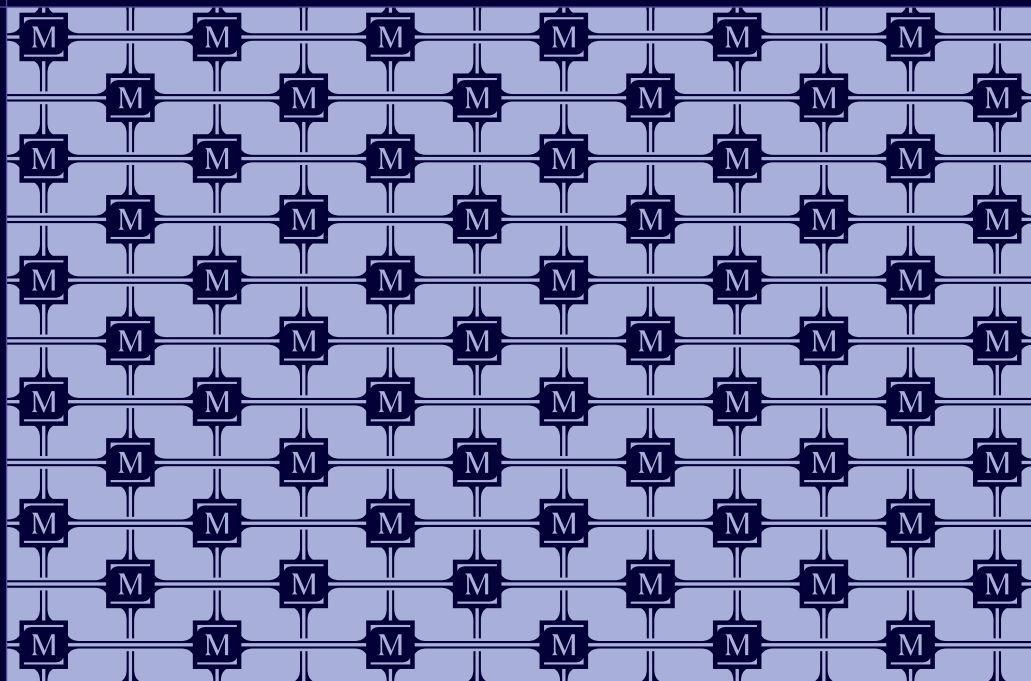


# Insurance Pocketbook

2026 | 6th Edition



# Foreword

As a collaborative and cohesive full-service practice, acting for policyholders, insurers, brokers and industry bodies, our team see the market from all sides. In our sixth edition of the *Insurance Pocketbook* (and the first published as Mallesons) 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.

## In this edition you will find:

- Analysis and commentary on a database of insurance related matters which are the subject of a published court decision over the period 1 January 2022 to 31 December 2025. Travis Toemoe and Peter Yeldham have also recorded a podcast with some further insight on what the data tells us.
- Commentary on regulatory matters from Mandy Tsang, as well as an overview of sell-side W&I Insurance.
- An in-depth analysis of the direct-to-consumer (D2C) life insurance sector from Sarah Yu, which includes commentary on the impact AI has had on the sector.
- Content relating to the 40th anniversary of the operation of the *Insurance Contracts Act 1984* (Cth). A highlight is our article exploring the history of the judicial interpretation of section 54.
- Interviews with:
  - former Chief Justice of the Federal Court of Australia, James Allsop AC
  - Carey Lynn, Managing Director - Head of Legal, Technical & Claims at Howden Specialty
- Back by popular demand, our 'Monument' column which deals with a historic issue in the insurance world. This year, we look at the *Bubble Act* of 1720 which was critical to the establishment of the insurance industry in London.

## NAVIGATING THE INSURANCE SCENE IN 2026

2026 will be another significant year for the insurance industry in Australia. We anticipate a volatile insurance market, particularly in light of M&A activity responding to world events. There is also a raft of regulatory reforms for insurers across different types of operational risks, and claims handling failures and misleading pricing practices continue as enforcement priorities.

We are grateful to all of those who were involved in the production of this sixth edition and also to our clients who are consistently encouraging of the *Insurance Pocketbook*.

If anything in this *Insurance Pocketbook* is relevant to your business – or you would like a presentation on its content - please do not hesitate to contact a member of our team.

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# Policies to precedent: analysis of insurance decisions from January 2022 to December 2025

In this edition of the *Insurance Pocketbook*, we wanted to innovate our coverage about case law. This article was inspired by the following conundrum: how do we verify the trends that we see in the insurance market every day, and how do we communicate these trends? To solve that problem, we have compiled statistics on published insurance decisions in Australia over the last 4 years.

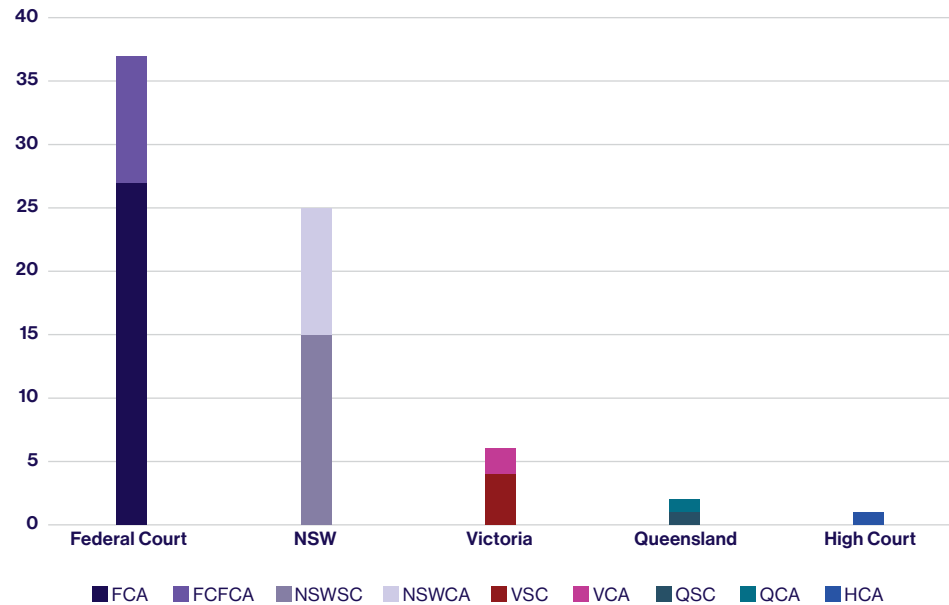
The analysis below draws on those aggregated results to highlight trends in where coverage disputes arise, how they are being resolved, and what this may suggest about the current trajectory of insurance litigation.

To produce the insights that follow, we have compiled and analysed a database of published Australian insurance coverage decisions. The methodology used to construct the dataset, including the criteria for inclusion and coding rules, is explained from page [12](#). The size and structure of the dataset we have curated now allows us to step back from single decisions and identify broader patterns emerging across insurance coverage litigation.

For further discussion of the findings, we encourage readers to listen to our accompanying podcast featuring Travis Toemoe and Peter Yeldham.

Against that backdrop, two high-level observations emerge from the data: insurance coverage litigation in Australia is highly concentrated in specific courts and coverage outcomes vary across sectors and policy types.

## Number of decisions by jurisdiction



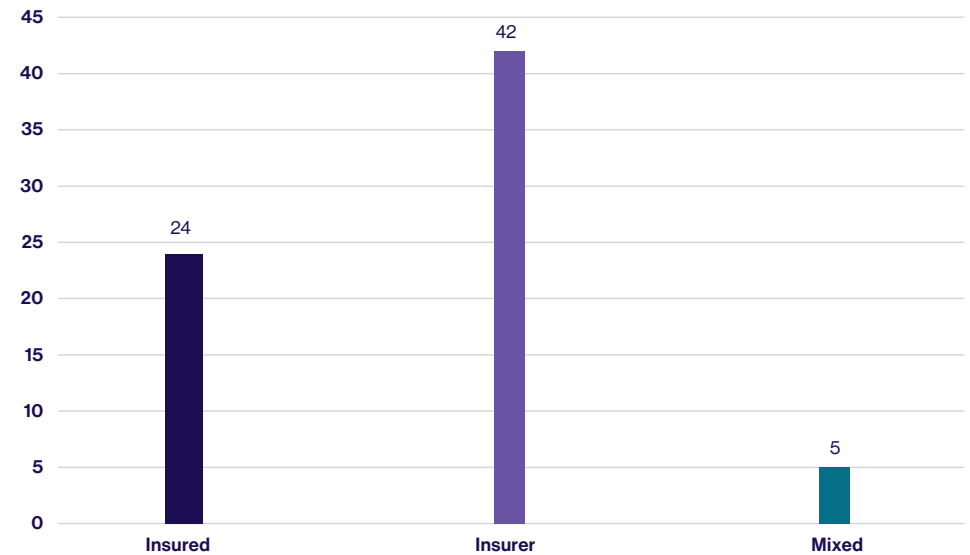
## 1 ANALYSIS OF DECISIONS BY JURISDICTION

- The overwhelming majority of the insurance cases heard at first instance and on appeal (over the last 4 years) were heard in the Federal Court and the Supreme Court of NSW.
- Of the 71 cases which met our inclusion criteria, 37 were heard in the Federal Court of Australia (including the Full Federal Court) and 25 were heard in the NSW Supreme Court (including the NSW Court of Appeal).
- There were no judgments which met the criteria delivered by the Supreme Courts of Western Australia, South Australia, Tasmania, the Australian Capital Territory or the Northern Territory.
- There was only one appeal heard by the High Court of Australia in our inclusion period, being *Allianz v Delor Vue* [2022] HCA 38.
- Our view is that these numbers reflect the attraction of, and efficiency of, the 'Insurance List' in the Federal Court of Australia and the Commercial List in the Supreme Court of New South Wales. These two courts appear to have the capacity to meet this demand, with the average number of days for a published decision in the Federal Court of Australia being 129 days and the Supreme Court of New South Wales being 49 days.

## 2 ANALYSIS OF OVERALL OUTCOME (WINNER)

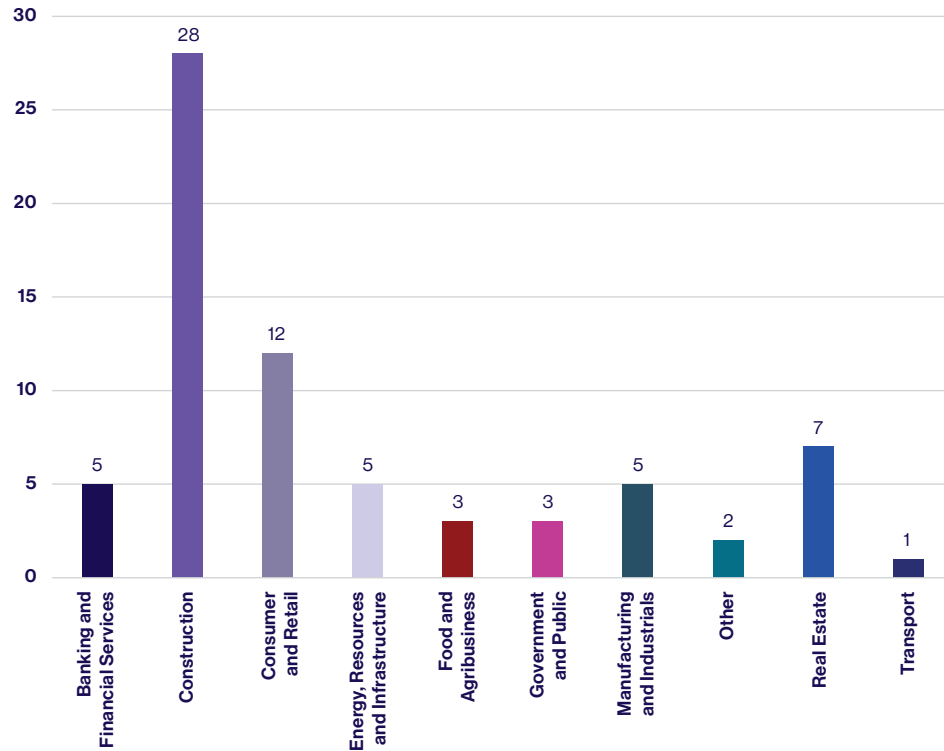
- Across the 71 final coverage decisions which met our inclusion criteria, insurers prevailed in 42 cases (59%), insureds prevailed in 24 cases (33%), and outcomes were mixed in a further 5 cases (7%). This reflects a clear, though not overwhelming, tilt in favour of insurers.
- While this headline statistic might suggest a systemic pro-insurer trend, the sectoral breakdown reveals a more nuanced picture (see over).

### Who won in contested coverage decisions?



### 3 ANALYSIS OF DECISION BY SECTOR

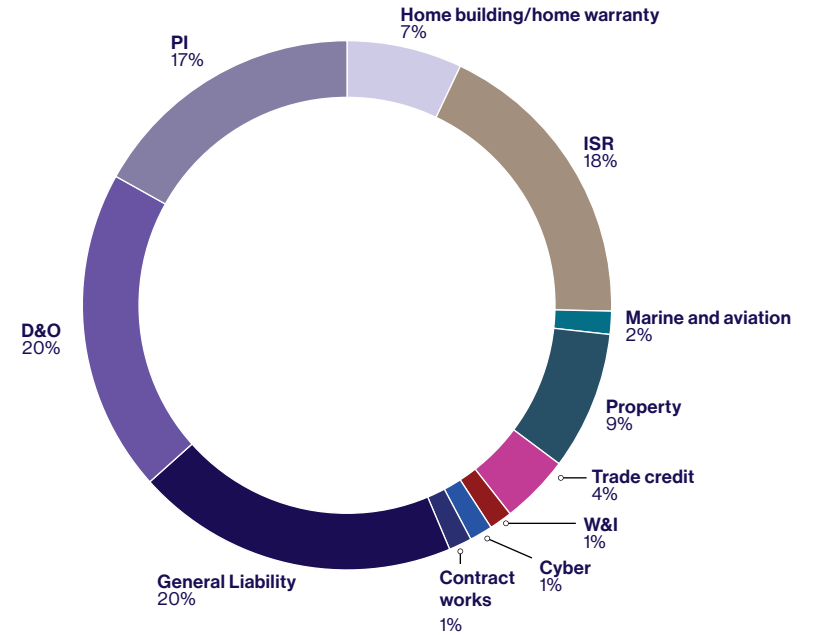
Number of decisions by sector



- The litigation of coverage disputes is heavily concentrated in the construction sector. Of the 71 coverage disputes decided, 28 (39%) arose in Construction. The next most active sectors were Consumer and Retail (12 cases, 17%) and Real Estate (7 cases, 10%). All other sectors each accounted for 5% or less of the total decisions.

### 4 ANALYSIS OF DECISION BY POLICY TYPE

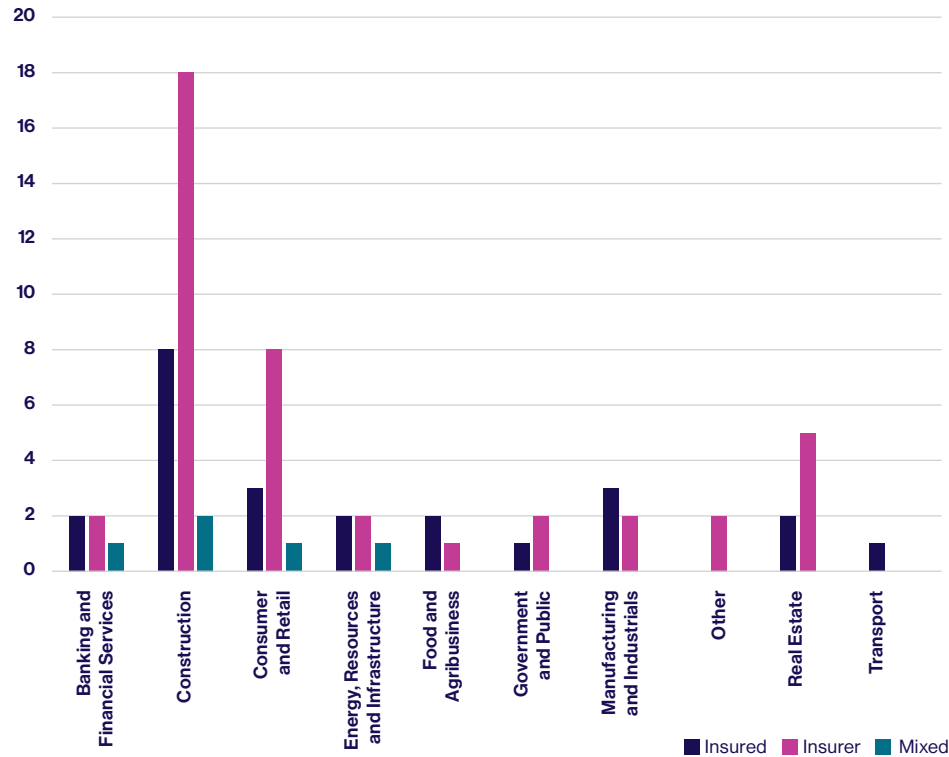
Proportion of decisions by policy type



- The categories of insurance policy which were litigated the most were:
  - D&O;
  - General Liability;
  - ISR; and
  - PI
- D&O and General Liability policies each accounted for 20% of the judgments, ISR policies accounted for 18% and PI policies followed closely with 17%.
- Looking behind the data, we have identified that the D&O cases are relatively agnostic as to sector.
- The construction sector accounts for most of these Professional Indemnity and General Liability cases.
- We note that ISR policies account for 18% of the data. A number of these cases relate to COVID-19 related business interruption claims, and those judgments were mainly given in 2022 (with a few across 2023 and 2024 and none in 2025).

## 5 ANALYSIS OF COVERAGE OUTCOMES BY SECTOR

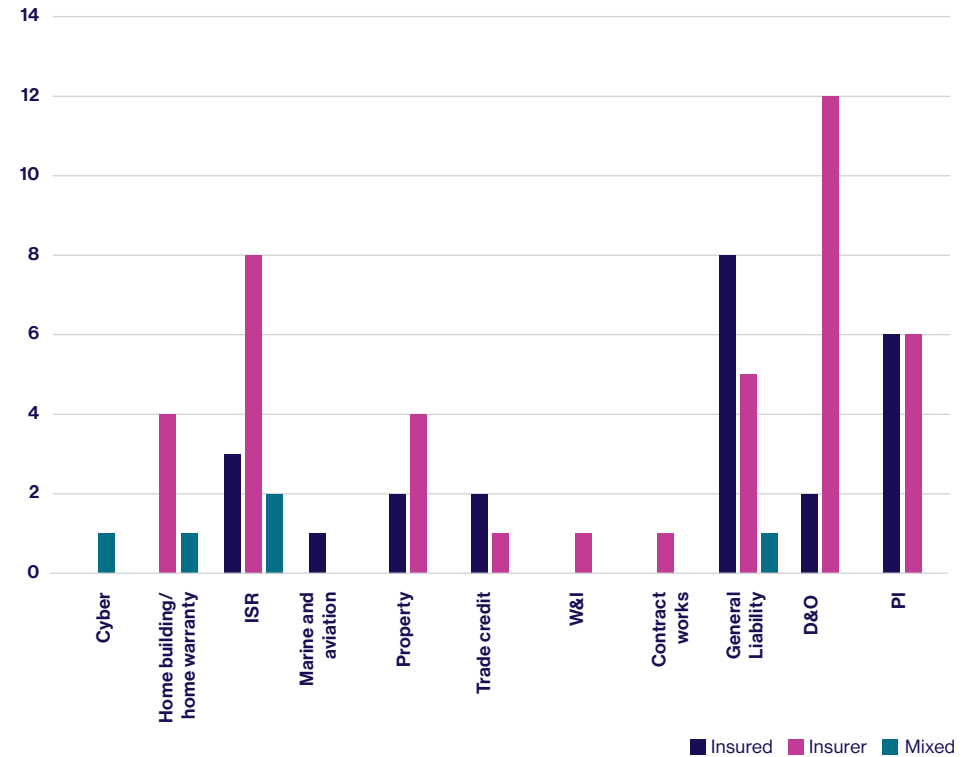
### Contested coverage outcomes by sector



- When the case outcomes are disaggregated by sector, it becomes apparent that the overall insurer advantage is skewed heavily by the Construction and Consumer and Retail sectors.
- The sectoral breakdown demonstrates that Construction alone accounts for 28 of the 71 coverage decisions (39%), with insurers prevailing in 18 cases (64%) compared to 8 insured wins (29%), producing a net insurer advantage of +10 decisions.
- Consumer and Retail contributes a further 12 cases (17%), with insurers winning 8 (64%) and insureds 3 (25%), adding a net +5 to the insurer advantage. Together, these two sectors account for 15 of the 18 net insurer wins across the dataset - approximately 83% of the overall insurer-win differential.
- When Construction and Consumer and Retail are excluded, the remaining sectors produce 31 decisions, with insurers winning 16 and insureds winning 13 (with 2 mixed outcomes), resulting in only a marginal net insurer advantage of +3.

## 6 ANALYSIS OF COVERAGE OUTCOMES BY POLICY TYPE

### Contested coverage decisions by policy type



- The data reveals that insurers have tended to be successful in cases involving D&O, ISR, Home Building and Property insurance.
- In D&O specifically, insurers won 86% of the contested coverage decisions that went before the courts.
- All contested D&O policy decisions turned on either policy coverage and construction, or non-disclosure and misrepresentation.

## 7 NOTES ON DATA SET

- 1 To prepare this analysis we have cultivated a database of published insurance decisions for the period 1 January 2022 to 31 December 2025. Set out below are some notes on what data we collected, what methodology we adopted and what was excluded from our data set.
- 2 Our data records final judgments by Australian courts in insurance coverage cases made between January 2022 and December 2025. By insurance coverage, we mean cases where insureds are seeking coverage and indemnity from insurers under an insurance policy.
- 3 We accept that the dataset we have does not include cases which were commenced and were subsequently settled or discontinued.
- 4 While every effort has been made to identify all published decisions that meet the inclusion criteria, it is theoretically possible that some relevant cases have not been captured. For example, interlocutory rulings resolving coverage issues may have been delivered *ex tempore* or otherwise remain unpublished. To that limited extent, there may be a risk that isolated decisions falling within the criteria are not reflected in the dataset.
- 5 At the outset we note that our analysis involved human judgment and that reasonable minds might differ on certain categorisations. For example, our team manually determined whether a decision constituted a substantive insurance coverage decision and fell within scope, which involved evaluative judgment in borderline cases. We also exercised discretion in coding each case by policy type and sector, particularly where disputes involved multiple policies or where the insured operated across more than one industry.

- 6 We applied the following inclusion criteria to determine which cases would be captured in our data:

### Jurisdiction and types of cases

- Our data only includes insurance coverage decisions made in Australian superior courts of record. This means all State Supreme Courts (including Courts of Appeal), the Federal Court (including the Full Federal Court) and the High Court. Decisions from inferior courts of record (Federal Circuit Court, District Courts and Local Courts and their equivalents) were excluded.
- We excluded:
  - all interlocutory decisions, which we define as cases that do not determine the rights and obligations of the parties on a final basis. Save that, where there were 'separate' or 'preliminary' questions on insurance coverage, these were included;
  - decisions about costs;
  - non-coverage decisions relating to insurance. These include proceedings brought by consumers or regulators against insurers for alleged breaches of consumer law or the *Insurance Contracts Act* (including ASIC/APRA civil penalty proceedings, appeals from AFCA determinations and class actions); and
  - court approvals of insurance business transfers in M&A contexts, such as scheme of arrangement approvals.

### Policy type

We categorised each case by the policy type which was under consideration. Our goal was to capture cases which considered financial lines and corporate insurance policies, rather than all forms of insurance.

- The final policy type categories applied were:
  - Professional Indemnity (PI);
  - Directors and Officers (which included management liability) (D&O);
  - Industrial Special Risks (which included business interruption) (ISR);
  - Property;
  - Cyber;
  - General Liability (which included policies which insure third party liabilities, but excluded public liability policies);
  - Trade Credit;
  - Warranty and Indemnity (W&I);
  - Construction All Risks;
  - Home Building/Home Warranty;
  - Marine and Aviation.
- We excluded decisions concerning certain statutory and general insurance lines, such as motor vehicle accidents, workers compensation and personal injury matters. Life insurance and public liability insurance decisions were likewise excluded, while home building insurance cases were only included where they raised coverage issues.

### Methodology

- The first stage of our review involved simultaneously searching case law databases for past coverage decisions, and setting up search alerts to capture incoming decisions for review. We manually filtered search results to exclude matters falling outside the inclusion criteria. We classified each case by policy type, sector, main issue and coverage outcome (making a determination as to whether the insured or insurer prevailed). Where multiple issues arose, we exercised judgment to determine the primary issue.
- Separately, we classified the insured's business by sector, using the following categories: Banking and Financial Services, Construction, Manufacturing and Industrials, Consumer and Retail, Food and Agribusiness, Healthcare and Pharmaceuticals, Government and Public, Energy, Resources and Infrastructure, Real Estate, TMT, Insurance, Transport, and Other (as a residual category where no primary sector predominated).
- All of the analysis was prepared by the Partners and staff of Mallesons.

# Interview with The Hon James Allsop AC



The Hon James Allsop AC is an international arbitrator and mediator. He also accepts appointments as early neutral evaluator, chair of inquiries and legal expert.

The Hon James Allsop AC is an international arbitrator and judge who currently sits as a Non-Permanent Judge of the Hong Kong Court of Final Appeal, a Judge of the Singapore International Commercial Court and a Judge of the Qatar International Court. He served as a Justice of the Federal Court of Australia between 2001 and 2008, and as Chief Justice of that Court from 2013 to 2023. He was President of the New South Wales Court of Appeal from 2008 to 2013. He was made a Companion of the Order of Australia in 2023 for eminent service to the judiciary and to the law.

We recently caught up with the former Chief Justice over lunch to discuss his trajectory in insurance law and glean some valuable insights from his over 40 years in practice.

## **What did you want to do when you were young, and how did you end up studying law?**

At school, I thought about doing something scientific or medical. A combination of high-school science teachers and not being able to stand the sight of blood was the end of that. I ended up beginning an arts/law degree at the University of Sydney, but jettisoning law after two years, after which I taught high school for three years. I enjoyed teaching very much. It was, as it happened, great training for the Bar - controlling schoolchildren and keeping them interested and focused was very good training for dealing with wilful and sometimes ill-attended judges.

After a year's teaching I got the bug to study again, and enrolled at the University of New South Wales, where I studied part-time in the evenings. Eventually, I went back to study full-time at Sydney University. There were a number of "mature age" (as we were known) students with me, all of us in our mid-20s. Studying with a little life experience meant I found it more engaging - I think law requires something of a mature brain.

## **Did you have significant mentors in respect of your professional development?**

I was fortunate to have many mentors early in my career. My first full-time legal role was as Associate to the Honourable Sir Nigel Bowen, then Chief Justice of the Federal Court. He was among the most intelligent and kind people I have known. As an articled clerk, I had the great advantage of working with Kim Santow and David Gonski at Freehills. After going to the bar, I had the good fortune to be briefed by some superb insurance lawyers: John and Phillip Wotton, Henry Herron, Kathryn Rigney, Tony Scotford, Normal Lyall and Pam Madafiglio and others.

At Eleven Wentworth, I shared a room with Lindsay Foster, Michael Pembroke and Tony Meagher. It was a fantastic floor with an excellent clerk. I had the benefit of learning from many senior counsel, including Robert Hunter QC and Brian Rayment QC, Simon Sheller QC to name just a few. Robert Hunter QC in particular had an indefatigable work ethic and taught me how to prepare large, fact-heavy cases without losing sight of the structure of a dispute.

Perhaps the most influential person in my training was a judge: the Hon Andrew Rogers, who presided over the Commercial List in the New South Wales Supreme Court. There had been no Commercial List like it - always jampacked on a Friday. It was not until I became a judge that I fully appreciated the depth of what he was doing - he was training the profession (albeit sometimes forcefully). If you didn't read your brief beforehand, you could lose a case in the Friday list. Nonetheless, he ran that list with a real social and human element. He understood how to deal with people; a superb list judge.

**When we talk about a duty of utmost good faith in insurance contracts, what does that mean to you?**

Good faith is sometimes a poorly understood concept, but the great strength of Australian jurisprudence is that we have had judges in this country who really understand insurance. I think that understanding how the industry works – the brokers, the underwriters, claims management; everything – is key.

To me, the notion of good faith is simple: faithfulness to the bargain. As Gleeson CJ said in *CGU Insurance Limited v AMP Financial Planning Pty Ltd* (2007) 235 CLR 1, good faith is not just about dishonesty but standards of decent commercial behaviour. It's not an equitable concept that comes from a fiduciary duty - it has underpinned our general law of contract since the 19th century through cases like *Mackay v Dick* (1881) 6 App Cas 251.

Once you accept that principle and accept that good faith is a norm of conduct, you see that this norm affects how to construe and interpret the insurance contract, how to understand issues of claims management and claims handling and how to understand breach of contract.

That said, I admit to some disappointment with how the High Court has recently dealt with the topic.

**Tell us about your reflections on 40 years of the operation of the Insurance Contracts Act 1984 (Cth). Has it achieved its purpose? Would the authors of ALRC No 20 be pleased?**

I would say its impact has been profound and overwhelmingly beneficial. It has largely achieved its purpose of recalibrating the relationship between insurers and insureds towards fairness, transparency and decent commercial behaviour.

Before the Act, non disclosure and misrepresentation operated as a nuclear option. Under the prudent underwriter test which applied before the Act, a non-disclosure allowed the insurer to avoid the policy. Materiality turned on what a hypothetical prudent underwriter would want to know, without proof of how the real underwriter would have approached the risk and the cover based on the information which had not been disclosed. It was absolutely draconian, although I should add that in my experience (most) insurers in those days would not go for the nuclear option unless they felt that they'd been taken advantage of.

The Act changed that. It requires insurers to show how and why the non disclosure would have made a difference - pricing, terms or acceptance. So the underwriter must effectively "get in the box". The result is a regime of proportionate, evidence based remedies that better reflect real underwriting and pricing.

I've already discussed the statutory duty of utmost good faith. The Act has really encompassed that duty fairly and balanced the risk of breach between insureds and insurers.

Trial work underscores the point: true understanding comes from living the facts chronologically. In *Allianz v Delor Vue* (2022) 277 CLR 445 (a case which I heard at first instance) the insureds acted with honesty and care; there was robust internal debate within the insurer, and a substantial offer was made. Those facts mattered. They illustrate both the integrity of the policy as a whole and the need, under the Act, to navigate any non disclosure issues with evidence and proportion rather than reflexive avoidance.

In practice, the Act has replaced a fairly asymmetric avoidance regime with a structured, proportionate framework grounded in proof. It requires insurers to articulate, with evidence, how non disclosure would have altered the underwriting outcome; and it embeds good faith as a standard shaping decent commercial conduct. The market has adjusted: avoidance is no longer a reflex, and when invoked it must be justified. Courts can separate hard edged commerciality from unfairness and ensure outcomes track the real risk bargain.

Would the authors of ALRC No. 20 be pleased? I think so. David Kelly's report was a tour de force of law reform. When Lord Mance (now of the UK Supreme Court) was undertaking a review of the English Insurance Act, I told him to read David Kelly's report – it was and is the best textbook on insurance law. Forty years on, the statute works as intended, protecting the integrity of underwriting through evidence and proportion while shielding insureds from overreach.

**Can we talk about the genesis of the FCA Insurance List? What are your reflections on the progress and success of that list?**

In my first year as Chief Justice, I spent probably 75% of my time tending to administrative matters. The reality is that the Federal Court is unique in that it is a national court with registries across Australia. We brought in a brand-new system, which I had been thinking about for some years. [Editors Note: As Chief Justice, his Honour led and oversaw a major cultural and structural transformation of the Federal Court through the National Court Framework, including the creation of eight national practice areas and the issuance of 28 national practice notes.]

In practice though, if I was going to talk about how I wanted cases to run, I had to go about doing it as well. I tried to be hands on, and the insurance list was designed to be the gold standard for how to case manage.

The intention of the Insurance List was to create a forum where insurance matters could be heard knowledgeably and promptly. Insurance is so important – to paraphrase Andrew Rogers, it is the oil that greases the machinery of commerce, and society generally – and it is vital that insurance matters are heard by people who understand the industry. I also understood from meeting with stakeholders at the time (including brokers, underwriters and solicitors) that there was an appetite for a specialised insurance list that could determine important questions regardless of where the proceedings originated.

# Interview with Carey Lynn



Carey Lynn is Managing Director - Head of Legal, Technical & Claims at Howden Specialty

We spoke with Carey at the end of 2025 to reflect on her experiences in the insurance industry.

## Tell us about your first job in insurance

After completing university and while studying at the College of Law, I gained hands-on experience as a paralegal at Phillips Fox (now DLA Piper) who were acting for a reinsurer on a high-profile insurance film financing dispute.

The role involved reviewing extensive discovery from the London and New York proceedings, preparing court bundles, and ensuring meticulous document pagination (stamping each page manually!).

Beyond administrative tasks, I attended meetings with Counsel, supported court hearings, and got stuck into legal research – this was way before AI! As well as building great experience early on in my career, I was lucky to have a nice office with lovely Sydney views and to come across some interesting film scripts.

## When did you realise that you liked working in insurance?

It was quite early on that I realised I loved learning about such a diverse range of industries that were the subject of insurance claims.

In my early years in law firms, I worked on insurance claims including: a spontaneous combustion incident at a coal mine, the liquidation of a wine company, a dispute between two insurers over who would pay for damage caused by a large tunnel project in Singapore, a reinsurance dispute following the collapse of HIH, and more.

I also worked on a \$100m claim defending over 20 London insurers against a claim by a large Australian financial institution relating to mis-selling by an acquired subsidiary (the key issue being whether cover applied to the mis-selling that occurred prior to the entity's acquisition).

I got to travel to London to take witness statements and, in doing so, got to meet with many underwriters and claims people, as well as understand the intricacies of the London market and how it worked. It no doubt ignited the flame for a move to London a few years later, this was supposedly for two years but it's now been almost 16 years.

## How do you know when it is time for a new job in insurance?

I've worked at two companies over the last 12 years (and had the same boss the whole time) – JLT and then Howden, but it feels like I've had many new jobs in that time.

Howden has had so much exciting growth and change in the almost six years I have been here, and I really believe we are a global broker like no other. The energy, passion and innovation here at Howden is contagious. There has been and continues to be so much change impacting the industry too (COVID, geo-political tensions, consolidation, technology and AI) and so every day and year has a different focus.

So, to answer the question, if you are working for a company and boss that inspires and empowers you, and have a great team around you, then you're on to a good thing. If not, then it's probably time to look around.

**Please tell us about your role at Howden in London.**

I'm Head of Legal, Technical & Claims for Howden's Specialty business. I'm responsible for approximately 200 claims advocates across the business who are aligned to the different specialisms, including; Financial Lines, Sport & Entertainment, Natural Resources, Aviation, Marine, M&A etc.

I'm also responsible for the Data Insights & Analytics team focused on providing insights to clients to mitigate risk and to leverage better deals in the market. Claims provides a gold mine of data and as an industry we need to get better at capturing and using it, so I'm very focused on that.

**The claims you work on – are they just based on English law or across jurisdictions?**

They are across jurisdiction - that is the beauty of the London market; it insures risks globally – so when the claim comes in you always need to check the law and jurisdiction clause. This was quite the change when I moved here from Australia.

I've personally worked on the claims off the back of the collapse of the Icelandic banks, the D&O claims arising from alleged bribery and corruption at a global sporting body based in Switzerland, the Dutch D&O claim flowing from the Fortis acquisition of ABN Amro, Madoff claims arising from the US, a POSI/D&O dispute in respect of a Mexican airline, a mis-selling claim involving a Norwegian bank .... which means I have travelled extensively too. I really enjoy the global side of the role that the London market offers.

**Do you spend much time with clients or more time running the Howden group?**

A big part of my role now is managing my team and the business more broadly. I get so much satisfaction from coaching and developing the next generation of leaders in Howden as well as setting the vision and strategy for Legal, Technical and Claims for the future and delivering on that. We are all about continual improvement.

However, I still do get involved with clients, and there is nothing I love more than hearing the problems that clients are facing and working across Howden to deliver innovative solutions for clients or getting an excellent outcome for a client on a claim.

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

I like to think of it as putting yourself in the other party's shoes and treating them how you would like to be treated. It's an ongoing requirement for both the insured and the insurer to act honestly, fairly, reasonably and transparently for all issues arising from the insurance, be it placement, during the policy, or throughout the claim.

For the industry it exists at common law and was codified in the ICA in Australia as an implied term in insurance contracts. However, it has no doubt evolved and been influenced by the introduction of more recent legislation and codes as well as community and societal expectations. It moves with the times as it needs to.

**How is AI changing the work you do? (if at all)**

We are embracing AI in two ways. Firstly, to drive efficiencies across claims processes and other manual tasks, e.g. contract and policy wording reviews, to free our claims advocates up to focus on the value-add client work. Secondly, to mine our data to drive better and more timely insights for clients.

We are also adopting efficiencies in our everyday work through use of Microsoft Copilot which often produces a good starting point or prompt.

**If we let you stand on a soapbox for one minute – what is a pain point that you see impacting the progression of claims?**

People go onto their banking apps and move money around instantly and they expect the same with insurance. However, in the London insurance market in particular, the variety and complexity of payment processes across carriers can cause friction and slow down the end to end claims journey. Continued progress around market wide standards (such as ACORD), coupled with greater interoperability between systems, presents a real opportunity to simplify processes and support faster outcomes for clients. At Howden, we are very involved in moving this along.

We can also move faster in adopting technology to speed up the claim adjustment process. For example, using drones, satellite imagery, and videos to assess physical damage, and AI for claims chatbots and loss modelling. We are on that path but need to move at speed now.

We also need to ensure we have enough young talent entering the insurance market to infill what is a relatively old working population and avoid issues down the line. There will be companies out there looking at the progress of AI and thinking that perhaps they'll scale down that recruitment.

But that seems to me very short-sighted, and in fact I'd say we should be taking advantage of the fact that other industries are holding back. There are some excellent potential recruits out there who might otherwise have gone directly into law, banking etc.

**What is the biggest change you have seen in claims handling over the last ten years?**

I've seen claims move from a back-office function to a real driver of revenue, a board and business priority, and a magnet for talent - although we always need more talent! At Howden, our claims advocates are in the pitch winning the business, are a trusted advisor for clients throughout the lifecycle of the policy on wording and coverage issues, and on developments or trends impacting the market. When the claim hits, we know the client and are there to strategically and proactively manage their claims to achieve the best possible resolution. The calibre and expertise of people in claims and entering claims is exciting, and we as an industry must continue to focus on and foster that.

**Do you have any predictions for trends in claims that will cross your desk in 2026?**

We will continue to see a rise in cyber claims. The threat actors are increasingly sophisticated, and we will see them continue to progress use of AI to enable unauthorised access and to mine data that they have stolen and similar. Some of those will always be high profile, but I couldn't predict which industry will be the target - in the UK this year we have had Marks & Spencer, Co-op, Harrods and Jaguar Land Rover. Equally in Australia there has been the Qantas data breach and attacks on various superannuation funds. It often surprises me which firms don't yet have cyber insurance and, given the increased awareness, perhaps in 2026 we'll begin to see D&O claims resulting from that.

Geo-politics will continue to impact the claims landscape – not just on cyber claims, but generally. The Russian aviation litigation was a big theme of 2025. There's such inconsistency in regulatory approaches (particularly between the US and EU at the moment) and global economic competition and tariffs are putting major burdens on firms, both financially and on their compliance functions. I'd expect that may result in increasing insolvencies around the world and with active regulators too (particularly in respect of corporate culture and non-financial misconduct) I believe could lead to an uptick in D&O claims.

Losses from natural disaster events have been on the rise in recent years. Although 2025 was a relatively benign year for cat losses, insurers are still paying out from the LA wildfires and past events. With 2025 being relatively benign it may not be the same for 2026 and beyond.

We are seeing a large uptake in M&A claims, no doubt given the uptake in purchase of these policies by sellers (and buyers) but with claims showing the value of these products in deals.

Lastly, the emergence of AI has got the industry focused on the claims that may flow from this new technology – definitely something we are all watching.

### **Do you have a favourite provision of the *Insurance Contracts Act 1984 (Cth)*?**

Gosh now you're testing me. I can't go past Section 54 of the ICA also known as "The Insured's best friend" – so the broker's best friend too!

### **What is one excellent but under-rated thing for Australians to do when visiting London?**

I'm a big runner and I love Richmond Park to run (or cycle), and I often take my Aussie visitors there. It's a gorgeous woodland park on the outskirts of London full of herds of deer. Also, perhaps what prompted my eldest child to ask for a live deer as a present.



# Regulatory Update: Key risk and compliance developments

As we look ahead to 2026, there is a packed agenda for insurers, spanning operational resilience, cyber and climate risk, proportionality and reinsurance affordability. ASIC has confirmed that claims handling failures and misleading pricing practices remain core enforcement priorities, with several high-profile matters listed for hearing.

## PRUDENTIAL STANDARD CPS 230 NOW IN EFFECT

Prudential Standard CPS 230 Operational Risk Management came into effect on 1 July 2025. CPS 230 requires APRA regulated entities to be well-prepared to ensure continuity of critical services to the community and respond to business disruptions. CPS 230 replaced five key standards across banking, insurance and superannuation to create one comprehensive standard.

The key requirements of CPS 230 are that an APRA-regulated entity must:

- identify, assess and manage its operational risks, with effective internal controls, monitoring and remediation;
- be able to continue to deliver its critical operations within tolerance levels through severe disruptions, with a credible business continuity plan (BCP); and
- effectively manage the risks associated with service providers, with a comprehensive service provider management policy, formal agreements and robust monitoring.<sup>1</sup>

CPS 230 reflects the importance of operational resilience in recent years as the financial system has become more interconnected and more dependent on digital technologies and service providers.<sup>2</sup> APRA Executive Director of General Insurance and Banking, Jane Magill noted that:

*"The simple message is that you can delegate the task, but you cannot delegate your responsibility. You're the risk taker, which is why we license and regulate you, as a primary insurer, not your material service providers."<sup>3</sup>*

## CLAIMS HANDLING MISCONDUCT TO REMAIN A KEY PRIORITY

In 2025, claims handling misconduct remained at the forefront of ASIC enforcement actions. Significant infringement notices and penalties were enforced against insurers for claims handling failures.

As we move forward, ASIC has emphasised that in the current environment of premiums ever-increasing, claims rising and insurance becoming less affordable, claims and complaint handling failures will remain a key focus.

## REVIEW OF 2022 UNFAIR CONTRACT TERMS (UCT) REFORMS

The Treasury is undertaking a review of the 2022 UCT reforms. Based on the feedback received on the consultation questions, the UCT reforms review will examine the effectiveness of the UCT provisions and consider whether any amendments are required to improve their operation.<sup>4</sup>

## REGULATORY SIMPLIFICATION REPORT

On 3 September 2025, ASIC published a report from its Simplification Consultative Group (REP 813 – Regulatory Simplification).<sup>5</sup> The report explores ideas to simplify regulation and ease regulatory burden and identifies four key areas of focus:

- *Improving access to regulatory information* by testing industry-specific 'roadmaps' to help people navigate regulatory requirements, considering how to better structure its regulatory guidance and launching a new-look website.
- *Reducing complexity in regulatory instruments* by developing best-practice principles for drafting clearer, simpler regulatory documents and simplification of 23 legislative instruments.
- *Making it easier to interact with ASIC*, for example, by allowing email lodgements for a range of higher-volume, time-sensitive forms as an interim measure. ASIC is also progressing a longer-term program, RegistryConnect, to modernise registry-related technology and processes.
- *Simplification through law reform*, including by introducing changes to the reportable situations regime, addressing underlying complexity of the law and making substantial holding notice forms easier to navigate and use.<sup>6</sup>

The push towards simplification comes as the Insurance Council of Australia revealed in November 2025 that regulation is currently costing insurance customers between \$2.5 billion to \$3.5 billion a year, with more than 30,000 regulatory obligations enforced by 25 different authorities under 300 different regulatory instruments.<sup>7</sup>

## ENFORCEMENT 2025 WRAPPED

In 2025, ASIC and ACCC took enforcement actions against a number of insurers, including for:

- making false or misleading statements to policyholders regarding the extent of their insurance coverage;
- engaging in unconscionable conduct in relation to policyholders' entitlements to benefits;
- unreasonable delays in processing insurance benefits; and
- failures to deal with consumers fairly and in good faith (under the *Insurance Contracts Act 1984* and the *Corporations Act*).

## ASIC ENFORCEMENT PRIORITIES RELEVANT FOR INSURANCE

On 13 November 2025, ASIC Deputy Chair, Sarah Court, announced ASIC's 2026 enforcement priorities.<sup>8</sup>

The enforcement priorities most relevant to the insurance industry include:

- claims and complaint handling failures by insurers
- misleading pricing practices impacting cost of living for Australians

ASIC Commissioner, Alan Kirkland also emphasised ASIC's continuing focus on misleading practices and announced that ASIC will undertake a review to examine the accuracy of transparency of premiums:

*"...we are particularly concerned where insurers don't make it easy for their customers to even understand how much their premium has changed from year to year.*

*ASIC can't set insurance premiums, but we can hold insurers accountable for their pricing practices and the accuracy of their communications with their customers."<sup>9</sup>*

## APRA'S 2026 INSURANCE PRIORITIES

In August 2025, APRA released its 2025-2026 Corporate Plan. In its report, APRA identified that they are focused on "promoting the safety and stability of the system in a balanced and efficient way", and set out its insurance initiatives with respect to their four strategic objectives:<sup>10</sup>

### Maintaining financial and operational resilience

- **Recovery and exit planning** (CPS 190 and CPS 900): Monitor insurers' implementation of CPS 190 and partner with selected entities to develop and refine bespoke resolution plans.
- **Operational resilience** (CPS 230): Assess insurers' implementation of APRA's new operational resilience standard. In the second half of FY25/26, APRA will also consult on draft standards and guidance to update core governance requirements.

### Responding to significant and emerging risks

- **Geopolitical risk** (APRA and CRF have developed a dedicated geopolitical risk workplan). Identify gaps in preparedness and strengthen resilience across a range of scenarios.
- **Cyber resilience** – APRA will:
  - prioritise targeted supervisory engagements to assess entities' progress in uplifting cyber resilience.
  - work with regulatory peers to strengthen incident response protocols.
  - work with entities to develop a system-wide view of entities' reliance on third-party services.
  - undertake targeted supervisory engagements with a group of larger entities to understand better emerging practices and potential risks associated with AI.

- **Climate risk:** APRA will release results of its Climate Vulnerability Assessment in the second half of FY25/26. The results will provide governments, insurers, policyholders and the community with a clearer understanding of how general insurance affordability may evolve over the medium term in response to the physical and transitional risks associated with climate change.

### Getting the balance right

- **Introducing further proportionality:** APRA will consult with insurers to create a third tier in its proportionality framework. This moves away from the two-tier system that differentiates prudential requirements between significant financial institutions (SFIs) and non-SFIs and will allow APRA to introduce more nuance into its prudential requirements.
- **Promoting access to cost-effective reinsurance:** APRA is consulting with general insurers on ways to maintain access to affordable and appropriate reinsurance in the face of rising global costs.
- **Reducing capital requirements for annuities:** APRA is consulting on a proposal to reduce prudential capital requirements for life insurers offering annuity products.
- **Removing unnecessary or duplicative rules:** APRA is addressing overlaps between reporting obligations under APRA's fit and proper requirements and statutory obligations under the Financial Accountability Regime.
- **Strengthening data sharing with other agencies:** APRA will continue to explore opportunities to share data with other regulators to reduce duplicative requests.

### Improving Organisational Effectiveness

- **Finalising the transition to APRA Connect:** APRA plans to fully transition all data collections to APRA Connect by December 2027.

## APRA UPDATES PRUDENTIAL AND REPORTING STANDARDS

On 21 November 2025, APRA finalised minor updates to Prudential Standard GPS 410 for the Transfer and Amalgamation of Insurance Business for General Insurers.<sup>11</sup>

In particular, the requirement that physical scheme documents for transfers of business must be available for public inspection has been removed. Publication of the scheme documents can now be shown by having a copy of the documents accessible and prominently displayed on the insurer's website.

## APRA REFINES PROPOSAL TO FACILITATE EASIER ACCESS TO ALTERNATIVE REINSURANCE AGREEMENTS

On 22 October 2025, APRA released its response paper outlining refinements to its proposed updates to the general insurance reinsurance framework.<sup>12</sup> As APRA remains focused on futureproofing the prudential framework to ensure insurers' flexibility to access a broader range of reinsurance solutions, its revised proposals focus on removing reinstatement

requirements where typically unavailable, use of the net whole-of-portfolio approach for reinsurance that covers single perils and enabling the Appointed Actuary to determine capital treatment for certain non-complex arrangements without APRA approval.<sup>13</sup>

## INSURANCE CODE OF PRACTICE

In 2025, the Insurance Council of Australia and insurers started the process of developing a new General Insurance Code of Practice. The redrafted Code will be consumer-centred, modern, fit-for-purpose and contractually enforceable.

The industry will undertake further consultation throughout the development and drafting process with Insurance Council of Australia Consumer Advisory Council, regulators, government and other expert parties. Public consultation will take place in the first quarter of 2026 with the Code expected to be lodged with ASIC for approval in mid-2026.<sup>14</sup>

## MANDATORY CLIMATE-RELATED FINANCIAL REPORTING

On 1 January 2025, ASIC introduced mandatory sustainability reporting for large businesses and financial institutions, including insurers, requiring businesses to provide more information about their material financial risks and opportunities relating to climate change and their investors.

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# Life Insurance Update: Direct Life 2.0 – beyond the frictionless fallacy

## INTRODUCTION

The direct-to-consumer (D2C) life insurance sector has long been driven by a quest for simplicity, from one-click applications and blanket exclusions to binary definitions that strip away necessary nuance. This engineered simplicity ultimately shifts the burden of complexity from the point of sale to the time of claim, diminishing value and eroding trust.

A decade into sustained regulatory scrutiny, law reform, and negative publicity, the D2C market continues to navigate significant challenges, including tightened rules on sales and a lingering trust deficit from prior selling practices. Supply has contracted. Seven insurers have exited in the past eight years, and the remaining now collectively generate less than a third of the new business the market saw in 2018.<sup>15</sup>

The inflection point is not about speed; it is about fit. Winners in Direct Life 2.0 will be those who move beyond the frictionless fallacy to deliver solutions through an effortless front-end supported by sophisticated design and uncompromising control.

## DIGITALISATION – MORE THAN A CHANGE OF SHELF

One answer to engineered simplicity is to stop treating D2C products as inferior subsets of comprehensive ones. The industry's pivot to digitalisation — powered by data, automation, and AI — is enabling first-movers to bring retail-grade propositions to the direct shelf, but digitalisation is more than just a change in shelf space.

### Misleading and unfair conduct risks

Insurers face amplified misleading conduct risk when selling a life insurance product in a short, screen-constrained interaction. Robust content controls are essential to ensure the full suite of consumer collateral and the interface provides information that is accurate, relevant, consistent, and comprehensible.

It is also important that the user interface does not inadvertently distort or subvert consumer decisions, even if it stops short of being misleading. Risky patterns include urgency cues that are not genuine, important information revealed piecemeal on constrained screens before a decision, and cancellation pathways that are unreasonably onerous compared to the application.

In February, the Government released the draft unfair trading practices law after years of consultation, including a general prohibition targeting online 'dark patterns' that unreasonably manipulate consumers or unreasonably distort the environment of decision-making.<sup>16</sup> While the current proposal does not extend to financial services, ASIC has articulated a clear view of consumer harm that could result from these unfair trading practices in financial services,<sup>17</sup> and is able to use its current toolkit, including the general obligation of Australian financial services (AFS) licensees to act efficiently, honestly and fairly, against entities within its regulatory reach.

### Reasonable steps in digital conversion

Digitalisation reshapes the 'reasonable steps' analysis by replacing human interaction with algorithms and user interfaces. For a complex product in a largely self-directed process, insurers are expected to evidence a class-based funnel that channels distribution consistent with the target market.

In practice, this may involve introducing deliberate, antecedent frictions such as mandatory knock-out questions, real-time verification of key inputs, and prominent acknowledgement of core exclusions and risks before any distribution act.

However, wording and interface design should be tightly controlled to avoid suggesting that personal circumstances have been considered or that the policy is suitable, so that they fall within the statutory carveout that permits target market status questioning without giving personal advice. These reasonable steps should also be balanced against commercial objectives such as conversion and customer experience.

## Underwriting quality

Direct life insurers have invested heavily to streamline underwriting as a core capability for digitalisation. While working to reduce friction, insurers should consider the potential risks of simplification, particularly if it involves less granular questions and under-sophisticated decision making processes.

To reduce friction, digital application journeys tend to compress underwriting into fewer, less-detailed questions, including simple yes/no gates, catch-all questions or self-certification against broad pre-existing condition definitions. Applicants can reasonably interpret these questions differently from insurers if the framing lacks precision or proper explanation. This may constrain an insurer's access to misrepresentation remedies, as a 'wrong' answer may nonetheless be found to have been given with reasonable care if the question lacks clarity or specificity.

A lack of sophistication in underwriting questions can also degrade underwriting judgment, causing insurers to accept risks that should have been declined or re-rated. Repeated acceptance of risks not fully assessed creates challenges for premium stability and product sustainability, which in turn may call into question an insurer's risk governance and compliance with design and distribution obligations (DDO).

## DIFFERENTIATION — SHARPENING THE NICHE

Advances in technology and richer data are expanding the frontier of what life insurers can build, unlocking a clear path to differentiation. Rather than forcing a generic retail-like product through the D2C pipe, some insurers are pivoting towards bespoke solutions for niche markets that are underserved by group and retail products.

### Design for the unmet needs

Greater flexibility outside superannuation rules and less reliance on homogenising retail comparison grids are pulling incumbents, white-label brand managers and insurtechs into niche markets that find the traditional one-size-fits-all products misaligned with their needs. These include:

- the 'Silver Economy', who want dignity-preserving cover without paying for benefits they might not use;
- the 'Gig Economy', with part-time and casual workers who need bite-sized, low-cost cover;
- high-debt first-home buyers who want to have sums insured automatically adjusted during their highest-risk years; and
- Gen Z and Millennials, who favour on-demand, low-cost cover controllable in-app.

However, design freedom is not without its challenges, as innovation carries heightened legal and regulatory risks. In our experience, the areas below are frequent sources of friction that should be ironed out pre-launch.

- **Characterisation of products:** the definitions of financial products and insurance are open-ended and can capture quasi-insurance products. The delineation between different types of insurance is not always clear, particularly in an innovative setting. A take-for-granted approach may risk operating outside an AFS licence and APRA authorisation.
- **Enforceability and legal footing of terms:** whether the contract terms are sufficiently rigorous to give effect to the innovative features; whether the terms are fair through the unfair contract terms lens; and whether they can be disclosed with sufficient clarity to consumers.
- **Prudential sensitivities and product sustainability:** including where a product feature carries heightened anti-selection risk, fraud risk, or concentration risk.

### Meet consumers where they are

It is often said life insurance is a product sold, not bought, but selling is getting increasingly hard. The historic growth engine of outbound telemarketing was switched off by the hawking prohibitions in 2021, and the current distribution models may come under strain as regulators intensify scrutiny of insurance aggregators and the Government considers tightening rules on lead generation.

To stay ahead of these regulatory tides, innovative players are moving from mass-marketing to strategic distribution partnerships, placing insurance where people feel the need for it. This includes when they take on big financial commitments, undergo major life events, or start high-risk activities, onboard to a new job and receive their first pay, progress through career milestones, and contemplate health and lifestyle choices.

However, Australian law places stringent guardrails on embedded insurance. For insurers to unlock the potential of contextual distribution partnerships, careful consideration should be given to:

- the way life insurance information is made available to the consumers, and particularly, whether the provision is in the form of real-time interaction and whether the provision of information may constitute an offer, request or invitation to apply for insurance;
- the broader business processes of which the insurance information forms part, including whether the life insurance product could constitute add-on insurance if the consumer purchases it after they intend to obtain another product or service;
- the role of the distribution partner and the extent of their involvement in the sale process, including whether they have the proper authorisation to carry out the function; and
- the fee arrangement with the distribution partner and whether payment could constitute conflicted remuneration if structured in certain ways.

Despite these regulatory hurdles, the rules exist to ensure the long-term health of the insurance ecosystem, not to stifle innovation. Given the pragmatic, pro-modernisation posture signalled by both APRA and ASIC, where novel features elevate regulatory risk, early and proactive engagement with regulators — whether via an informal steer, the regulatory sandbox, or targeted relief — can help de-risk delivery, align expectations and avoid costly rework.

These discussions land best when there is a clear, evidence-based line of sight from a well-defined target market to each innovative feature, supported by consumer testing and a proportionate plan for monitoring, review and change management (including triggers, metrics and escalation where outcomes diverge from assumptions).

## GOVERNANCE — CLOSING THE GOVERNANCE GAPS

Success in digital transformation and product innovation relies heavily on robust internal systems to monitor execution, identify issues and support agile iterations.

However, the life insurance industry faces a unique set of challenges in mastering the operational basics, due to the structural weight of its long-tail product lifecycle and complex legacy books, and dated back-ends inherited from decades of consolidation. The difficulty is compounded by the lack of consumer engagement during the early years of a policy, which can leave errors undetected for years.

### Incident management and breach reporting

Life insurers report to ASIC a lower volume of reportable situations compared to other financial services industries and take a longer time to identify breaches.<sup>18</sup>

Delays and failures in breach reporting may attract civil penalties and indicate systemic failures of an AFS licensee's general obligations to act efficiently, honestly and fairly and to have adequate risk management systems.

ASIC's recent open letter to the direct life insurance industry sets the regulatory expectations for a data-driven internal governance framework that is built on:

- **metrics** including product performance and consumer outcomes (feedback, complaints and claims);
- **insights** derived from analysing data;
- **actions** to fix problems and improve outcomes; and
- **processes** for timely escalation, proper oversight and prompt remediation.<sup>19</sup>

In light of this, life insurers and distributors may wish to review their incident management systems, policies and procedures, including the business rules to assess significance and materiality, to ensure they remain fit for purpose.

### Third-party oversight

As direct life insurance relies on an intricate web of service providers, including brand managers, distributors, administrators, aggregators and distribution partners, it is critical for insurers to ensure that these third-party arrangements do not create gaps in governance.

The DDO requires product issuers to take reasonable steps that will, or are reasonably likely to, result in distribution being consistent with the TMD. Although the issuer is not obliged to ensure that no distribution occurs outside the target market, it must have effective arrangements to manage the risks identified in its distribution. These arrangements can be evidenced by:

- nuanced distribution conditions in the TMD to direct distribution towards the target market;
- robust due diligence in the selection of distributors; and
- adequate supervision and monitoring including regular information collection and performance assessment.

The risk based obligation could also extend to outcomes influenced by downstream participants engaged by distributors, over whom insurers may have limited visibility. ASIC's proceedings against Choosi Pty Ltd for false and misleading representations in life insurance comparison services send a clear message that distribution misconduct is within its regulatory radar.<sup>20</sup> Without strong third-party governance arrangements, including clear contractual rights for data access and performance audits, insurers remain exposed to governance risks from downstream subcontractors.

APRA's new CPS 230 has significantly lifted the standard of third party risk management, mandating board level oversight of service provider arrangements and imposing reporting, due diligence, contractual controls, monitoring and notification requirements. It also looks through to fourth parties used by material service providers to deliver critical operations.

## AI — DE-RISKING THE ACCELERATOR

AI is steadily reducing pain points in life insurance by streamlining processes and enhancing the customer experience, while also promising to accelerate growth through smarter risk assessment and faster decisions.

ASIC's recent open letter to the direct life insurance industry sent a clear warning: AI can quickly invert from a de-risker helping companies meet their compliance obligations to a risk itself if governance lags adoption. While pursuing AI-driven growth, insurers must stay across emerging AI-specific rules and best practice and vigorously assess their AI use cases through the lens of existing, technology-neutral obligations.

### Data Privacy

Data is the foundational asset in the age of AI, but holding valuable personal data does not give insurers an unrestricted right to use it.

Under the Australian Privacy Principles, personal information collected for one purpose should not be used for an unrelated secondary purpose without a proper legal basis and without managing customer expectations (typically via consent, or where a use is directly related and reasonably expected).<sup>21</sup> The standard differs depending on the sensitivity of the personal information being used or disclosed – sensitive information like health information or information such as government-identifiers (e.g. Medicare numbers) require a higher standard of consent and protection than other types of non-sensitive personal information. In practice, this means using historic datasets with AI models to support underwriting decisions, claims triage or fraud detection should be supported by a privacy impact assessment, if they contain personal information.

De-identification helps but is not a guaranteed safe harbour. As models and linkage techniques improve, there is an increased risk that individuals could be re-identified by combining anonymised insurance records with other datasets.

While capitalising on AI-enabled growth, insurers should adopt measures to manage privacy risk at the source. Effective steps include data segregation strategies that keep statutory policy/claims records separate from training datasets, time-boxed model-development sandboxes using synthetic or transformed data, and plain-language consumer notices about such training uses.

### ADM transparency and explainability

As automation in life insurance evolves and expands, insurers should assess whether their use of AI, including any third-party insurtech components, constitutes automated decision-making (ADM).

From 10 December 2026, privacy policies will need to disclose how personal information is used to make automated decisions that could be reasonably expected to affect an individual's rights or interests – for example, underwriting or claims decisions. This will require mapping the use of automated decision making through AI and other technology to identify how personal information is used and how relevant decisions are made using the automated processes.

An ADM is an outcome where a computer programme uses personal information to make or do a thing that is substantially and directly related to making a decision that could reasonably be expected to significantly affect the rights or interests of an individual. Whether a given use case constitutes ADM will turn on how determinative the model output is, how 'substantially and directly' it contributes to the outcome, and the degree of human review in the chain.

As AI use cases mature, insurers should ensure that they retain the ability to explain and audit automated decisions. Under the Life Insurance Code of Practice, insurers should provide an explanation for underwriting and claims decisions and share any personal information relied upon, if requested.<sup>22</sup> These obligations apply regardless of whether the decision is made by a human, a rules engine or an AI model.

### Algorithmic errors and bias

When an algorithm is flawed, AI transforms from a tool of efficiency into a source of systemic failure. Examples include pricing mistakes caused by an incorrect ordering of pricing algorithms<sup>23</sup> and flawed configuration of discounts<sup>24</sup> in general insurance, and misleading hotel room rates information as a result of flawed ranking logic.<sup>25</sup> For insurers, any such mistake could have significant implications for their compliance, conduct, and consumer protection obligations. ASIC has signalled increased scrutiny of misleading pricing conduct, underscoring the need for robust controls over digital and algorithmic pricing systems.

Without sufficient safeguards, algorithms can not only cascade errors but also produce unfair outcomes for vulnerable individuals or groups, particularly if AI use cases evolve from a rule-based assistive role to a decision-making agent. This may impact an insurer's ability to act efficiently, honestly, and fairly, and lead to contraventions of the insurer's obligation to act with utmost good faith towards the policy owner and any third-party beneficiary, anti-discrimination laws and Australia's international human rights obligations. Although an insurer's duty to act efficiently, honestly and fairly is not an obligation to achieve perfection, it does require compliance steps to be taken that are reasonable in the circumstances. Insurers should ensure AI models are not based on protected attributes unless justified by actuarial evidence and watch for proxy discrimination, where a non-prohibited attribute effectively substitutes for a protected one.

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# Warrantor and Indemnifier Insurance? Sell-side W&I insurance – an overview

Warranty and Indemnity (W&I) insurance is a familiar product to the readers of the *Insurance Pocketbook*, in particular, those who are active in the M&A, real estate and energy acquisitions space. It is a risk allocation tool that is now a cornerstone of large transactions in Australia, either as a 'buy-side' policy (a policy obtained by a buyer independently of the seller) or a 'sell-buy-flip' policy (a policy initiated by the seller and then 'flipped' to the buyer to take to the finish line). There is, however, a third type of W&I insurance which is more rarely used than the other two, and that is a pure 'sell-side' policy. This article aims to provide an overview of sell-side W&I insurance, its relevance, the underwriting process to obtain it and the implications for the insureds.

## WHAT IS A SELL-SIDE W&I POLICY?

Put simply, a sell-side W&I policy insures the seller. Like a typical W&I policy, it covers breaches of warranties given under a sale agreement; however, unlike a typical policy which insures the buyer for a breach of warranty, a sell-side W&I policy protects the *seller* in the event of *its own breach*. Put another way, whilst typical W&I policies cover loss on a primarily first-party basis where the buyer is covered for its own loss, a sell-side policy operates as a liability policy (like a professional indemnity insurance policy) and covers the seller for the loss it has caused to the buyer. In practice, the seller transfers the risk of exposure for its own warranty breaches to an insurer.

Unlike in a buy-side-policy-insured deal which includes a no- or limited-recourse regime, the sale agreement in a deal insured by a sell-side policy will allow for recourse to the seller and, indeed, usually does not even mention the W&I policy. Before a seller can access a sell-side W&I policy, the buyer would need to claim against the seller. The seller would then notify that claim to the W&I insurer. Again, as is the case with a liability policy, the seller would need to then provide information and assistance to the W&I insurer to investigate and respond to the claim, with the seller's loss under such claim and certain expenses to be paid out under the W&I policy.

## BENEFITS OF A SELL-SIDE POLICY

Some of the benefits of a sell-side W&I policy are set out below:

Benefit	Explanation
Preserves the purchase price	A buyer taking out a W&I insurance policy usually requests a full or partial contribution from the seller towards the costs of the policy, which chips at the purchase price. Furthermore, the purchase price of an insured deal is usually slightly lower than it would have otherwise been, as the deal bars the usual contractual claims available for warranty breaches. A sell-side W&I policy does not have the same issue (although the seller needs to separately pay for the sell-side policy).
Protects the seller where there is recourse	If the seller is exposed to potential liability arising out of its warranty breaches, for example, if a buyer insists on full or substantial recourse to the seller under the sale agreement, a sell-side W&I insurance policy can protect the seller against liability arising out of warranty claims, thereby providing the seller with some peace of mind. This is particularly important for sellers who wish to have a 'clean exit' from the sale, such as investors who wish to apply the sale proceeds to a new endeavour or exiting/retiring founder-shareholders.
Buyer would (ordinarily) not be aware of the existence of the insurance, disincentivising buy-side claims	For a potential claimant, the existence of an insurance policy is sometimes a key consideration for making a claim against the seller because it facilitates the claim, or at least increases the likelihood of recovery under the claim. A sell-side W&I policy should not act as an incentive because the buyer would normally not know that it has been taken out by the seller, and indeed there could be confidentiality provisions in the policy prohibiting the disclosure of the policy to the buyer (and other third parties).
Streamlines negotiations	Provided that the seller negotiates at arm's length (the 'pub test' to apply including, relevantly, 'as though the transaction was not insured'), the seller heeds the insurer's comments on the transaction documents and otherwise conducts adequate sell-side diligence, the assurance provided by insurance could make the seller more comfortable with the risk and liability regime requested by the buyer. For the seller, this could expedite the transaction, preserve the purchase price and make for an overall smoother transaction.

## REQUIRED MATERIALS

As with a buy-side or a sell-buy-flip W&I policy, the insurer will need access to information and materials supporting the underwriting process. However, for a sell-side policy underwriting process, the required materials are less extensive. Notably, whilst the W&I insurer will need access to the transaction documents (including the disclosure letter) and the data room, it will not require access to the buyer's due diligence, including the buyer's RFIs. We are aware based on our work with W&I insurance brokers in Australia including WTW and Bellrock that some insurers also do not require access to the seller's due diligence, although this could assist insurers if provided, and may still be required by other insurers.

The W&I insurer will instead undertake an RFI process with the sellers and target management and would expect the relevant key individuals to be available during this process.

Sellers should be cautious not to mistake this less extensive underwriting process with a compromised approach to underwriting. Insurers will have the same, if not a keener, focus on the underwriting process, given they will not have access to some of the materials outlined above. For example, the underwriting questions addressed to the insureds (in this case the sellers) are usually more detailed.

Inadequate due diligence and other slips therefore remain traps to avoid, as considered next.

## 5 TRAPS TO AVOID

### 1 Inadequate due diligence

The quality of seller due diligence can significantly impact the insurer's coverage appetite in a sell-side policy underwriting process. The data room and, if relevant, the seller's due diligence, should therefore be able to substantiate the warranties for which the seller is seeking coverage under the policy. The seller's responses to the underwriting questions should also reflect a deep understanding of the subject matter and the veracity of the warranties to support the coverage sought.

### 2 Forgetting about the sale agreement

The W&I policy and the sale agreement should always be considered together because the policy 'wraps' around the agreement and does not operate in a vacuum. This holds especially true for a sell-side W&I policy because, unlike a buy-side policy where some limitations on the seller's liability are disregarded as a matter of legal application or market practice, a sell-side policy will usually incorporate all limitations under the corresponding sale agreement. Therefore, sellers should not lose sight of the importance of contractually shielding or reducing their liability under the sale agreement. Any residual liability will expose the seller to proceedings, albeit that if covered under the policy, the W&I insurer will engage with the seller for the management and payment of the claim.

### 3 Forgetting about the exclusions under the policy

Sellers will remain liable for matters excluded under a sell-side W&I policy. Some of these are common to buy-side W&I policies, such as:

- consequential losses;
- losses arising out of forward-looking information;
- purchase price adjustments;
- certain liability matters for which insurance should exist at the target level (e.g., as applicable, cyber liability, product liability, professional indemnity liability and pollution liability);
- sanctions; and
- mandatory Lloyd's exclusions e.g. war and radioactive contamination.

There are two other exclusions which are significant in the context of a sell-side W&I policy. These are as follows:

Exclusion	Commentary
Issues within the sell-side deal team's actual knowledge	<p>As with a buy-side W&amp;I policy, a sell-side W&amp;I policy will not protect the insureds (in this case, the sellers) for breaches which they knew about.</p> <p>The practical impact of this exclusion will be more significant for a sell-side policy. Unlike a buy-side process where buyer deal team members elicit knowledge via a due diligence and Q&amp;A process, the knowledge of the sellers is captured without any such process (although the proof of it will be a question at the time of a claim).</p>
Seller's fraud	<p>Seller's fraud is not usually excluded in Australian buy-side W&amp;I insurance policies. However, it will be an exclusion in a sell-side policy, to the extent fraud has given rise or contributed to the claim. Whilst not surprising on public policy grounds, it is a noteworthy departure from a typical buy-side policy.</p>

#### 4 Losing confidentiality

As noted above, the existence of a sell-side W&I policy should be kept, and may be required to be kept, confidential. The seller and its advisors therefore ought to be careful not to disclose the fact of insurance negotiations and the possibility of the policy being taken out with the buyer, including in commercial discussions and drafting notes in the sale agreement. This could risk complicating recourse negotiations, cause the insurer to withdraw from the process, or limit payments under the policy, ultimately depriving the seller of the benefits it had been seeking in the first place.

#### 5 Inappropriate limit of liability

The limit of liability under a sell-side policy remains a key point of discussion between a seller and its W&I insurance broker. Because a sell-side policy operates as a liability policy, there may not be value in insuring the seller for more than the liability it has under the sale agreement. Conversely, the seller should discuss with its broker if it intends to deliberately insure for less than its liability to, for example, save costs. One way to achieve this may be to select a higher self-insured retention, rather than reducing the limit.

#### CONCLUSION

A sell-side W&I policy transfers the seller's warranty-breach risk to an insurer and responds akin to liability/professional indemnity cover, acting as a backstop to contractual liabilities rather than a substitute. Used well, it preserves price dynamics whilst providing comfort where recourse remains under the sale agreement. Whilst rarer, it is by no means irrelevant and could be just the right product in the right circumstances.

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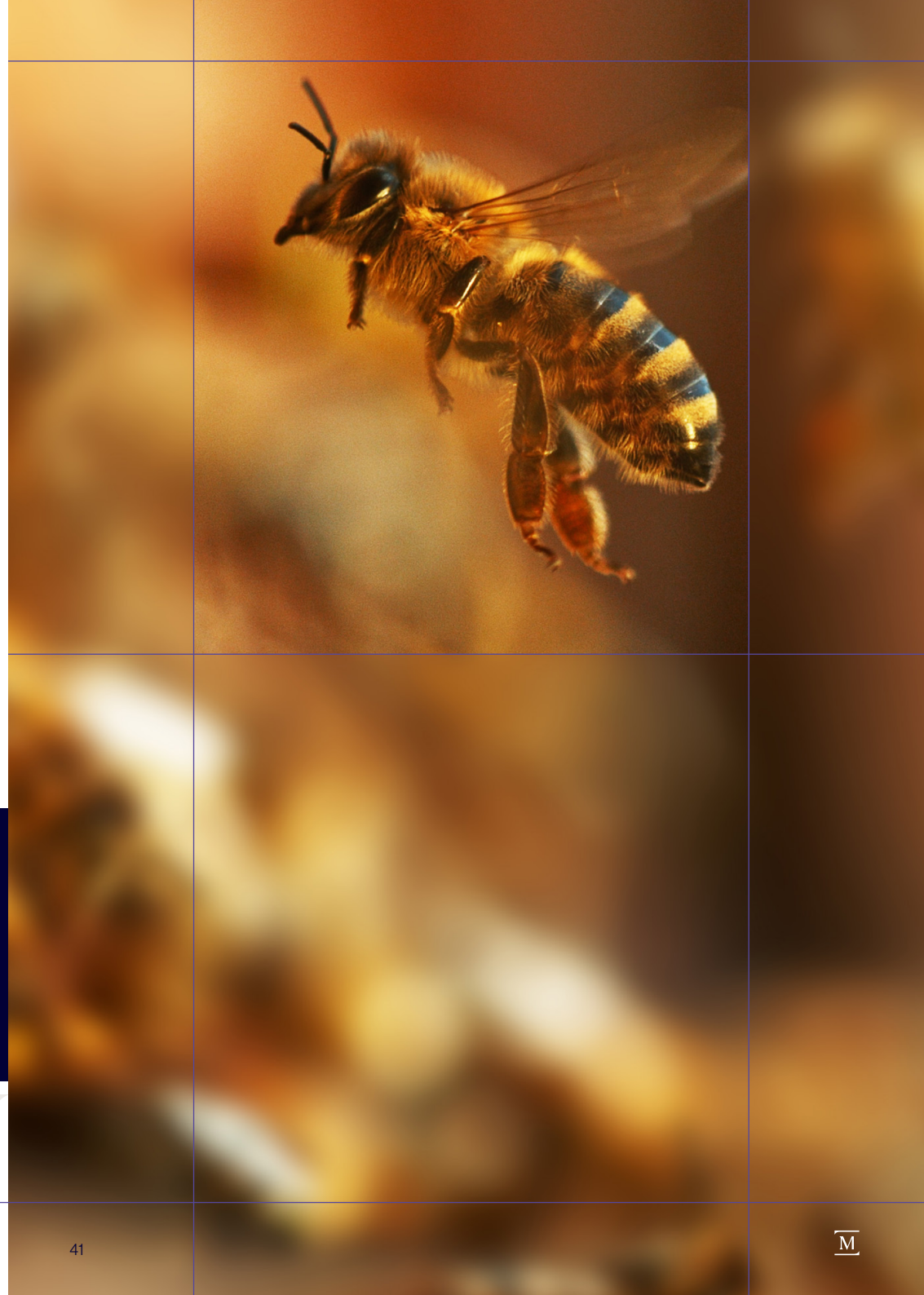
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# Section 54: From remedial reset to principled limits

This year marks 40 years of operation of the *Insurance Contracts Act 1984* (Cth) (ICA).<sup>26</sup> The ICA can trace its origins to a report of the Australian Law Reform Commission (ALRC) released in 1982.<sup>27</sup> When compared with other common law jurisdictions, Australia was somewhat of a trailblazer when it implemented a comprehensive legislative regime governing general insurance.<sup>28</sup>

Section 54 of the ICA (titled '*Insurer may not refuse to pay claims in certain circumstances*') was included in the ICA to address a 'mischief' whereby an insurer could rely on a provision in an insurance contract to wholly avoid liability even when there was no harm to the insurer, creating a disproportion in loss between the insurer and insured.<sup>29</sup> The intent was that s 54 would concentrate the focus on the real substance and effect of what had occurred, with the objective being to create a more equitable result between insurer and insured.<sup>30</sup>

Section 54 has been the subject of extensive judicial consideration and decisions.<sup>31</sup> While these decisions have clarified how the section operates, applying the provision can still prove difficult. Australian courts have ultimately taken a purposeful approach to interpretation, guided by the intent of s 54.



## INTENTION AND OBJECTIVE OF SECTION 54

It is useful to include a simple example to illustrate the mischief to which s 54 was directed.

A home insurance policy might include a provision:

- imposing an obligation on an insured to "not leave the dwelling uninhabited for more than 30 consecutive days in one year"; or
- providing exclusions from cover: "the cover does not apply if the dwelling has been uninhabited for more than 30 consecutive days in any year"; or
- limiting the insured risk through a term as follows: "the policy covers the dwelling if it has not been uninhabited for more than 30 consecutive days in any year".<sup>32</sup>

In each case, prior to the ICA, an insurer could (based on that drafting) refuse a claim if the insured failed to comply with any of the obligations, even if the breach did not cause the claimed loss. For example, the insurer could deny recovery for a theft if the insured had left the dwelling uninhabited for more than 30 consecutive days in a year even if the theft occurred while the house was habited.

The object of s 54 ICA was to protect insureds from the reliance by insurers on provisions that enabled them to deny cover on the basis of conduct of an insured that breached the insurance contract but in reality caused little or no prejudice to the insurer.<sup>33</sup>

Section 54 seeks to achieve this balance by:

- preventing an insurer from refusing to pay a particular claim only because an insured failed to comply with particular terms of the insurance policy<sup>34</sup>; and
- focusing attention on the extent to which the relevant act or omission of the insured actually prejudiced the insurer (if at all).

We accept there is a view that the protections provided by s 54 are disproportionately in favour of insureds.

## HOW HAS THE LAW IN RELATION TO SECTION 54 DEVELOPED

In this article, we look at three key decisions from the High Court of Australia that have refined the way section 54 is approached. There is a plethora of decisions on s 54 and this is a merely a small sample.

What is evident in each of these decisions is that the section applies flexibly depending on the underlying facts of each case.

### *Occurrence-based policies: Ferrcom (1993)*

*Ferrcom Pty Ltd v Commercial Union Assurance Co of Australia Ltd* (1993) 176 CLR 332 was the High Court's first opportunity to interpret s 54. It showed that the section could operate without too much difficulty in occurrence-based insurance policies which cover first-party loss.

In this case, the policy insured against damage to an unregistered mobile crane but required the insured (Ferrcom) to notify the insurer of any material change in facts or circumstances. The crane was later registered, meaning it could drive on public roads, but due to a failure of Ferrcom's broker, the insurer was never notified. The crane subsequently overturned and suffered damage. When Ferrcom claimed against the policy, the insurer refused liability based on Ferrcom's failure to notify of the registration. Ferrcom challenged that denial, relying on s 54.

The Court found that on the available evidence:

- the insurer would have, if notified, cancelled the policy in question and issued a separate and new policy, which would have included an endorsement excluding liability in the event of an overturning incident; and
- the prejudice to the insurer was the lost opportunity to cancel the policy and issue the new policy referred to above, in which case the insured would not have been insured for the overturning. The insurer's liability was reduced to nil.

This decision shows that s 54 can apply uncontroversially in occurrence-based policies. The process of determining "prejudice" (if any) to the insurer required comparing what actually occurred with the position that would have occurred if the insured had not engaged in the relevant act or omission.

*From form to substance: Highway Hauliers (2014)*

In *Maxwell v Highway Hauliers Pty Ltd* (2014) 252 CLR 590, the High Court confirmed that focus is not on the form of the insurance policy but the substance. In other words, the correct approach is to assess whether the policy, in effect, allows an insurer to refuse to pay a claim, not to look into exactly how the policy produced that effect.

Highway Hauliers operated a freight transport business. Two of its vehicles were damaged during a period of insurance but the insurer refused to pay the claim, arguing the drivers had not undertaken the relevant testing. The insured sought to rely on s 54 to overcome the 'testing' requirement, while the insurer argued the failure to achieve the necessary test scores was inherent within the claim.

The High Court disagreed with the insurer's argument and held that "*it is sufficient to engage s 54(1) that the effect of the Policy is that the Insurers may refuse to pay those claims by reason only of acts which occurred after the contract was entered into. Precisely how the Policy produced that effect is not to the point.*" Thus, s 54(1) applied to remedy the failure of the drivers to undertake the required testing, because that failure was not causative of the damage.

Reflecting on the decision, Robert McDougall (formerly a Judge of the Supreme Court of NSW) commented that Highway Hauliers "*explained clearly and concisely how s 54(1) should be interpreted and applied.*"<sup>35</sup> He said "*[i]t is now established that the question to be determined by the courts will be whether the effect of the policy is that the insurer may refuse to pay only by reason of the acts which occurred after the contract was entered into. This applies irrespective of how that effect is produced by the contract of insurance or the type of contractual term relied upon to deny liability to the claim.*"<sup>36</sup>

*Contribution between Insurers: Watkins v Pantaenius (2016)*

*Watkins Syndicate 0457 at Lloyd's v Pantaenius Australia Pty Ltd* (2016) 244 FCR 5 demonstrates that s 54 can be relevant as and between two insurers of an insured where contribution is sought between them.

Watkins, a yacht owner, held insurance under two policies of insurance with two different insurers:

- the first provided cover within 250 nautical miles of Australia's mainland but stipulated that all cover would be "automatically suspended" when the yacht cleared Australian Customs and Immigration and would recommence only when it cleared Australian Customs on return; and
- the second specifically provided cover for a yacht race from Fremantle to Bali.

Watkins' yacht ran aground on the return journey from Bali. He was within 250 nautical miles of Australia's mainland but had not yet cleared Australian Customs. There was no issue that the second policy responded, but the second insurer sought contribution from the first.

The Court determined that s 54 was relevant in determining liability between insurers (even when the insured was not involved in the dispute between those insurers). The Court concluded that but for the suspension of cover on leaving Australian waters and the omission of failing to clear Customs on return, the first policy would have responded. In other words, Watkins' failure to clear Customs was an "act or omission" of the insured that entitled the first insurer to deny cover, thus engaging s 54(1).

Therefore, the Court held that the operation of s 54(1) on the first policy was relevant in determining a question of contribution between the two insurers. The Court agreed with the primary judge that the second insurer could set up "putative liability" of the first insurer as a basis for a claim for contribution.

### WHAT HAVE THESE DECISIONS REVEALED ABOUT HOW SECTION 54 OPERATES?

Although only a sample, these decisions provide clarity on how s 54 operates. First, its application is highly dependent on the facts and circumstances of any given case, including the specific provisions of the insurance policy. For example, whether or not an act or omission on the part of an insured causes prejudice to an insurer will depend on the specifics of the policy involved and the context of the underlying claim made, including any temporal aspect of the cover. Second, it is important to understand the scope of the insured risk in an insurance policy. That is because s 54 operates only against provisions that exclude liability for claims within the scope of the policy but denied because of acts or omissions of the insured which affect the entitlement to cover. Section 54 does not change the nature of the cover or operate to alter the insured risk. Furthermore, it is the substantive effect, not the precise wording, of provisions in an insurance policy that determines whether s 54 is engaged.

# Monument: What goes up must come down

## From The South Sea Bubble To Insurance Regulation Down Under – A History Of Lloyd’s Of London And The Bubble Act Of 1720

If you have ever visited London and walked down Lombard Street, you may have noticed a supermarket at number 16. There is little to suggest that this unassuming address was once the birthplace of a global modern insurance market. Indeed, it is the former site of Lloyd’s Coffee House, a coffee shop established in 1691 which today gives its name to Lloyd’s of London,<sup>37</sup> a leading specialist insurance and reinsurance market generating over A\$110b in gross written premiums.<sup>38</sup>

The history of how that coffee shop became an eighteenth-Century mecca for British seafarers, shipowners and merchants and eventually emerged as the hub for European and global risk solutions, is a story of economic growth, venture and innovation on the one hand and sovereign debt, shonky investments and very strong feelings about the successor to the Spanish Throne on the other.

### **But first, coffee – emergence of Lloyd’s Coffee House**

After the Great Fire of London destroyed much of the city in September 1666 (a tragic event which laid the foundations of modern firefighting and the fire levy, discussed in our 2025 edition of this publication), coffee shops quickly became the new meeting houses to obtain shipping news and transact business.<sup>39</sup>

Edward Lloyd’s Coffee House on Tower Street (and later, at 16 Lombard Street)<sup>40</sup> would rent out tables where businessmen took the opportunity to sell insurance to shipowners.<sup>41</sup> Insurers would take on a portion of maritime risk in exchange for a premium by writing their names under the title of a ship on a specially prepared paper slip in the coffee shop. Hence, the term ‘under-writing’ emerged in the insurance context.<sup>42</sup>

Business at Lloyd’s Coffee House remained steady throughout the late-17th Century, but it was not until major developments emerged in the Atlantic slave trade that the humble café became brimming with trade.

### **A Death, a Debt and a Dream**

After the King of Spain died childless in 1700, Britain fought in a European war for over a decade to ensure that its candidate would win the Spanish Throne over the French-affiliated successor. In an ironic turn of events, war eventually gave way to peace talks after the British-preferred candidate actually became the Holy Roman Emperor and he was deemed too much a Caesar to hold Spain as well.

The War of Spanish Succession concluded in 1715 with a series of peace treaties. The War had two major consequences for Britain. First, Spain’s weakened position led to the 1713 Treaty of Utrecht, under which Spain granted Britain’s South Sea Company (the focus of this section) a monopoly over the supply of slaves to Spanish colonies.<sup>43</sup> Second, Britain had been left with significant debt.<sup>44</sup>

Britain had enormous public confidence in the Atlantic slave trade and planned to curtail its debt by trading through the South Sea Company,<sup>45</sup> a strategically formed public-private partnership founded by an Act of Parliament in 1711.<sup>46</sup>

The plan was straightforward: Britain’s creditors would surrender their debt to the newly formed South Sea Company which would, in return, issue shares of equivalent value to them. Initially, the government would make annual payments to the company of around £570,000 (over A\$150 million in today’s currency), which would generate an eye-watering 6% interest for redistribution to shareholders, jump-starting the share price.<sup>47</sup>

Unfortunately for Britain, not everything went according to plan. Despite the monopoly, the Spanish colonies imposed heavy taxes, restricted ship-mooring and took a large percentage of profits. The South Sea Company’s monopoly was generous in name but became miserly in practice, and the company struggled to yield its promised returns.<sup>48</sup>

Plans were made for the government to pump the South Sea Company with more funds. It purchased around £31m in national debt (over A\$10 billion today) at £7.5m,<sup>49</sup> and interest on the debt was to be kept low. In 1718, King George I himself also took governorship of the company, a royal seal that sent stocks soaring. The company’s stock price skyrocketed fivefold to £1050 in the first 6 months of 1720.<sup>50</sup>

Buoyant share sales drove the stock price even higher, but the company was hollow in substance, reportedly floating on corruption, political favour and baseless predictions. Government officials were offered speculatively priced shares and options; company insiders would bribe officials and then use tips from those officials about national debt consolidation dates. All this unfolded amidst extravagant claims about the company’s prospects.<sup>51</sup>

Without genuine trade, the South Sea Company found itself achieving little more than recycling its own paper against the debt it had acquired. In September of 1720, stocks plummeted, losing 80% of their peak value by December.<sup>52</sup> Investors lost thousands, there was a marked increase in suicides and widespread anger flooded London’s streets.<sup>53</sup> It had all come crashing down.

### **Enter the Bubble Act**

To avert future similar economic bubbles, Britain enacted the *Bubble Act* of 1720, which forbade the incorporation of any joint-stock companies without approval by Royal Charter or an act of Parliament being passed.<sup>54</sup> The Act specifically prohibited societies and partnerships from ‘assuring Ships or merchandise at sea or for lending money upon bottomry’ unless chartered, crippling the marine insurance industry.<sup>55</sup> This effective ban on new insurance companies led to more entrepreneurial, and at times less secure, means of insurance evolving. Eighteenth century England had no meaningful prudential controls on insurance.

### From Coffee House to Insurance Powerhouse

Amidst this regulatory chokehold, investors and insurers gravitated towards Lloyd's Coffee House—the trusted marketplace that had converged maritime news and capital into trade over the past three decades.

In addition to private insurers and underwriters, mutual associations had evolved by that point as a means of pooling resources to cover risk.<sup>56</sup>

Without incorporation, however, these ventures had no legal personhood and could not contract or bring claims in their own name. The workaround, ingeniously devised by lawyers at the time, was to appoint trustees to hold the assets and take legal action on the venture's behalf.<sup>57</sup> As to the question of who bore the debts, the lawyers borrowed the partnership concept from equity and operated largely under Deeds of Settlement.<sup>58</sup> The result was an arrangement that walked and talked like a company, and would be recognised by courts of equity.<sup>59</sup>

### Gone Overboard: Fate of the Bubble Act

Over the following century, only two companies received Royal Assent to offer marine insurance: the Royal Exchange Assurance Corporation and London Assurance Corporation.<sup>60</sup> The practical effect of the *Bubble Act*, which was largely protectionist in design and ambition,<sup>61</sup> was that marine insurance was left legally in the hands of those two chartered companies (who reportedly did not write significant amounts of marine business),<sup>62</sup> and otherwise to private underwriters and mutual associations, who often could not meet claims made against them due to bankruptcy and fraud.<sup>63</sup> Whereas, Frederick Martin reports that unsophisticated underwriters, on the other hand, reportedly secured over 90% of the marine market by 1819.<sup>64</sup>

The British Parliament eventually responded to this lack of capacity and competition by repealing the *Bubble Act* in 1825. This reform was opposed by, not surprisingly, the two chartered companies and Lloyd's.<sup>65</sup>

### From Monopoly to Market

The flood gates were thus opened for insurance companies to be freely formed and operate, unrestricted by *Bubble-Act* limits on capital raising. Incorporated insurance companies expanded into the marine market and maritime insurers began selling all manner of policies.

The 19th—20th Centuries were a period of insurance boom, formed in response to new types of risk and liability.<sup>66</sup> Lloyd's evolved from informal maritime risk-sharing over coffee into the world's leading specialist insurance market today, providing every insurance imaginable across every sector, including for monumental moments in human history, such as insuring the launch of the first commercial communications satellite, the Intelsat 1, into geosynchronous orbit in 1965.<sup>67</sup>

### From Paper Slips to Statutes: Insurance Regulation Down Under

Regulation of entities assuming financial risk on the public's behalf did not die with the *Bubble Act*'s repeal. Over 300 years of regulatory architecture travelled through the expansion of the British Empire down under. Indeed, the regulatory need that produced the *Bubble Act* can be seen in Australia's framework today.

At the centre of the Australian regulatory framework is the Australian Prudential Regulation Authority (APRA), which supervises financial soundness, resilience, and governance. APRA imposes strict capital rules, including a minimum \$5 million requirement for any new insurer, scaling up as deployed capacity increases, and sets resilience standards to withstand economic shocks and operational turbulence. These safeguards are designed to prevent the kind of hollow foundations that toppled the South Sea Company.

Complementing APRA, the Australian Securities and Investments Commission licenses financial services providers through the Australian financial services licensing regime and enforces conduct and disclosure obligations to curb unfounded claims that fuel speculative frenzies. Consumer protection is reinforced by the Australian Competition and Consumer Commission, which polices competition and consumer law, and the Australian Financial Complaints Authority, which provides external dispute resolution.

Three centuries on, the core obligations endure: remain transparent, solvent, and act in good faith—reflected in the *Corporations Act*'s duty to act efficiently, honestly and fairly, safeguarding the balance between venture and regulation.

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



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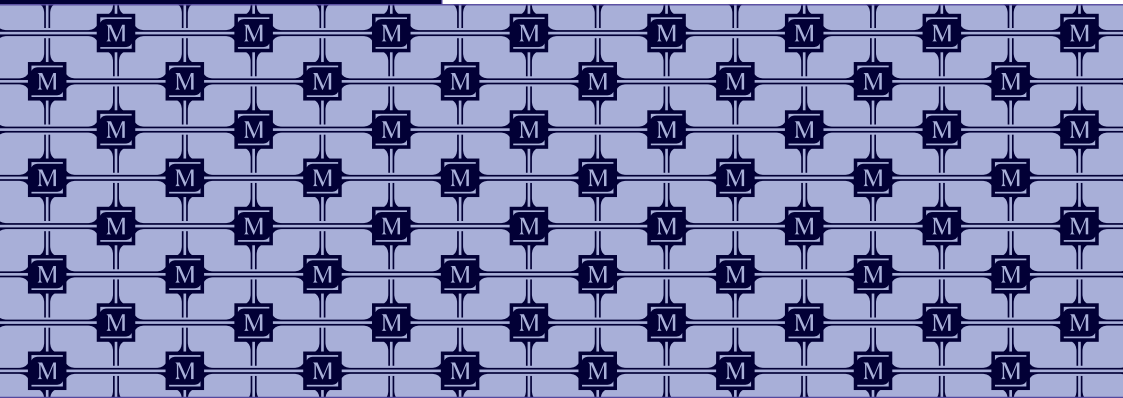
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