGES TO POLICY TERMS CAN OCCUR

***Integrity Life Australia Limited, in the matter of Integrity Life Australia Limited* [2025] FCA 92**

SNAPSHOT

- All or part of the life insurance business of a life company may be transferred to another company under a scheme confirmed by the Federal Court of Australia (**Court**) pursuant to Part 9 of the *Life Insurance Act 1995* (Cth) (**Life Act**).
- In deciding whether to confirm a scheme, courts must have regard to '*the interests of the policy owners of a company affected by the scheme*', per section 194(2)(a) of the Life Act.
- The question of whether policy owners will be adversely affected requires a comparison of their security and reasonable expectations without the scheme with what it would be if the scheme were implemented.
- Where benefits to a policy owner are otherwise at risk, a court may confirm a scheme that is in the interests of policy owners as a whole, even if there are adverse impacts by loss or reduction of rights or the increase of premiums, including the substitution of existing insurance policies for equivalent or nearly equivalent insurance policies issued by the acquiring insurer.

INSURANCE ISSUES CONSIDERED BY THE COURT

- In what circumstances can a court confirm a Part 9 scheme?
- Can a court confirm a Part 9 scheme where changes to policy terms and conditions and premium rates disadvantage some policy owners?

Facts

- Integrity Life Australia Limited (**ILAL**) and AIA Australia Limited (**AIAA**) made an application under Part 9 of the Life Act for confirmation of a scheme for the transfer of part of the life insurance business of ILAL to AIAA (**Scheme**).[178]
- ILAL intended to complete the run-off of certain ILAL life policies including those known as the Integrity Policies and the Ex-CUNA policies (together with other policies, the **Retail Life Insurance Business**):[179]
  - to protect the contractual benefits of policy owners; and
  - to provide options for continuing the cover of policy owners in light of ILAL's deteriorating financial position.
- Under the Scheme, certain ILAL policy owners would have their policy replaced with equivalent cover under an AIAA corresponding product.[180]
- ILAL provided evidence that it was necessary to structure the Scheme this way, as the size of the transferring in-force Retail Life Insurance Business was too small for a life insurer to receive and be able to manage profitably on the existing terms and conditions.[181]

Analysis by the Court

Issue 1: In what circumstances can a court confirm a Part 9 scheme?

- In deciding whether to confirm a scheme, a court must have regard to, amongst other matters, '*the interests of the policy owners of a company affected by the scheme*' per section 194(2)(a) of the Life Act.
- Jackman J noted that the courts have not been faced with an application to confirm a scheme where:[182]
  - (a) '*the transfer is a consequence of the depleted financial capital position of the transferor and the main object of the scheme is to safeguard the ongoing cover of policyholders and the security of those benefits, which would otherwise be imperilled in the immediate future*'; and
  - (b) '*the scale and nature of the transferring business is such that policy terms need to be replaced in their entirety for some products by those of the transferee insurer in order for the scheme to be commercially viable*'.
- Jackman J noted that although the Court has a broad discretion, it is not unfettered and must be exercised on the evidence, having regard to the objects of the Life Act, principally the protection of the interests of policy owners

in a manner consistent with the continued development of a viable, competitive and innovative life insurance industry.[183]

- Jackman J emphasised that there is no authority to the effect that a court cannot confirm a scheme if the proposed scheme will have a material effect on a policy owner or some policy owners.[184]
- Jackman J cited English authorities which were in substance applicable to the Court's decision under section 194 of the Life Act. These authorities emphasised that:
    - it is not the case that any scheme which leaves someone adversely affected must be rejected; and
    - a court does not have to be satisfied that no better scheme could have been devised.

Issue 2: Can a court confirm a Part 9 scheme where changes to policy terms and conditions and premium rates disadvantage some policy owners?

- Of relevance to the Court were the following factual circumstances:
    - ILAL had reported breaches of prudential standards relating to its capital and solvency position and had been subject to directions issued by APRA and under its supervision;[185]
    - the actuarial evidence was that ILAL was not in a strong financial position to address the potential risks that may emerge;[186]
    - if the Scheme did not proceed, then ILAL's capacity to meet policy owner benefits in full was expected to be exhausted, such that ILAL policy owners would lose the benefit of their cover by November 2027;[187]
    - the Scheme was likely to result in material improvement in the benefit security of transferring ILAL policy owners, as AIAA would remain in a sound financial position after the proposed transfer;[188]
    - most transferring policy owners would have their rights and benefits under their existing policy replaced by the equivalent or nearest equivalent rights and benefits under the AIAA policy wording, and their premiums would be adjusted accordingly;[189]
    - the changes to policy terms and conditions and premium rates may be disadvantageous to some policy owners either because of the loss or reduction of benefits, or because of significant increases in premiums, or both; and[190]
    - the actuarial evidence was that the Scheme was in the interests of policy owners as a whole, and that such adverse impacts by loss or reduction of rights or the increase of premiums were acceptable in the circumstances.[191]
- The Court was aware of the novelty of the Scheme, in particular as the terms and conditions of a significant number of transferring policies would be replaced by an equivalent or nearly equivalent policy issued by AIAA.
- Jackman J relied on evidence that the novel structure of the Scheme was necessary as:[192]
    - the size of the transferring in-force retail life business was too small for a life insurer to receive, to be able to manage profitably, on its existing terms and conditions; and
    - ILAL was not able to identify any insurer that would accept the transferring business without changing its product onto the receiving insurance product terms.
- The actuarial evidence which the Court relied on was that:
    - in some cases, the AIAA product provides more generous benefits than the ILAL product;
    - the reasonable benefit expectations of ILAL policy owners in relation to policy administration and systems, claims management, investment management and the management of guarantees were expected to be met as there were no material differences between AIAA and ILAL in those areas; and
    - the intended premium increases if the Scheme did not proceed.
- In summary, counsel who appeared for AIAA neatly encapsulated:[193]

    This Scheme is of course unusual, in that in certain respects, ILAL policyholders will be detrimentally affected by the Scheme. It is however clear, that overall, given a comparison between their position if the Scheme is not confirmed and the transfer does not proceed, with their position under the Scheme if the transfer occurs, looked at holistically, all ILAL policyholders will be better off overall if the Scheme is confirmed.

Result

- Pursuant to section 194 of the Life Act, the Scheme was confirmed by the Court without modification.[194]

CASE NOTE

PLANE SPEAKING DECISION ON EXCESS AND EROSION

***Matheson Property Group Pty Ltd (Trustee) v Virgin Australia Holdings Limited (No 4)* [2024] FCA 280**

SNAPSHOT

- This decision concerned an insurer's liability to pay Defence Costs, and at what time those Defence Costs were payable. The decision was part of a class action (unrelated to insurance) which is ongoing at the time of publication.
- The case applied the well-accepted principles for construing polices of insurance in determining whether the insurer's liability to pay Defence Costs is triggered before or after the excess is reached.

INSURANCE ISSUES CONSIDERED BY THE COURT

- Principles for construing insurance policies.

Facts

- This case note concerns the fourth decision of Lee J of the Federal Court in a representative proceeding commenced pursuant to Pt IVA of the *Federal Court of Australia Act 1976* (Cth). A fifth decision (unrelated to insurance) was delivered in November 2024.[195] The class action remains ongoing at the time of writing.
- The background to the class action is that Matheson Property Group Pty Ltd (**MPG**) represents a class comprising various holders of unsecured notes issued by the first respondent Virgin Australia Holdings Limited (**Virgin**) pursuant to a prospectus dated 5 November 2019, which MPG asserts was misleading and deceptive.
- Prior to the commencement of the class action, a deed of company arrangement (**DOCA**) was entered into with respect to various entities in the Virgin group of companies, including Virgin (**Deed Companies**).[196] Relevantly, pursuant to the DOCA:
  - a Deed Company is not liable for any amounts (including Defence Costs) which are not indemnifiable under an insurance policy; and
  - persons bringing a claim against a Deed Company (such as MPG) must indemnify the Deed Company in respect of any uninsured amounts.
- Virgin held a directors and officers insurance policy with Liberty Mutual Insurance Company Australia (**Liberty**). Liberty had agreed to indemnify Virgin in connection with the class action proceeding, subject to various matters, including the application of the excess in the policy.[197]
- Among other pre-administration insurers, Liberty had been joined to the proceeding pursuant to rule 9.05 of the *Federal Court Rules 2011* (Cth).[198] This joinder arose out of application from Virgin, but orders were ultimately made by consent. The insurers' involvement arises from the need to determine whether insurance responds to the claims the subject of the class action.
- In this fourth decision, Lee J ordered that Liberty also be joined as a respondent to two cross claims in the class action.
- The relevant question before the Federal Court in this (fourth) decision was whether Liberty's liability to pay Defence Costs was triggered before or after the excess is reached, as this would determine whether defence costs up to the amount of the excess were payable by Liberty or MPG (pursuant to the indemnity).
- It was uncontroversial that the definition of 'Loss' included Defence Costs pursuant.[199]
- The following clauses were central to the determination of this question:

2. Extensions

The following extensions are subject to all the terms, conditions and exclusions, including all definitions and the Limit of Liability, Sub-Limits of Liability and applicable Excesses of this Policy:

2.1 Advancement of Costs & Expenses

Liberty will pay for Defence Costs and the reasonable costs and expenses incurred under any Insuring Clause or applicable extension as and when they are incurred prior to final resolution of any Claim, Self-Report, Raid or Inquiry. However, each Insured shall repay to Liberty all payments of Defence Costs or any other costs and expenses incurred on that Insured's behalf if, and to the extent, it is established that such Defence Costs or other costs and expenses are not in fact insured under this Policy.

…

3. Optional Extensions

The following optional extensions are subject to all the terms, conditions, extensions and exclusions, including all definitions and the Limit of Liability, Sub-Limits of Liability and applicable Excesses of this Policy and shall apply only if they are specifically included in the Schedule.

3.1 Company Securities Liability

Liberty will pay to or on behalf of the Company the Loss which the Company is legally liable to pay as a result of a Securities Claim.

The Co-Insurance Percentage which applies to this extension is specified in the Schedule.

…

3.2 Excess

Liberty will only pay in respect of a claim under this Policy the amount which is above the applicable Excess. The Excess shall be the first amount borne by the Company and shall remain uninsured.

- As to the construction of these clauses:
  - in reliance on clause 6.2 and the chapeaux to clauses 2.1 and 3.1 (including the specific reference to 'Excesses'), Liberty and Virgin argued the first $5m incurred by Virgin is uninsured due to the application of the excess, such that Liberty is only required to pay amounts (including Defence Costs) once the excess had been exhausted; [200] and
  - conversely, MPG contended that the words '*as and when they are incurred*' in clause 2.1 provided an immediate right to the advancement of defence costs.[201] MPG further relied on the policy's silence on when the excess applies to submit that it does not apply until the total overall liability under the policy was calculated, at which point the excess would reduce Liberty's liability to indemnify and the $5m excess would be repayable pursuant to clause 2.1.[202]

Analysis by the Court

Applicable principles in construing policies of insurance

- There was no dispute between the parties as to the applicable principles for construing insurance policies. Lee J set out the Full Court's summary of the principles in *Liberty Mutual Insurance Company Australian Branch t/as Liberty Specialty Markets v Icon Co (NSW) Pty Ltd* [2021] FCAFC 126; (2021) 396 ALR 193 at [151]–[152] per Allsop CJ, Besanko and Middleton JJ[203] (which included a reference to the requirement to apply a '*businesslike interpretation*') and emphasised the following sentence:[204]

> *It should always be recalled, however, that a broad or a narrow meaning of a policy may only reflect the breadth or the narrowness of cover that has been purchased by the premium.*

Application to the policy

- At the outset, Lee J observed that a '*notable feature*' of the policy was the $10m sub-limit for company securities liability, together with the $5m excess for the optional extension. In Lee J's view, the amount of excess relative to the cover available '*[said] much about the market for company securities liability cover in the Australian market*', including the *'increasing sensitivity of various insurers to writing cover for this type of liability'* in securities class actions over the last 20 years.[205]
- Consistent with the well-accepted principles of policy construction, Lee J considered and addressed the relevant policy provisions in detail in the judgment.
- Lee J concluded it was apparent that, '*the bargain between the parties is that by reason of clause 6.2, Liberty will not bear any payment obligations under the policy before the excess.*'[206]
- Lee J further stated it was '*tolerably clear*' that MPG's construction '*overlooks the significance of the chapeaux*'.[207] The chapeaux to clauses 2 and 3 set out the circumstances under which the extensions and optional extensions apply and were '*plainly intended*' to qualify the application of the two clauses.[208]
- Read as a whole, there was no proper basis for MPG's assertion that the total loss is required to be calculated before the excess is applied.[209] MPG's construction did not accord with a '*sensible businesslike interpretation of the policy*', especially in circumstances where:[210]
  - clause 6.2 requires the excess to be the '*first amount borne*' by the insured;
  - the policy provided for the payment of defence costs prior to the conclusion of the relevant proceeding; and
  - the excess was not an insignificant amount and MPG's interpretation would have required Liberty to pay Defence Costs up to the amount of the excess and then await repayment at some later point.

Result

- Lee J agreed with Liberty and Virgin, holding that Liberty is not required to pay any amounts under the policy (including Defence Costs) unless and until the $5m excess is fully eroded. A declaration was made to that effect.

CASE NOTE

COAL-APSED EXPECTATIONS: INSURER AND INSURED DIG INTO EQUIPMENT DISPUTE

***Baralaba Coal Company Pty Ltd v AAI Ltd trading as Vero Insurance* [2024] FCA 532**

SNAPSHOT

- Insurers may be liable to indemnify insureds for damage occurring outside the coverage period, if that damage is secondary damage relevantly and intimately connected to some primary damage attracting liability under the insurance policy.
- As for other commercial contracts, the court will construe ambiguous terms *contra proferentem*, that is, against the interests of the party seeking to rely on the clause.

INSURANCE ISSUES CONSIDERED BY THE COURT

- Whether the insurers were obligated to indemnify the insureds for additional damage sustained during repairs of primary damage covered under insurance policy.
- Whether exclusion clauses relating to contract works and damage during testing and commissioning applied to exclude liability to indemnify for damage during repairs.
- Whether the insurers were discharged from liability by operation of a release signed by the applicants.

Facts

- Baralaba Coal Company and Wonbindi Coal (the **Insureds**), operated a coal mine at Baralaba in Queensland. The operations were covered for property damage by an Industrial Special Risks insurance policy (the **ISR Policy**) issued by various insurers with Vero as lead insurer (the **Insurers**).
- The insured property included a radial coal stacker used to convey coal onto a stockpile. In March 2019, the stacker was damaged in a storm (the **Storm Damage**). The Insurers indemnified the Insureds for the Storm Damage and arranged repairs. In October 2019, during testing of the repairs undertaken, the stacker sustained further damage (the **Repairs Damage**).[211] The Repairs Damage occurred after the ISR Policy coverage period had expired.[212]
- The Insureds submitted that the Insurers were obligated under the ISR Policy to indemnify them for reinstatement of the stacker to its 'pre-damaged state', which included remediating the Repairs Damage.[213]
- The Insurers submitted that they had no obligation to indemnify the Insureds for the Repairs Damage on the basis that:
  1. The stacker was 'substantially reinstated' following the Storm Damage. The Repairs Damage did not arise from the Storm Damage and did not occur during the ISR Policy coverage period.[214]
  2. In the alternative:
     a. the Storm Damage was excluded by the operation of two exclusion clauses in the ISR Policy; or
     b. the Insureds signed a form of release prior to the Storm Damage, which had the effect of discharging the Insurers from any liability occasioned by the Repairs Damage.

Analysis by the Court

Extent of obligation to indemnify

- The ISR Policy required the Insurers to pay for the cost of 'reinstatement' of damage. Reinstatement was defined as restoring the property to '*a condition substantially the same as, but not better or more extensive than, its condition when new*'.[215]
- The Insureds contended that the Insurers' obligation of reinstatement crystallised

following the Storm Damage and remained unfulfilled until payment of the cost of the Repairs Damage, which occurred in the course of the making of repairs consequent to the Storm Damage, was paid.[216] Whereas, the Insurers' submitted that the Repairs Damage occurred as a result of a separate event after the ISR Policy expired, which did not engage a new obligation to reinstate under the Policy.[217]

- To support their view, the Insureds referenced Barwick CJ's dissenting reasons in *GIO v Atkinson-Leighton Joint Venture*,[218] which concerned damage to an embankment resulting from successive storms. The Insureds interpreted Barwick CJ's reasoning to mean that once the insurer's obligation to reinstate crystallised, that obligation had to be performed despite any intervening events.[219]
- Derrington J rejected the insured's submission that once an insurer's obligation to pay for repair costs crystallises it must be performed despite *any* intervening events that increases those repair costs.[220] Having regard to the authorities, Derrington J did observe that the question of whether an insurer's primary obligation extends to remediating further damage turns on how close the connection between the intervening event and the primary obligation is.[221]
- Conversely, an insurer is not required to extend cover where the only connection between the insurer's obligation to indemnify and the additional damage is that the further damage occurred during the process of reinstatement.[222] Derrington J held that the Insurers' obligation extended to covering the cost of the Repairs Damage, as it was '*directly related to and connected with the insurers' performance of their obligation to remedy the original harm*.'[223] The Repairs Damage occurred during testing of the Storm Damage.
  The fact that the damage occurred after the expiry of the ISR Policy was not determinative of cover as the Insurers' obligation to meet the cost of reinstatement had already attached during the coverage period.[224]

Exclusion clauses

- Derrington J then considered whether any of the exclusions in the ISR Policy would affect the cover sought by the Insureds.

(a) <u>*Contract works exclusion*</u>

- Clause 14(a) of the Policy excluded coverage for damage to property the subject of 'contract works' exceeding $1M.[225] 'Contract works' was not defined.[226]
- Derrington J held that Clause 14 did not affect the Insurers' obligation to meet the cost of reinstatement in respect of property damage where the cause was not excluded by the ISR Policy. Put another way, the Policy already responded to the Storm Damage and the exclusion did not operate to exclude cover for the Repairs Damage just because repairs were being undertaken. The exclusion was relevant to the cause of the initial subject event, not the additional damage. To find otherwise would be to apply an '*unbusinesslike construction*' of the clause and,[227] in any event, ambiguous exclusion clauses in insurance contracts are to be construed *contra proferentem*.[228]

(b) <u>*Testing and commissioning exclusion*</u>

- Clause 19 of the ISR Policy excluded damage to insured property '*in the course of construction or erection, dismantling, revamp or undergoing testing or commissioning*'.[229]
- Derrington J accepted the Insureds' argument that 'testing and commissioning' should be interpreted as being related to the activities of 'construction or erection' or 'revamp', stating that it would be an *'unusual construction' to construe the clause as generally excluding damage in the course of repair or maintenance*.[230]

Release

- In the alternative, the Insurers sought to rely on a release executed by the Insureds upon accepting the final indemnity payment for the Storm Damage which was expressed to be '*in final satisfaction and discharge of all claims … arising from*' the Storm Damage.[231]
- Derrington J held that the context of the release demonstrated that the release was limited to payments to be made to the repairer in relation to the Storm Damage only and not any subsequent damage.[232]

Result

- Derrington J held that the Insureds were entitled to be indemnified for the costs of the Repairs Damage.[233] The decision has not been appealed.

CASE NOTE

WILL THE REAL INSURED PLEASE STAND UP

***Chubb Insurance Australia Limited v WSP Structures Pty Ltd* [2024] FCAFC 123**

SNAPSHOT

- The central issue on appeal turns on the construction of the word 'Insured', where the same word is used in different parts of a policy (and could be given different meanings). In her dissenting decision, Derrington J said that there is a difference between a construction which 'affords comprehensive cover to third party professional consultants, including architects and engineers on the one hand, and a construction which affords more limited and directed cover to those persons on the other.'
- The Court considered the commercial rationale behind extending coverage to third parties involved in a primary insured's business activities.
- The decision, which was an appeal from a 2023 decision by the Federal Court, relied on orthodox principles of policy construction, including the importance of giving words their natural and ordinary meaning unless context requires otherwise.

INSURANCE ISSUES CONSIDERED BY THE COURT

- Whether an engineering firm engaged by the principal contractor was a 'sub-contractor', and thereby an insured under the Policy.
- The weight to be given to the commercial purpose of a contract when construing a policy.

Facts

- This case is an appeal from *WSP Structures Pty Ltd v Liberty Mutual Insurance Company t/as Liberty Specialty Markets* [2023] FCA 1157,[234] a decision reported on in the *2024 Insurance Pocketbook*.
- These proceedings involved the determination of the proper construction of a policy issued by Liberty Mutual Insurance Company (**Liberty**) to Icon Co Nominee Pty Ltd (**Icon**) (**Policy**).[235] Excess layers of cover were provided by Chubb Insurance Australia Limited (**Chubb**) and Tokio Marine & Nichido Fire Insurance Co Ltd (**Tokio**) on the same terms as the Policy.[236]
- In November 2015, Icon engaged WSP Structures Pty Ltd (**WSP**), a consulting engineering firm, under a subcontract to conduct engineering design work for the Opal Tower development in Sydney.[237]
- In 2018, structural damage was observed at Opal Tower.[238] Subsequently, multiple proceedings were brought against Icon and WSP (among others) in relation to property damage at Opal Tower.[239] Icon and WSP agreed to participate in settlements of these claims.[240] WSP sought indemnity under the Policy, including the excess cover provided by Chubb and Tokio.[241]
- Liberty accepted that WSP was an insured under the policy and that its settlement payment was covered, but refused to indemnify it as WSP had elected to proceed with an indemnification claim under its own professional indemnity policy.[242]
- Chubb and Tokio denied that WSP was covered under the terms of the policy at all.[243]
- The primary judge (Colvin J) concluded that WSP was a 'sub-contractor' within the meaning of the Policy and was to be indemnified as an Insured.[244]
- Chubb and Tokio appealed the first instance decision. Liberty also launched a cross-appeal against Chubb, contingent upon the success of Chubb and Tokio in their appeal.[245] In such an event, Liberty sought an application, to withdraw its prior admission of liability to WSP, to be considered by the primary judge in a remission of the matter.[246]
- Whilst the first instance proceedings concerned four main issues, only one issue arose on appeal, namely: whether WSP was an 'Insured' for the purpose of the Policy.[247]

Analysis by the Court

Relevant terms of the Policy

- The Schedule of the Policy recorded 'Insured' as 'Icon Co Nominee Pty Ltd', a number of named related entities '*and/or subsidiary and/or controlled and/or joint venture companies and/or principals and/or financiers and/or contractors and subcontractors…*'[248]
- The Definitions section of the Policy defined 'Insured' to mean (emphasis added):[249]

    1. *the Insured named in the Schedule and/or;*
    2. *joint ventures (incorporated or not) in which the Insured is a co-venturer and is responsible for arranging insured; and/or*
    3. *Principals and/or owners;* ***and/or***
    4. ***sub-contractors engaged by any of the above****; and/or*

    […]

    8. *architects, engineers and other professional consultants, but only in relation to their manual on-site activities; and/or* […]

Consideration of the Policy

- In determining that WSP was an insured under the Policy, the primary judge (Colvin J) found:
    - the Policy sought to extend cover to those beyond named insureds (set out in the Schedule);[250]
    - the words 'and/or' following each item in the list implied that an entity could at once be multiple types of 'Insured', thus WSP's role as engineers did not prohibit it from also being considered a sub-contractor;[251] and
    - the evident interest of the Icon parties in obtaining the insurance was to ensure there was coverage for activities Icon entities would be undertaking as part of the business defined in the Schedule to the Policy.[252] Coverage for those who had been subcontracted by Icon was '*obviously necessary to obtain that kind of coverage*'.[253]
- In challenging the first instance decisions, each of Chubb and Tokio's submissions were either rejected by the Full Federal Court or found to be consistent with the primary judge's analysis.[254] These include:
    - The Appellant Insurers submitted the primary judge's construction left Item 4 of the Schedule (relating to '*sub-contractors engaged by any of the above')* with '*no work to do to the extent that it refers to subcontractors engaged by principals or owners, being the subject of Item 3, which is picked up in Item 4 by the reference to 'any of the above*".[255] The Full Federal Court majority (O'Callaghan and Jackman JJ) noted this submission was not put to the primary judge and its criticism was thus misplaced.[256] Despite this, the majority concluded that a reasonable person in the position of the parties would have simply assumed that the overlap was a result of over-inclusive shorthand drafting and did not detract from the ordinary and natural meaning of Item 4 of the Schedule, let alone its validity.[257]
    - The Appellant Insurers submitted that the proper interpretation regarding the conjunction 'and/or' used throughout the 8 item list was that there could be more than one insured in any one situation, not that an entity could not fall under more than one category of insured.[258] The Full Federal Court majority upheld the primary judge's conclusion that entities could fall within one or more of the categories listed, noting that while it was true that there could be more than one insured in any situation, this was not a result of the 'and/or' conjunction.[259]
    - The Appellant Insurers submitted that the primary judge's inclusion of professional consultants as insureds under the Policy had '*little commercial benefit*' to the Icon Group as this would represent an additional cost to be incurred by them for the extended cover.[260] The Full Federal Court majority rejected this submission, upholding the primary judge's finding that Icon would suffer commercial detriment if it did not have coverage where its subcontractors' action caused it liability as this would mean Icon would then need to pursue its subcontractor through a separate claim.[261]
- The Full Federal Court held that the question of whether the primary judge's reasoning justified potential cost by way of premium was a matter for Icon Group's commercial judgement.[262] There was no evidence they would find the judgement so unreasonable as to depart from the considerations for the usage of '*ordinary and natural meaning of the language used by parties*'.[263]
- Finally, the Appellant Insurers submitted that the primary judge's construction had the effect of transforming a public and product liability insurance policy, intended to be used in the construction industry, into an '*occurrence-based insurance policy*' favouring those that were already insured under other professional liability policies.[264] This submission was rejected by the Full Federal Court majority on the basis that such '*generalised categorisations*' of insurance policies had no bearing on the manner in which they are construed.[265] In this way, the Policy remained a policy for liability for property damage that extended to subcontractors by way of its definition of 'Insured', not as a result of the 'type' of insurance policy it was/or was perceived to be.[266]
- In constructing their approach to policy interpretation, the majority judges reflected the necessity to give weight to the plain and ordinary meanings of words, insofar as they were congruent with a commercial operation of the Policy. The majority judges also set out that this balancing exercise operated in both directions, with their conclusion that a commercial judgment would have to be sufficiently unreasonable to depreciate the ordinary and natural meanings of words.[267]

Result

- The Court held there was no material error in the primary judge's reasoning, with the appeal dismissed. The cross-appeal by Liberty was also dismissed.[268]
- In a dissenting judgment, Derrington J concluded that as the damage caused by WSP resulted from its off-site work, no indemnity should be extended to it,[269] and so the appeal should be allowed.
    - While her Honour agreed with the majority judges in respect of their adoption of a policy interpretation that provided it a commercial and business-like operation,[270] the dissenting decision diverged in determining the scope of the term 'Insured'.

- Drawing attention to the limited circumstances in which cover is provided to joint venturers, sub-contractors, architects, engineers and other professional consultants, her Honour suggested that a '*powerful rationale*' would be needed to neutralise such limitations.[271]

- In giving weight to these limitations, Derrington J deemed that the context of the policy necessitated that the listing of sub-contracts within the definition of 'Insured' was '*subject to the particular insured not falling within the more specific extension*'.[272]

- Chubb's special leave application to the High Court was refused.

CLASSIC CASE

WHAT DO YOU GET WHEN YOU CROSS AN INCOME PROTECTION POLICY WITH AN INNOCENT MISREPRESENTATION?

Australian Securities and Investments Commission v TAL Life Limited (No 2) **[2021] FCA 193**

SNAPSHOT

- This case considered an insurer's obligation to act in accordance with the duty of utmost good faith. Chief Justice Allsop made clear:
  - that for policies of this nature providing income protection, the insured should be seen and treated not just as business risks but as humans, as the human and social elements of such insurance should be at the front of an insurer's mind in its conduct towards an insured; and
  - the importance of dealing with insureds with fairness, decency and fair dealing.
- Chief Justice Allsop stated that the issue was not the correctness or otherwise of the decision that was made, but how the Insured was treated by TAL in the process of reaching the decision.

INSURANCE ISSUES CONSIDERED BY THE COURT

- The duty to act with utmost good faith in section 13 of the *Insurance Contracts Act 1984* (Cth) (**ICA**).
- If a policy has been avoided *ab initio*, does ASIC still have authority and standing to bring a claim before the court seeking declarations for regulatory breaches by an insurer?

Facts

- An Insured (**Insured**) of TAL Life Limited (No 2) **(TAL**) was diagnosed with cervical cancer and claimed under an income protection policy (**Policy**) she held with TAL. Prior to the issue of the Policy, numerous communications had occurred between TAL's representatives and the Insured, including as to:[273]
  - the Insured's duty of disclosure;
  - the consequences of a failure to make disclosure (including possible rights of avoidance by TAL); and
  - directed at ascertaining the Insured's medical history.
- After the Insured claimed on the Policy, TAL sent the Insured a letter which enclosed various forms, including authorities (**Medical Authorities**) permitting TAL to access the Insured's Medicare records and her medical records (**Claims Pack**). The letter stated that the paperwork was required to make a claim and that TAL would start assessing the claim once the paperwork was received. The Insured promptly completed and returned the paperwork.[274]
- There was no dispute or issue in relation to the Insured's condition. The claim was accepted. That was communicated to the Insured, and payments commenced.[275]
- Shortly afterwards, TAL received (by reason of the Medical Authorities) Medicare records and medical information. They indicated that the Insured had earlier suffered mental health 'issues'. The Insured had not disclosed any mental health 'issues' when applying for the Policy.[276]
- TAL had a practice of obtaining Medicare and medical records to carry out a '*policy validity investigation*' to investigate any non-disclosure or misrepresentation by an Insured for the purpose of determining whether it could reject a claim or avoid a Policy.[277]
- Around 6 months after accepting the claim and commencing payment, and having received all Medicare records and medical records, TAL undertook a retrospective underwriting to re-underwrite the risk. It did so without notice to or consultation with the Insured. A decision was made that had the mental health 'issues' been disclosed when the Policy was initially applied for, TAL would not have offered cover at all.[278]
- TAL then verbally informed the Insured that it avoided the Policy by reason of section 29(3) of the ICA, which dealt with non-disclosure and misrepresentation for life insurance. TAL also sent a letter to the Insured confirming that avoidance. The letter:
  - asserted that the Insured had breached

her duty of utmost good faith; and

- stated that TAL was entitled to recover any payments that had been made under the Policy, and although TAL would not be seeking payment '*at this stage*' that it reserved the right to '*request recovery in the future*'.[279]

- Prior to informing the Insured of these matters, TAL did not:[280]
  - inform the Insured that a purpose of obtaining the Medicare or Medical records was to undertake a policy validity investigation and/or that it was undertaking such investigation;
  - give the Insured an opportunity to address matters or provide any further documents or information (despite that being what would have occurred had the issues been considered at the time of the 2013 policy application); or
  - indicate other than that the claim had been accepted and payment would continue.
- Allsop CJ found that TAL's records indicated that there was a deliberate decision or policy not to inform the Insured of the investigation.[281]
- In response to the TAL avoidance, the Insured asserted that any non-disclosure was innocent and stated that she did not believe that TAL would not have given her any policy at all. She sought internal and external review.[282]
- Ultimately, matters were settled between TAL and the Insured, with TAL paying a further sum to the Insured on the basis that the Insured keep all benefits paid to her. The settlement was reached with both parties agreeing that the policy was void *ab initio* and without any admission of liability.[283]

Analysis by the Court

The Claims Pack Representations

- Allsop CJ considered whether TAL represented (and misrepresented) in the Claims Pack that it had a right to delay processing of the Insured's claim and to withhold payment of benefits until she provided the executed Medical Authorities (**the Claims Pack Representation**).
- Allsop CJ determined that such representations had not been made, as a matter of fact. Rather, the representation made was that the provision of incomplete or inadequate information by the Insured may delay the assessment process.[284]
- Allsop CJ also considered, in the event that the above conclusion was wrong, whether there would have been a misrepresentation. It was held that a misrepresentation would only have been made as to TAL's right to require the Medicare authority to be executed and provided.[285]
- Allsop CJ's reasoning demonstrates that the following needs to be borne in mind when interpreting life insurance policies:[286]
  - given both the commercial and social purpose and object of the contract is relevant to interpreting it, the nature and extent of the policy should be examined as it would be read and construed by '*the ordinary insured*';
  - in interpreting a document such as this to give it business sense, '*the business person is to be understood as the ordinary insured*'; and
  - the sense and meaning of a policy such as this will be '*that which insureds in their ordinary dealings would give the document*'.

Breaches by TAL of the duty of utmost good faith

- ASIC alleged that TAL had engaged in six breaches of the duty of utmost good faith, contravening section 13 of the ICA.
- TAL's conduct occurred before a breach of section 13 of the ICA attracted penal consequences, and the Court did not consider any penalty.[287]
- In considering the content of the duty of good faith owed by insurers to insureds, Allsop CJ emphasised the need to consider insureds not only as 'risks' but as people,[288] further stating:

> *The content of the [duty]… and its application in individual cases… involves consideration of the human context of the people concerned. It is the acting towards each other (with commercial standards of decency and fairness) that is expected of both the insurer and insured by the terms of s 13.* [289]
>
> *Fairness, decency and fair dealing are normative standards judged by reference to community expectations […] The obligation upon insurers and the content of the duty in any given case is informed, in part, by the important part insurance and insurers play in the life of the commercial community and of the general community. People rely upon it and them for their commercial and personal stability and wellbeing.*[290]

- Allsop CJ identified the following matters regarding the nature of the duty of utmost good faith:[291]
  - a lack of honesty is not a pre-requisite to a breach;[292]
  - something less than conduct falling short of actual impropriety might be sufficient for there to be a breach;[293]
  - dishonesty, caprice and unreasonableness express the ambit of what constitutes a breach;[294]
  - what may be required is that an insurer act with due regard to the legitimate interests of an insured as well as to its own interests;[295]
  - the duty '*encompasses notions of fairness, reasonableness and community standards of decency and fair dealing*';[296] and
  - what is required is that an insurer act consistently with commercial standards of decency and fairness, with due regard to the interests of the insured. In this respect, Allsop CJ stated:[297]
    - *'It is impossible to be prescriptive. as to how decent and fair conduct by an insurer should be judged in all cases';*[298] *and*
    - *'It is inappropriate to draw conclusions of principle or of rules from other articulated fact situations about a duty of this character'.*[299]
- In assessing the propriety of how an insurer conducted itself, it was important to do so recognising that the Insured was a person to whom, and to whose financial security, the policy was important. Allsop CJ's view was that such considerations:

> […] *inform the context and circumstances by reference to which standards of behaviour, set by Parliament, expected of participants in commerce, in particular here, insurance, are to be judged*.[300]

(a) Alleged Breach 1

- First, ASIC alleged that TAL breached the duty when it made the Claims Pack Representation, which ASIC alleged was false.
- Allsop CJ concluded that the alleged representation was not made. Consequently, no breach could be established.[301]

(b) Alleged Breach 2

- ASIC also alleged that TAL breached the duty by relying on the Medical Authorities to obtain information which was then used to investigate whether there were grounds to avoid the Policy by reason of non-disclosure and not just the claim itself.[302] The breach, however, as alleged, was limited to the act of requesting such medical information.
- Allsop CJ found such alleged breach was not made out.[303] However, in obiter, Allsop CJ, also observed that the conduct 'echoed' of using such information for a 'wrongful purpose', as the policy had no term making clear that the medical information could be used beyond assessing the medical condition claimed for.

(c) Alleged Breaches 3 and 4

- ASIC also alleged that that TAL's avoidance of the Policy was:
  - not soundly based in medical opinion;[304] and
  - was effected on the basis of purported non-disclosure or misrepresentation without giving the Insured any notice of the investigation or opportunity to address any concerns about non-disclosure.[305]
- Allsop CJ was of the view that the third and fourth alleged breaches could not be separated because of the retrospective underwrite undertaken by TAL.[306]
- Allsop CJ found the duty of utmost good faith was breached by TAL because TAL failed to tell the Insured of its investigation and concerns, meaning the retrospective underwrite process undertaken lacked input from the Insured, and lacked the decency and fairness required such in the circumstances.[307]
- In reaching this conclusion, Allsop CJ stated:
  - *A decision to invoke a right or an asserted right under s 29(3) to avoid the contract is a matter in relation to the contract. TAL was therefore obliged to act towards the … Insured with the utmost good faith in how it went about deciding and dealing with the question*.[308]
  - *Standards of decency, fairness, fair dealing and reasonableness demanded that the… Insured be given a proper opportunity to put matters to TAL [before avoidance]: to explain what happened.*[309]
- Allsop CJ emphasised that the Insured should have had a proper opportunity to provide an explanation to TAL, particularly when the re-underwrite involved recreating that opportunity, which would have occurred had there been disclosure.[310]

(d) Alleged Breaches 5 and 6

- Finally, ASIC alleged that in all the circumstances TAL breached the duty by asserting that the Insured had breached her duty of utmost good faith and threatening to seek recovery of the moneys paid to the Insured.[311]
- Allsop CJ found the duty was breached in the ways alleged, noting that the Insured was treated without decency or fairness. Moreover, the threat to recover over $24,000 was '*harsh and unfair and lacked a degree of common decency,*' particularly in the context of the lack of notice of the investigation and the Insured's modest means and catastrophic illness.[312]

Jurisdiction of the Court to hear the matter

- Finally, the question arose about whether the Federal Court had jurisdiction to hear the proceeding when TAL and the Insured had agreed that the Policy was void *ab initio* (i.e. that it had never occurred). TAL submitted there was no jurisdiction because there was no contract of insurance to which section 13 of the ICA applied.[313]
- Allsop CJ rejected that argument, concluding that the Court had jurisdiction over the proceeding as ASIC had standing and power to seek declaratory relief, and was doing so in fulfilment of its '*statutory duty to bring about and oversee compliance, including encouraging proper standards* of contractual behaviour'. The fact of the subsequent agreed avoidance by TAL and the Insured was said not to '*affect any criticism of TAL's treatment of the Insured*'.[314]

Result

- TAL was found to have breached its duty of utmost good faith to the Insured.

CLASSIC CASE

THE LONG AND WINDING ROAD

***Maxwell v Highway Hauliers Pty Ltd* [2014] HCA 33**

SNAPSHOT

- Section 54 is one of the most litigated provisions in insurance cases across Australia. This classic case furthers the proposition that section 54 is firmly a remedial provision for insureds.
- In this matter, the High Court of Australia dismissed an appeal from the insurers and concluded that an insured was entitled to rely on section 54(1) of the *Insurance Contracts Act 1984* (Cth) (**ICA**).
- The practical effect of the decision was that the insurers were unable to refuse paying a claim notwithstanding the fact that the insured had failed to comply with a condition of the policy (namely, that drivers of B-doubles be suitably qualified).

INSURANCE ISSUES CONSIDERED BY THE COURT

- The circumstances in which section 54(1) of the ICA will be engaged – in particular, in a situation where a requisite condition of cover was not met.

Facts

- Highway Hauliers Pty Ltd (the **Insured**), owned a fleet of vehicles which it used to operate an interstate freight transport business. The fleet of vehicles included cars, trucks, prime movers and trailers that were able to be linked together.[315]
- The Insured entered into an occurrence-based insurance policy (the **Policy**) with a syndicate of Lloyd's Underwriters (the **Insurers**) through Maxwell, as the authorised nominal defendant on behalf of the Insurers. The Insurers agreed that they would indemnify the Insured against loss, damage or liability occurring to or in respect of the vehicles during the period of cover.[316]
- There were two insuring clauses in the Policy: Section 1 of the Policy provided first party cover for damage to the vehicles (if in an accident, lost or damaged) and Section 2 of the Policy provided cover for legal liability or damage to another party's property as a result of an accident.[317]
- Between 2004 and 2005, two of the Insured's vehicles were involved in accidents. In each case, a prime mover linked with two trailers collided with third parties.[318] Following each accident, the Insured made a claim on the Insurers for indemnity in accordance with Section 1 and Section 2 of the Policy.[319]
- The Insurers, however, refused to pay each claim. In denying the claims, the Insurers relied on an endorsement to the Policy, which formed the subject of the litigation between the parties. The endorsement stated:

  > *No indemnity is provided under this policy of Insurance when Your Vehicle/s are being operated by drivers of B Doubles … unless the driver … Has a PAQS driver profile score of at least 36, or an equivalent program approved by Us.*[320]

- The Policy defined 'PAQS' to refer to People and Quality Solutions Pty Ltd, a company which undertook psychological testing of drivers' attitudes towards safety.[321]
- It was uncontested that the drivers had not undertaken a PAQS test or an equivalent program approved by the Insurers.[322] The Insurers maintained that there was '*an absence of relevant cover … by virtue of the fact that the vehicle was being driven by an untested driver*'.[323]
- The Insured commenced proceedings in the Supreme Court of Western Australia against Maxwell, as the defendant on behalf of the Insurers, seeking indemnity under the Policy. The Insured sought to rely on the remedial effects of section 54 of the ICA. The Insured was successful at first instance, and again before the Court of Appeal. The Insurers appealed to the High Court.

Analysis by the High Court

Arguments around section 54 of the ICA

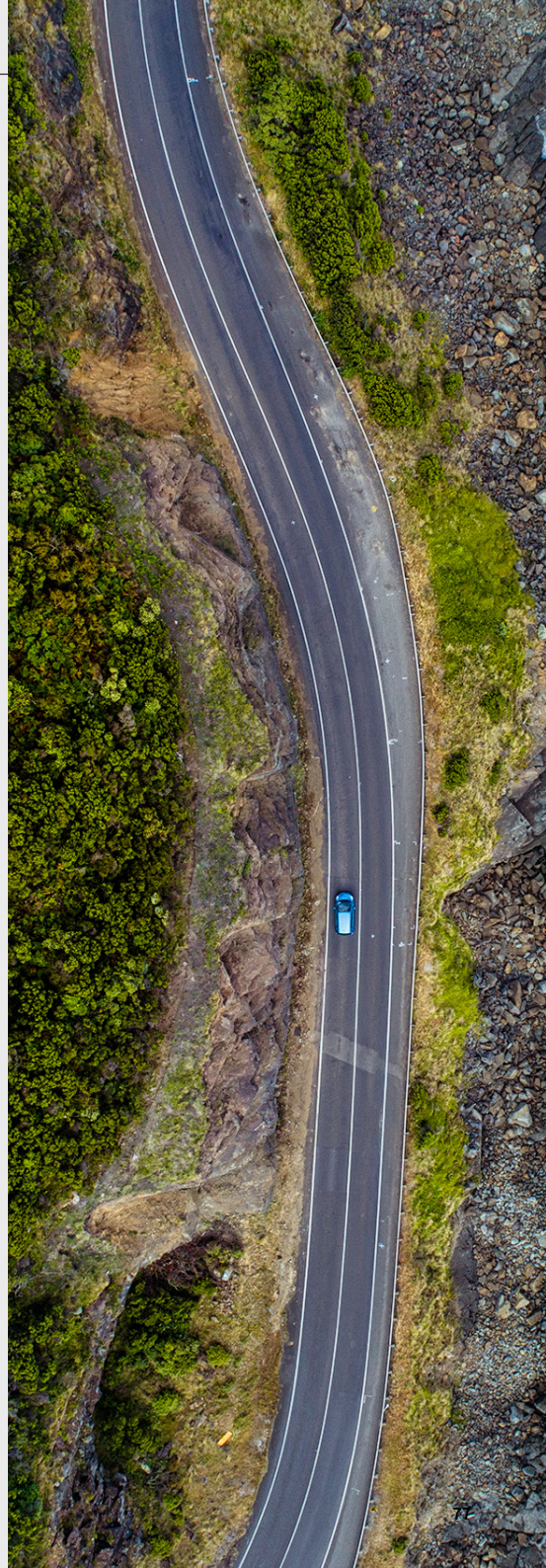
- The only issue before the High Court was whether section 54 of the ICA was engaged, in which case the Insured was entitled to indemnity, notwithstanding the fact that the

drivers operating the vehicles had not been tested in accordance with the endorsement to the Policy. This required the High Court to consider the text of section 54(1) – namely would the effect of the Policy be that, but for section 54, the Insurers '*may refuse to pay a claim … by reason of some act of the insured or of some other person, being an act that occurred after the contract was entered into*'?

- The Insurers conceded at trial that their interests were not prejudiced to any extent as a result of each vehicle being operated by an untested driver.[324] For this reason, if section 54(1) was engaged, the Insurers could not refuse to pay either claim.
- The Insurers' position relied on two arguments.
- First, the Insurers argued that the word 'claim' in the text of section 54(1) referred only to a claim for a risk which was insured by the Policy.[325] The Insurers sought support for their argument from a statement of the plurality of the High Court in the leading case of *FAI General Insurance Co Ltd v Australian Hospital Care Pty Ltd*,[326] where it was suggested that section 54 '*does not operate to relieve the insured of restrictions or limitations that are inherent in* [the] *claim*'.[327]
- Second, the Insurers argued that the claim made by the Insured was not for an insured risk that was covered by the Policy. The Insurers argued that the effect of the endorsement was that no indemnity was provided for an accident which occurred when a vehicle was being operated by an untested driver. The characteristics of drivers were, on the Insurers' argument, integral to the description of the risks covered. In this regard, the Insurers sought to rely on the Queensland Court of Appeal judgment in *Johnson v Triple C Furniture & Electrical Pty Ltd*.[328] The facts in that case were not dissimilar, where a policy of aviation insurance contained an exclusion which provided that the policy would not operate while a pilot had not satisfactorily completed a mandatory flight review. The Queensland Court of Appeal concluded that the failure of a pilot to undertake a necessary flight review did not constitute an 'omission' for the purpose of section 54(1) and section 54 was therefore not engaged (and the orders that the insurer indemnify the insured were set aside).

Result

- The High Court unanimously rejected the Insurers' appeal, and all of the Insurers' submissions. The decision turned on a few matters:
  - First, the High Court began by considering the purpose of section 54 of the ICA. With reference to the Australian Law Reform Commission's seminal report (ALRC Report 20 which pre-dated the ICA), the High Court reflected that the object of section 54 was to strike a fair balance between the interests of an insurer and an insured with respect to a contractual term designed to protect the insurer from an increase in risk during the period of insurance cover.[329]
  - Second, and having regard to the policy purpose of section 54, the High Court concluded the balance between policyholders and insurers should be struck regardless of how such a contractual term protecting the insurer was framed. Accordingly, no difference was to be drawn between a term framed as an obligation of the insured, or as a continuing warranty of the insured or as a limitation on the defined risk of the contract.[330]
  - Third, the High Court concluded that the Insurers argument about the meaning of 'claim' in section 54(1) was misconceived. Drawing on the reasoning of the High Court in the earlier decision of *Antico v Heath Fielding Australia Pty Ltd*,[331] the High Court noted that section 54 assumes nothing more than the existence of a claim and of a contract the effect of which is that the insurer may refuse to pay that claim by reason of some act (or omission) which the insured (or someone else) has done or omitted to do after the contract has been entered into.[332] Section 54 therefore did not focus on the legal character of a reason which entitles an insurer to refuse to pay a claim.[333]
- The High Court rejected the Insurers' argument made in reliance on *Johnson* and in doing so concluded that the Queensland Court of Appeal had erred in the *Johnson* decision and overruled it. This was because the operation of the aircraft (in that case) in breach of the flight review requirement was an 'act' which occurred after the contract was entered into, thereby triggering the operation of section 54.[334]
- In conclusion, the High Court held that section 54 was engaged because:
  - each vehicle was being operated at the time of the accident by an untested driver – this was an 'act' (for the purpose of section 54) that occurred during the period of insurance;[335] and
  - there was an omission of the Insured during the period of insurance to ensure that each vehicle was operated by a driver who had undertaken a PAQS test or an equivalent program.[336]
- Part of the ongoing relevance of this decision is the proposition that in testing the boundaries of section 54, the words in this section should not be given a narrow and technical definition.



CLASSIC CASE

LIAR, LIAR, PREMISES ON FIRE!

***CIC Insurance Ltd v Bankstown Football Club Ltd* (1997) 187 CLR 384**

SNAPSHOT

- The case concerned a claim for indemnity under an industrial special risk insurance policy (**Policy**) in respect of property damage from multiple fires.
- The failure of Bankstown Football Club (**Insured**) to commence the required restoration and repair work within a reasonable time necessitated that CIC Insurance Ltd (**Insurer**) was liable only to pay the indemnity value of the property at the time of the first fire.
- It was unreasonable for the Insurer to have withheld payment after the Policy Expiry Date and therefore interest was payable from that date in accordance with section 57 of the ICA.
- This case provides helpful guidance in relation to the interaction between section 58 (regarding renewal notices and automatic statutory polices) and sections 59 and 60 (regarding policy cancellation) of the *Insurance Contracts Act 1984* (Cth) (**ICA**).

INSURANCE ISSUES CONSIDERED BY THE COURT

- Whether the Insurer was required to issue to the Insured a Policy expiry notice in accordance with section 58 of the ICA when it had previously notified the Insured that it had cancelled the Policy in accordance with sections 59 and 60 of the ICA.
- How 'reinstatement' should be construed under the Policy and its effect.
- Whether interest in accordance with section 57 of the ICA was payable.

Facts

Background

- The Insured was insured by the Insurer under the Policy.
- The following events relevantly occurred:
  - on 8 January 1992, a fire occurred which caused significant damage to the Insured's property (**Initial Fire**);[337]
  - on 9 January 1992, the Insured submitted a claim for indemnity under the Policy in relation to the damage caused by the Initial Fire (**Insurance Claim**);[338]
  - on 22 July 1992, the Insurer notified the Insured that indemnity in relation to the Insurance Claim was denied and that it was cancelling the Policy on the basis that the Insurance Claim was fraudulent;[339]
  - on 22 July 1992, the Insured wrote to the Insurer requesting a refund of premium paid in accordance with the Policy and advising that the Insured intended to pursue the Insurance Claim;[340]
  - on 28 July 1992, the Insurer wrote to the Insured advising that it had cancelled the Policy, providing the relevant cancellation certificates and crediting the required Policy premium;[341]
  - on 30 October 1992, the Policy period expired (**Policy Expiry Date**); and
  - on 3 March 1993, a further fire occurred during which the Insured's property sustained additional significant damage (**Subsequent Fire**).[342]
- The Policy provided that, in the event of any physical loss, destruction or damage to insured property, the Insurer was required to indemnify the Insured in accordance with the Basis of Settlement clause.[343]
- The Basis of Settlement clause relevantly required the Insurer to pay to the Insured:
  - the **Reinstatement Amount** being the cost of reinstatement, replacement or repair of damaged property calculated at the time of the reinstatement, replacement or repair; or
  - if elected by the Insured, the **Indemnity Value** being the diminution in value of the damaged property at the time the damage was incurred. However, if this was elected by the Insured, the Insurer could instead choose to reinstate, replace or repair the damaged property.
- The Policy also relevantly provided that any reinstatement, replacement or repair works must be carried out with 'reasonable despatch' by the Insured, failing which the Insurer shall not be liable to make any payment greater than the Indemnity Value (**Reasonable Despatch Provision**).[344]
- Section 58 of the ICA states that renewable insurance cover applies for a set period and

is typically renewed or renegotiated. If an insurer fails to notify the insured at least 14 days before expiry and the insured does not secure alternative coverage, the original policy is automatically extended on the same terms and duration.

Positions of the parties

- The Insured commenced proceedings against the Insurer, seeking a declaration that the Insurer was required to indemnify it in respect of the Initial Fire,[345] and also sought declarations that:
  - there was a deemed renewal of the Policy under section 58 of the ICA, meaning a statutory policy (on the same terms as the Policy) operated at the time the Subsequent Fire occurred (**Statutory Policy**); and
  - the Insurer was required to indemnify the Insured under the Statutory Policy in respect of the damage caused by the Subsequent Fire.
- The Insurer's position was that:
  - it was not required to indemnify the Insured in relation to the Initial Fire on the basis that the Initial Fire was caused by the Insured, and therefore the Insurance Claim was fraudulent; and
  - in circumstances where the Insurer purported to cancel the Policy under sections 59 and 60 and therefore a statutory policy under section 58 did not operate, cover was not available in relation to the Subsequent Fire.

Analysis by the Court

Primary Judgment

- The Insured was successful at first instance, and Cole J rejected the proposition that the Insured was responsible for the Initial Fire and therefore that the Insurance Claim was fraudulent.[346] This was not challenged on appeal.
- Cole J also concluded that, given the Insurance Claim was not fraudulent, the Policy had not been validly cancelled and therefore, given the Insurer did not notify the Insured of the Policy Expiry Date, the Statutory Policy came into operation in accordance with section 58.[347]
- Cole J concluded that the Insurer was liable to indemnify the Insured in respect of the Initial Fire (under the Policy) and the Subsequent Fire (under the Statutory Policy), as well as pay the Insured general damages for breach of the Policy.[348]
- Cole J also relevantly found that the Insured was entitled to interest in accordance with section 57 from the date on which it was unreasonable for the Insurer to withhold payment, being three months after the Initial Fire, at which time it should have completed the necessary investigations.[349]

Court of Appeal Judgment

- The Insurer appealed the primary decision and the appeal was allowed in part.
- The Court of Appeal relevantly concluded that:
  - section 58 was not triggered and therefore the Statutory Policy did not come into operation. The Court of Appeal concluded that, in order for section 58 to be triggered, the relevant policy must be 'in effect' and a policy cannot be 'in effect' if it is cancelled;[350]
  - the parties by their conduct did not abandon the Policy prior to the cancellation. The conduct of the Insured in asserting the continued operation of the Policy (i.e. by pursuing the Insurance Claim) prevented an inference of mutual abandonment being drawn;[351] and
  - the Insurer was obliged to reinstate the damaged property and this obligation existed until the damaged property was reinstated, irrespective of whether events occurred in the intervening period which increased the cost of reinstatement and would not otherwise be covered by the Policy (e.g. the Subsequent Fire).[352]
  - the Insured was entitled to:
    - reinstatement costs actually incurred in rectifying the combined damage caused by the Initial Fire and the Subsequent Fire;
    - general damages for breach of the Policy; and
    - interest pursuant to section 57 from three months after the Initial Fire until the date of payment.[353]

High Court

The Insurer appealed and the Insured cross-appealed the Court of Appeal decision.

Statutory Policy

- The High Court was required to determine whether section 58 applied and, if it did, its effect.
- In order to determine the effect of section 58, the High Court considered the commentary in the Australian Law Reform Commission Report (No. 20) (**Report No. 20**) regarding the purpose of a draft of section 58. Report No. 20 reflected that section 58 was intended, in the absence of a renewal notice, to cure the possibility of:
  - an insured overlooking the expiry of a policy and suffering an uninsured loss; and
  - a substitute insurer being deprived of information relevant to the nature of the risk insured.
- The Court concluded that the Insurer had notified the Insured of the proposed cancellation in accordance with sections 59 and 60, and on that basis:
  - there could be no contention that the Insured overlooked the Policy Expiry Date; and
  - the possibility of the above consequences did not exist at 14 days prior to the Policy Expiry Date (i.e. when notification of the expiry would have otherwise been required under section 58).[354]
- The Court therefore concluded that the Statutory Policy did not come into operation.[355]

Reinstatement

- The High Court was required to determine how 'reinstatement' under the Policy should be construed and its practical effect on these claims.
- The majority (Brennan CJ, Dawson, Toohey and Gummow JJ) considered various authorities in relation to the meaning of 'reinstatement' in the context of insurance policies and whether reinstatement costs needed to be incurred by the Insured before the Insurer became liable to pay them.
- The majority noted that the Insured did not:
  - elect to receive the Indemnity Value and therefore the Insurer was required to indemnify the Insured for the Reinstatement Amount;[356] and
  - take steps to reinstate, replace or repair the damage caused by the Initial Fire or the Subsequent Fire. This is because, without payment by the Insurer, it lacked the financial resources to do so.[357]
- The majority concluded that, in circumstances where the Insured did not take steps to reinstate, replace or repair the damage (notwithstanding that this was due to financial reasons), the Insured failed to take steps within a 'reasonable despatch'. As a result, the Insured was only entitled to the Indemnity Value in accordance with the Reasonable Despatch Provision.[358] The majority therefore did not need to engage further with the meaning of reinstatement.

Section 57 Interest

- The High Court was required to determine whether interest was payable by the Insurer under section 57.
- The Court concluded that it was unreasonable for the Insurer to withhold payment from the Policy Expiry Date and therefore the Insured was entitled to interest from the Policy Expiry Date because, by that time, the Insured had not:
  - elected to receive the Indemnity Value; and
  - had not taken steps to reinstate the damaged property as required under the Reasonable Despatch Provision, meaning the Insurer was liable to pay the Indemnity Value.[359]

Result

- The High Court found that:
  - the Insurer was liable to indemnify the Insured under the Policy for the Indemnity Value in relation to the Initial Fire only;[360]
  - the Statutory Policy did not come into operation and therefore the Insurer was not liable to indemnify the Insured in relation to the Subsequent Fire; and
  - interest was payable under section 57 from the Policy Expiry Date.[361]

CLASSIC CASE

ALL THAT GLITTERS ISN'T INSURED

***Ebraham v AAI Limited t/as GIO Insurance* [2018] VCC 18**

SNAPSHOT

- The insured's claim for indemnity under a home and contents insurance policy for stolen jewellery was denied, and the policy cancelled, due to a failure to prove ownership and value pursuant to the requirements of the policy.
- This case exemplifies the high bar for insurers to prove the fraud of an insured.

INSURANCE ISSUES CONSIDERED BY THE COURT

- Was GIO entitled to deny indemnity and cancel the policy?
- Could GIO rely upon sections 13 and 56 of the *Insurance Contracts Act 1984 (Cth)* (**ICA**) as a basis for refusing indemnity?
- Could the insured rely upon sections 54 and 31 of the ICA in answer to GIO's denial of indemnity?

Facts

- Mr Emad Ebraham (the **Insured**) was holidaying in Ballarat on New Year's Eve in 2014. When he returned home on 1 January 2015, he said that he discovered that his house had been burgled.[362]
- Amongst other items, jewellery was allegedly stolen.[363] The Insured stated that the jewellery was given to him by his father in Lebanon in November 2013, together with a receipt in Arabic from a jeweller known as 'Samir Jewellery Products' (**Samir**).[364] The Insured also submitted a jewellery valuation from 'Baghdad Jewellery' valuing the jewellery at $186,629 (**Jewellery**).[365]

The Insured held home and contents insurance with GIO with a period of insurance from 25 August 2014 until 25 August 2015 (the **Policy**). The Policy was constituted by the Certificate of Insurance and Product Disclosure Statement (**PDS**). The PDS contained provisions in relation to proving ownership and value of insured items. For items valued over $3,000, proof of purchase that identified the item, and a valuation by a qualified jeweller or professional valuer was required.[366]

- On 2 January 2015, GIO was notified of the burglary and a claim was made under the Policy.[367]
- GIO declined indemnity on 14 August 2015 and cancelled the Policy on the basis that:[368]
  - the claim had been made fraudulently;[369]
  - the Insured had failed to comply with his duty of utmost good faith;[370] and
  - the Insured failed to comply with the PDS because he failed to prove ownership of the Jewellery and the valuation was from an unqualified person.
- The Insured brought proceedings in the County Court of Victoria claiming that GIO had breached the Policy by denying indemnity.[371]

Reasoning of the Court

Was GIO entitled to deny indemnity under the terms of the Policy?

- GIO submitted that the Insured had failed to:
  - establish that the alleged burglary occurred;
  - establish the value of the Jewellery; and
  - prove ownership.[372]
- Despite some dissatisfaction with the Insured (and his wife's) witness evidence, Ryan J considered that GIO failed to establish, on the balance of probabilities, that a burglary did not occur. Had that been the only ground upon which GIO sought to deny indemnity, it would not have been entitled to refuse indemnity.[373]
- GIO also contended, and the Insured's counsel '*properly conceded*', that the valuation provided by 'Baghdad Jewellery' was not done

by a qualified jeweller or professional valuer as required under the PDS. The Insured did not discharge the burden to establish the value of the Jewellery.[374]

- Likewise, the onus was on the Insured to establish proof of ownership. The Insured's proof of ownership was unsatisfactory on the basis that GIO's investigators identified numerous concerns as to its validity and GIO's investigators were unable to find any evidence of Samir's existence. Further, the Insured failed to adduce any other evidence to prove ownership of the Jewellery (e.g. photographs, Customs declarations, or disclosure to Centrelink).[375]
- Consequently, Ryan J held that GIO was entitled to refuse indemnity on the basis that the Insured did not provide reasonably sufficient proof of ownership nor a proper valuation of the Jewellery. These were conditions precedent to indemnity under the Policy.[376]
- Ryan J emphasised that the fact that information supplied by the Insured was insufficient did not mean he had failed to give honest and complete information.[377]

Fraudulent claims – Was GIO entitled to rely on section 56 of the ICA?

- GIO pleaded that the Insured had submitted a fraudulent claim under section 56 of the **ICA.**[378]
- To satisfy section 56, GIO were required to discharge the *Briginshaw*[379] standard of proof – namely that '*clear or cogent or strict proof [was] necessary*'[380] to establish that the Insured knowingly made a false statement; in connection with the claim; to induce a false belief in GIO; for the purpose of obtaining payment or some other benefit under the Policy.[381]
- Whilst GIO alleged that the Insured knowingly made false statements in a wide range of matters, for the purpose of section 56, Ryan J considered it was only relevant if false statements were made in respect of:

  (1) the burglary;

  (2) ownership of the Jewellery and reliance upon the Samir receipt; and

  (3) the valuation of the Jewellery.[382]

- Whilst having '*serious concerns*' about the veracity of the Insured, Ryan J found that GIO failed to lead any evidence which proved these matters to the requisite *Briginshaw* standard.[383]

Was GIO entitled to rely on section 13 of the ICA to deny indemnity? (i.e. the duty of the utmost good faith)

- GIO also relied on section 13 of the ICA, which '*enshrines in statutory form the common law obligation to act in good faith…*',[384] to deny indemnity. Failure to act in '*utmost good faith*', does not necessitate a finding that an insured acted dishonestly, but that the conduct required '*may have elements in common with an absence of clean hands as is understood in equity.*'[385] Likewise, a breach of the utmost good faith obligation does not mean that the claim made is fraudulent.[386]
- GIO alleged that the Insured breached section 13 in making the claim, namely, the fact of the burglary, the lack of adequate proof of ownership and an unprofessional valuation. GIO also sought to raise certain non-disclosures relating to two previous jewellery insurance claims. Ryan J rejected this as it was not relied upon in GIO's letter denying indemnity, nor pleaded.[387]
- Ultimately, Ryan J found that the Insured's failure to substantiate his claim to GIO's satisfaction did not itself give rise to a finding that the Insured breached his duty of utmost good faith. No dishonesty was proved, nor was the Insured's conduct found to be '*capricious, unreasonable or involved unfair dealing*'.[388]

Defences advanced by the Insured - sections 54 and 31 of the ICA

- The Insured sought to rely on sections 54 and 31 of the ICA.
- To rely on section 54(3), the Insured needed to prove that an act or omission occurred after the Policy was entered into which did not cause or contribute to the loss that gave rise to his claim.[389] The issue was whether the Insured's failure to substantiate his claim was an act or omission to which section 54 applied.[390]
- The Insured's inability to prove his claim to the satisfaction of GIO, was differentiated by Ryan J against instances where section 54 had been successfully invoked (e.g. failure to notify a material variation or not giving notice of a potential claim within the time prescribed or at all).[391] Ryan J considered the Insured's failure was not an act or omission to which section 54 applied as he did not engage in an act or omit to do an act after the inception of the Policy.[392] Regardless, if that finding was wrong, then prejudice would be caused to GIO as it would have cancelled the Policy and reduced its liability to nothing.[393]

Was GIO entitled to cancel the Policy pursuant to section 60 of the ICA?

- GIO notified the Insured that it was cancelling the Policy in accordance with section 60 of the ICA.[394] Under section 60(d) of the ICA, an insurer may cancel a policy if the insured has failed to comply with a provision of the contract. The Insured failed to comply with the requirement to provide reasonable proof of ownership and valuation to substantiate his claim. Accordingly, GIO was entitled to cancel the Policy on that basis.[395]

Result

- The Insured's claim was dismissed, and he was ordered to pay GIO's costs on a standard basis.[396]
- Whilst GIO was held to be entitled to deny indemnity and cancel the Insured's Policy on the basis that the Insured failed to reasonably substantiate his claim in accordance with the PDS, it was not entitled to refuse payment on the basis of any fraud pursuant to section 56 of the ICA, as no fraud was found.
- This case exemplifies the high standard that Insurers must meet to prove fraud on the part of an insured, so it is important to clearly plead and prove a section 56 defence (on the balance of probabilities) in accordance with *Briginshaw* (as codified).

MONUMENT: FIRE INSURANCE, FIRE MARKS AND THE LEVY – A BRIEF HISTORY SINCE THE GREAT FIRE OF LONDON

If you go for a stroll in The Rocks area of Sydney or any old neighbourhood in London, you might see curious metal plaques, some no bigger than the palm of your hand, which brandish the façade of historical buildings. These plaques or fire marks exhibit the emblem or name of extinct insurance companies enamelled in artistic detail. These days, fire marks are collectors' items and can be found in online marketplaces, estate sales or the history displays of longstanding insurers. In the 17th, 18th and 19th centuries, they signified that the building they marked was insured by a particular insurer. Back when the closest thing to a public fire authority was the insurance companies' private fire brigades, a fire mark could be the difference between beckoning firefighters or them walking away.

The origin of fire marks is inseparable from the history of fire insurance and the history of fire insurance is inseparable from the Great Fire of London. We explore how this tragedy shaped both insurance and firefighting, and how they tested relationships between insurers, the community and the state. Come on this journey with us, which culminates in the inevitable fire levy.

The Great Fire of London

In the early hours of Sunday, 2 September 1666, a fire broke out in a bakery in the City of London. The resulting conflagration, which would come to be known as the Great Fire of London, accelerated through narrow alleyways, blazing through adjoining timbered structures and riding the wind to engulf the city over a period of 4 days. By the time the fire subsided, much of the town had been reduced to dust.

Rebuilding, Nicholas Barbon and the emergence of fire insurance

The rebuilding of the City commenced soon after the Great Fire. Dr Nicholas Barbon, medical doctor turned property developer, is said to have become 'one of the most prominent London builders of his age' after the Great Fire, undertaking significant developments along the western edges of the City.[397] A year after the Great Fire in 1667, Barbon established the first fire insurance business, it being alleged that he had 'worried that his wealth was tied up in property that could burn in another fire'.[398] In 1680, Barbon restructured the business into a company, probably called The Insurance Office or The Fire Office. This was, as far as we know, the first fire insurance company. After The Fire Office was established, other insurance companies followed suit in as early as 1681.

Helping the insurance companies by reducing their risks were legislative reforms, enacted following the Great Fire aimed at improving the infrastructure of the City, which prescribed wider road widths, required the outside of buildings to be made of brick or stone (and not timber) and regulated the form and sizes of buildings and the distance between them (amongst other things).

Pausing here, it should be noted that Barbon did not invent the concept of insurance or even fire insurance. We know, for example, of a Florentine man living in London in 1427 who sued his insurers after Spanish privateers captured his ship. Specifically on fire insurance, it appears that in 1633, Charles I was petitioned for a patent for the sole right of issuing insurance against fire in and about the City of London but, whilst the King was enthusiastic, nothing seems to have come of this. That is an article for another day.

Enter, private fire brigades and fire marks

In the absence of any public or organised fire brigade, each fire insurance company, including The Fire Office, established a private fire brigade to provide firefighting services exclusively to their respective insureds. A building insured by a particular insurer was identified by the fire mark of that insurer. Fire marks were usually painted in gold or red and included the insurance policy number. It was not unusual to find more than one fire mark on the same building. The Fire Office's fire mark was a phoenix rising from the flames. Another insurer, The Amicable Contribution, formed in 1696, chose the design of a handshake (and eventually changed its name to the Hand-in-Hand Fire and Life Insurance Society).

In a fire, if an insurance company's fire brigade did not see the fire mark of the insurance company on a building, they would not intervene, the exception being if the unmarked or competitor-marked building put another marked building at risk of the fire spreading to it. One insurance company, Povey's Exchange House Office, went as far as penalising its firemen who aided or assisted uninsured persons for a reward. It would not be easy to imagine such business models in today's world, in particular given insurers' and the public's shared values and common interest in loss minimisation, and it did eventually fall out of practice, but this took many decades. That said, even back then, some insurance companies operated in contrast to this. The Westminster Fire Office, for example, required its firefighters to extinguish 'all fires that shall come to their knowledge', an arguably more palpable approach for the modern reader.

Insurance companies funded their fire brigades themselves. Whilst it seems they did not charge their insureds for their fire brigades, they did charge for the issue of fire marks. Given some priced their fire marks at 8 times the cost of manufacture, it would not be unreasonable to think that at least some part of the brigades' funding would have come from the marks.

To prevent fraud, such as to stop uninsured persons from holding out that they were insured or to stop an uninsured person from insuring a building that had already burned down, an insurance company would require its insureds to pin the company's fire mark to building soon after the policy was taken out. Of course, some fraud occurred, but insurance companies and fire brigades had their own solutions. In one town in the United States for example (where insurance companies did not own their own fire brigades but relied on firefighting teams), firefighters put out a fire at a house with a stolen fire mark. Having failed to secure a reward from the insurer, they returned the next day and burned the house down to the ground.[399]

Unsurprisingly, fire marks had to be removed if the policies did not continue in force (although the practice of removing fire marks was not always followed, as is evident from those fire marks in The Rocks and in London) and the custom eventually fell out as fire marks lost their original purpose and became items of advertisement for insurers, as discussed below.

Mark the end of marks – unification and subsequent socialisation of the brigades

By the end of the first quarter of the 19th century, insurers would frequently find themselves insuring the same buildings and, given the growth in their businesses, were no longer seeing a benefit in maintaining the exclusionary firefighting business model. This contributed to policy numbers slowly disappearing from fire marks. The marks themselves remained but the private brigades' coverage of virtually the entire City meant that they were primarily advertisement for insurers. Eventually, firefighters began cooperating and, in 1833, the fire brigades of all of the insurance companies in London merged to form the London Fire Engine Establishment. Despite all appearances, the Establishment was a private enterprise and continued to be funded by the insurance companies.

Although it was regarded as a public authority and was open to providing fire services to the public, the Establishment's legal priority, and the source of its funding, was insured properties. The Establishment was in such a difficult position that it implied in a letter to Westminster, after the Burning of Parliament in 1834, that Westminster Hall would have been allowed to burn if the Establishment were to have been called by an insured property in danger. The cost of running the Establishment was also increasing, such that after the 1861 Tooley Street Fire (causing today's equivalent of £200m in losses), insurance companies raised premiums by as much as 300%. Finally in 1866, after three decades of lobbying by the Establishment, the enterprise was turned over to the City. Notwithstanding, insurance companies were required to pay the City an amount proportionate to their annual business written within the boundaries of the City (a levy) to contribute to the cost of running the Establishment (what is now the London Fire Brigade). In this way, the insurance companies continued to fund the public fire authority similar to how they were funding their private brigades.

Fire marks in Australia

British fire insurance companies commenced operations in the Australian colonies from the 1830s and, like they did in Britain, issued fire marks until around the time of Federation. What are now the public fire authorities of Australian States and Territories evolved differently in their respective jurisdictions. However, they also began as insurer-funded private enterprises which were eventually taken over by municipal and then state and territory governments.

It is claimed that unlike the fire brigades of London, Australian fire brigades never turned away from a fire, whether or not the building bore the mark of the relevant insurance company (although the same doubt has been raised in respect of the London brigades as well). It has also been claimed that, in the absence of any Australian newspaper recording such events, such accounts were no more than urban myths which were just too effective at advertising insurance policies. Given fire marks had already become items of advertisement in London by the time the fire insurance business picked up in the colonies, this would not be difficult to accept.

Having lost their purpose, fire marks were probably turned to scrap metal for World War I, destroyed in demolitions and taken off buildings as collectors' items and souvenirs. Like in Britain, most that is left of fire marks is the fire levy. However, they can still be found online and in flea markets for, sometimes, not-insignificant prices. Chitty's 1925 book *Fire Insurance Officers and "Fire Marks" in Australasia* also has a very extensive catalogue of the marks, along with broader information about insurance companies which no longer exist in name. Some museums, like the Museum of Fire in Sydney, will display them, and if you ever find yourself in the Sydney office of the Insurance Council of Australia, you will find a good number of these plaques there too. Finally, if you consider yourself lucky, look up every once in a while, and you might catch sight of this relic of the past.

Disclaimer: Whilst every effort has been made to draw information from reliable sources, KWM does not warrant the accuracy or completeness of this column.

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142. *ASIC v AGI* at [97].
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145. *ASIC v AGI* at [104].
146. *ASIC v AGI* at [105] citing *Karpik v Carnival plc* [2023] HCA 39; (2023) 98 ALJR 45 at [32] which considered the cognate 'transparency' provision in section 24 of the *Australian Consumer Law*.
147. *ASIC v AGI* at [107].
148. *Australian Securities and Investments Commission v H C F Life Insurance Company Pty Limited* [2024] FCA 1240 ('**ASIC v HCF Life**') at [19].
149. *ASIC v HCF Life* at [26], [37].
150. *ASIC v HCF Life* at [2].
151. *ASIC v HCF Life* at [98].
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153. *ASIC v HCF Life* at [83]. Interestingly, Jackman J nonetheless referred to the opinion of Desmond Derrington J that the formula could be encapsulated in the question: is it reasonably possible that a reasonable person would probably (or most probably) know of the relevance of the fact? ('*What Have They Done to the Common Law? Disclosure and Misrepresentation*' (1988) 1 Insurance Law Journal 1 at 3).
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159. *ASIC v HCF Life* at [110].
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170. *ASIC v HCF Life* at [141].
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201. *Matheson (No 4)* at [18].
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203. *Matheson (No 4)* at [23].
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298. *ASIC v TAL* at [197].
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