

# re:insurance

## The duty of disclosure - The French approach

As the proposed reforms to existing English insurance law relating to the duty of good faith envisage the adoption of a more continental approach, we examine the duty from a French perspective.

Prior to 31 December 1989, French insurance law approached the insured's duty of good faith in a manner familiar to the English market by requiring the insured to volunteer circumstances that might affect the insurer's assessment of the risk.

However, it was felt that assureds were often incapable of identifying the matters that should be disclosed and the law of 31 December 1989 amended the Code des Assurances (Insurance Code) by substituting for the general duty of disclosure the use of a questionnaire.

Article 113-2 of the French Code thus requires the assured to give precise answers to the questions put to him by the insurer, in particular by way of a questionnaire which the insurer supplies at the time of entering into the policy, relating to the circumstances that will enable the insurer to appreciate the nature of the risk.

Article 112-3 adds that if, prior to the entering into the policy, the insurer submits written questions to the assured, whether by means of a questionnaire or otherwise, the insurer cannot complain if he only receives a general response to an imprecise question. Therefore, the insured will not be blamed if the insurer has failed to submit a question relating to an important aspect of the risk. It is for insurers to submit questionnaires that are as complete and detailed as possible.

### Continuing duty and alteration of the risk

However the continuing duty of disclosure imposed on the assured under French law is not circumscribed by the use of a questionnaire. Article 113-3 of the French Insurance Code requires the assured to volunteer new circumstances which either increase the risk, create a new risk, or affect the correctness of the facts disclosed to the insurer at the time of entering into the policy. The insured must declare these changed circumstances to the insurer within fifteen days of his becoming aware of them. This provision does not apply to life assurance. It should be noted that the duty is actually a continuing one and does not merely arise on renewal or amendment of the policy.

The policy may provide that cover will be terminated if the insured fails to disclose the new circumstances within the time limit stipulated but, in order to rely on such a provision, the insurer must demonstrate that it has been prejudiced by the delay.

Article 113-4 states that where, during the policy period, the risk has increased so that had the new circumstances been notified to the insurer at the time of underwriting the policy or upon renewal, the insurer would have declined to offer cover or would have required a higher premium, the insurer has the right to terminate the policy or to propose a revised premium.

If the insurer adopts the first option, the insurer must reimburse the unused proportion of the premium. If the insurer chooses the second option but the assured does not accept the revised premium, the insurer can terminate the policy, having first given the assured notice of his intention to do so.

### Waiver

A concept familiar to both English and French jurisdictions is that of waiver or acquiescence. In France this is addressed by Article 113-4 which provides that an insurer cannot rely on an increase in the risk, of which he has become aware by whatever means, where he has impliedly agreed to continue the policy, in particular by accepting premiums or by paying a claim. Article 113-4 does not apply to life insurance nor to health insurance.

### Fraudulent or innocent misrepresentation - the effects

Article 113-8 states that an insurance policy will be void where there has been a deliberate misrepresentation by the insured which changes the subject matter of the risk and this applies even where the misrepresentation is irrelevant to a claim. In such a case, premia paid are retained by the insurer and the insurer remains entitled to all outstanding premia.

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## Welcome

Welcome to this inaugural edition of the Hill Dickinson insurance/reinsurance newsletter.

In this issue we explore a number of topics currently affecting the insurance/reinsurance market, from recent case law to new legislation.

Operating out of Hill Dickinson's London City office we offer a comprehensive insurance and reinsurance service to financial institutions.

We would invite readers to contact us with any queries on the issues discussed within the newsletter, suggestions for future article topics or with any specific questions on insurance/reinsurance matters.

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Again, the assured under a life policy is advantaged as the insurer's entitlement to the retention of premia where there has been deliberate misrepresentation does not apply to life insurance. There is also a further rule specifically applicable to life insurance under Article 132-26 of the Insurance Code which provides that a mistake relating to the age of the assured does not render the policy void. However, where the amount of the premium is incorrect by reference to the real age of the assured, the benefits under the policy must be adjusted accordingly.

Article 113-9 requires a misrepresentation on the part of the assured to be made in bad faith for the policy to be avoided. If a non-fraudulent misrepresentation is discovered prior to a claim having arisen, the insurer has the right to maintain the policy in force in consideration of the payment of an increased premium. If the assured refuses to pay an increased premium, the insurer may terminate the policy and refund that part of the premium attributable to the uninsured period.

Where the non-fraudulent misrepresentation is discovered after a claim has been made, the amount of the claim will be reduced by the same proportion that the premium actually paid bears to the premium payable but for the misrepresentation.

Although reported cases in France are much rarer than in England, as the law is codified, the following cases have provided additional clarification of the Insurance Code in practice:

In MACIF -v- Gee, 17 July 2001, the Cour de Cassation (the highest court in France) held that the termination of a policy by an insurer, based on Article 113-4 of the Insurance Code, with or without reservation of rights, does not prevent the insurer from also seeking a declaration that he is entitled to avoid the contract based on Article 113-8 (i.e. where there has been a deliberate misrepresentation). The court said that the right to terminate a contract (in English terms the right to treat the contract as repudiated) as to the future, is not incompatible with the right to avoid a contract retrospectively. The two remedies are complementary. The context of this decision was a motor accident. The policyholder had answered a questionnaire by stating that he would be the sole driver of a vehicle which he would use occasionally in a specified region of France. Following an accident, it was discovered that in reality the car was being used by his grandson on a

regular basis in the Paris region. The insurer first terminated the policy under 114-4 by reason of the increased risk and subsequently avoided the policy by reason of the fraudulent misrepresentations.

In D -v- Caisse Nationale de Prevoyance Assurances and Caisse Regionale de Credit Agricole Mutuel Pyrenees Gascogne, the Court of Appeal of Agen (decision 587 of 30 May 2002) considered mortgage protection policies. The court found that at the time of the initial loans, the borrower and policyholder had made false statements as to his state of health. Subsequently two new loan contracts were entered into and, on this occasion, the policyholder gave a true account of his state of health. The court held that the original misrepresentations were not cured by the true representations made subsequently in relation to different and separate contracts, even though the contracts were made with the same lenders and insurance companies. It is the duty of the assured to volunteer the facts, enabling the insurer to have a proper appreciation of the risk,

In decision number 99-87.330, the Court of Appeal of Dijon on 3 November 1999 held that the deliberate concealment of circumstances which increase the risk as provided by Article 113-2 of the Insurance Code attracts the avoidance of the policy, under Article 113-8. Once again, this case involved a motor policy where the assured deliberately failed to declare at the time of an amendment of the policy that his driving licence had been suspended as a result of a drink driving offence.

## Overcoming the questionnaire

It is clearly onerous for insurers to have to devise questionnaires for each type of cover and for every type of insured, at the same time attempting to formulate questions as comprehensively and in as detailed a manner as possible so as not to fall foul of Article 112-3.

In order to bypass these difficulties, insurers in France have successfully adopted a number of strategies:

- The use of standard form declarations/representations drafted by the insurer and which the insured is invited to sign. For example, in relation to property covers, these will typically address: the incidence of previous claims; construction materials; security measures required; the nature of goods stored on premises and the nature of business activities in the locality of

the insured premises. Such standard form declarations have usually been upheld by the French courts.

- Alternatively, insurers have chosen to include in the policy wording a clause incorporating by reference a standard set of declarations and representations.
- In place of a questionnaire or standard declarations, a further alternative approach is to address the definition of the 'insured'; the cover is made conditional upon the 'insured' complying with a set of specified criteria.

These approaches appear to be similar to warranties under English law.

### Insured's duty of good faith when making claims

Where the policy so provides, the insured will lose his right to an indemnity for breach of his duty of good faith in the context of submitting a claim or for failure to comply with obligations arising from a loss, which may include taking protective or salvage measures following a loss; failing to arrange a formal inspection in order to certify a loss which has occurred in the course of the carriage of goods; failure to comply with time limits for notification of a loss; prejudicing insurer's rights of subrogation or in the case of a personal injury, failing to submit to a medical examination.

Article 112-4 of the Insurance Code requires that the loss of indemnity must be clearly and visibly specified in the policy.

Article 113-11 makes it unlawful for policy wordings to deny an indemnity by reason of the insured's failure to comply with laws or regulations (provided that such breaches do not constitute crimes or an intentional tort).

Normally, a policy will exclude a claim by reason of delay on the part of the insured in declaring the loss to the authorities or in the production of information, without prejudice to the insurer's right to claim the loss and damage suffered by the insurer consequent upon the insured's delay.

Whereas prior to 1 May 1990 there was an automatic loss of indemnity for a delay in notifying a loss, since 1 May 1990, the insurer must demonstrate prejudice attributable to the delay. (Article 113-2 as amended by the law of 31 December 1989).

It should be noted that where the insurer is entitled to deny a claim for any of the reasons set out above, the policy remains in force.

Article R124-1 provides that in the case of professional indemnity cover, the insurer may not refuse a claim attributable to failures on the part of the insured arising after the loss as against the third party victims or beneficiaries of the cover. The same applies in relation to employer's liability cover for accidents at work. The law considers that the third party claimant's rights crystallise at the moment of the loss.

Secured creditors of goods are also entitled to maintain a direct action against the insurer and are unaffected by any post-loss failures on the part of the insured.

### The duty of good faith works both ways

Although a duty of good faith is imposed upon the insurer under English insurance law, French insurance law goes further:

- At the moment of underwriting the contract, the insurer has a duty to inform and advise the insured as to the suitability of the cover and the wording of the policy : (Cass. Civ. I, 19/01/1988, RGAT 1988, p.479, note J.Bigot),
- When a claim has been made, the insurer must not use delaying tactics, including in particular, delay shortly before a limitation period is due to expire. (Cass. Civ. I, 6/12/1994; RGAT 1995 1995, p.57 note J.Kullman).
- It has been held that the insurer had a duty to draw the insured's attention to the necessity of taking out comprehensive insurance in circumstances where the policy wording contained an exclusion clause which constituted a trap for the unwary insured. : (Cass. Civ. I, 6/01/1994, RGAT 1994 1986, note L.Mayaux).
- The courts have tended to sanction insurers for resisting claims at the point in time when they have been provided with all necessary information to enable them to effect a settlement.

### The Principles of European Insurance Contract law

The Principles of European Insurance Contract Law (PEICL) aim to establish a voluntary insurance contract law regime across the EU including the UK. The provisions include the information to be provided pre-contract (2.201) and in the contract (2.501).

Under article 2.101, the proposed assured must inform the insurer of circumstances of which he is or ought to be aware and which are the subject of clear and precise questions. Perhaps unsurprisingly, this approach is therefore consistent both with current French law and the reforms proposed by the Law Commissions (as to which see below).

Where the insured has breached his duty of disclosure but a claim under the policy has not yet arisen, under the PEICL, the insurer can either propose a reasonable variation that will allow the policy to continue or terminate it (2.102). If the breach is innocent, however, the insurer can only terminate the contract if it can show it would not have concluded the contract at all had it been aware of the information.

In the case of non-disclosure becoming apparent where an insured event has occurred, if the breach is innocent, the claim is unaffected.

The insurer will only be able to rely on a negligent non-disclosure or misrepresentation if there is a causal connection between the loss and the breach (2.102(5)). In that event, the insurer's remedies under the PEICL depend on what the insurer would have done had no breach occurred. If the insurer would not have concluded the contract at all, the claim can be rejected. If the insurer would have charged a higher premium or imposed different terms, the claim will be reduced accordingly.

The insurer will have no remedy in respect of a question which was left unanswered; if information was "obviously incomplete or incorrect"; if the information was not material; if the insurer led the applicant to believe it was not required or in respect of information of which the insurer was or should have been aware. (2.103).

Only in the case of fraud will the insurer be entitled to avoid the policy altogether and retain the premium (2.104). The insurer will be under a duty to warn the prospective assured of any inconsistencies between the cover offered and the applicant's requirements. (2.202). Failure to do so would expose the insurer to liability for losses arising from the breach and the insured would have the right to terminate the contract. Again this is similar to current French law.

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## The English Law Commission and Scottish Law Commission joint review of insurance contract law - Pre-Contract Disclosure and misrepresentation in the context of consumer insurance law

On 15 December 2009, the two Commissions published a report and draft Bill. They recommend abolishing the existing duty of disclosure and instead requiring insurers to ask questions about what they want to know. The draft Bill applies only to insurance purchased by individuals for purposes wholly or mainly unrelated to their trade, business or profession. The draft Bill abolishes the duty to volunteer material facts. Instead, consumers are required to take reasonable care not to make a misrepresentation.

Where an insurer has been induced by a misrepresentation to enter into an insurance contract, the insurer's remedy will depend on the consumer's state of mind:

- Where a misrepresentation is honest and reasonable, the insurer must pay the claim. The applicant is expected to exercise the standard of care of a reasonable consumer, bearing in mind a range of factors, such as the type of policy and the clarity of the question. The test does not take into account the individual's own subjective circumstances (such as knowledge of English), unless these were, or ought to have been, known by the insurer.
- Where a misrepresentation is careless, the insurer has a compensatory remedy. This is based on what the insurer would have done had the consumer taken care to answer the question accurately and completely. For example, if the insurer would have added an exclusion, the insurer need not pay claims which fall within the exclusion but must pay all other claims. If the insurer would have charged more, it must pay a proportion of the claim.
- Where the misrepresentation is deliberate or reckless, the insurer may avoid the policy. The insurer would also remain entitled to retain the premium, unless there was a good reason why the premium should be returned.

For a misrepresentation to be considered "deliberate or reckless" the insurer must show on the balance of probabilities that the consumer: (a) knew that the statement was untrue or misleading, or did not care whether it was or not; and (b) knew that the matter was relevant to the insurer, or did not care whether it was or not.

However, if a reasonable person would have known that the statement was untrue, the burden of proof would be on the consumer to show that he or she had less than normal knowledge. Similarly, if the question was clear, it would be up to the consumer to show why he or she did not think the matter was relevant.

### A period of change

We have focused in this article on certain important differences between French and English insurance law regarding disclosure and misrepresentation. The changes proposed by the Law Commission and/or by the PEICL will, if adopted in the UK, constitute a significant departure from traditional English insurance law principles relating to these areas. Both sets of proposals lean towards the existing law and practice in France which makes the French experience of 20 years standing of particular interest to UK insurers. We will be continuing to monitor that experience and to report on further developments as these take place at EU and national levels.

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## Basel II - time for a rethink?

Prior to the arrival of the credit crunch there was a significant amount of activity in the insurance and reinsurance market aimed at addressing the mitigative impact of insurance on the capital banks were required to set aside for the purpose of operational risk (oprisk). Imaginative solutions were produced by insurers to address the imperatives of the Basel II Framework requirements which would, in effect, transfer oprisk from the banks' balance sheets to that of the insurers. However, the global meltdown in the financial sector understandably diverted banks' and insurers' attention to more pressing needs and it is only recently that the institutions have revisited the issue of integrating insurance coverages with their oprisk to see whether insurances can replace oprisk capital.

By way of a reminder, the Basel II Framework provides that a bank which adopts the Advance Measurement Approach (AMA) in terms of calculating its oprisk capital requirements (and there are only 35 - 40 banks which currently have achieved the AMA standard) for regulatory minimum capital requirements can use insurance to offset part of its oprisk capital requirements. The recognition of insurance mitigation is limited to 20% of the total oprisk capital charge (which amounts to between 12 - 15% of the bank's capital; thus, the actual reduction is between 2.4-3% of the entire oprisk capital charge i.e. banks cannot claim 100% capital relief). The reason for the restriction on relief is due to the perceived 'uncertainties' surrounding insurance products, e.g. the uncertainty of payment (such as policy defences and whether a claim falls within indemnification provisions) and the timing of payment.

In utilising such policies there are a number of basic requirements:

- The insurer must have a minimum claims paying ability rating of A (or equivalent) (this has generated some uncertainty as what determines payment are policy responses; paying ability risk (more akin the credit risk) is a separate issue). >>>



- The insurance policy must have a minimum term of at least one year. This is because it is perceived that an insurance policy of 12 months duration begins to 'degrade' after inception (whilst erosion of limits and reinstatements may be an issue, it is hard to see how an unimpaired insurance policy can 'degrade' over the period). Insurers have approached this requirement in a number of ways, for example, issuing a two year policy which is cancelled on the expiry of the first year or issuing a policy with a form of discovery extension period.
- The insurance policy has a minimum notice period for cancellation (by either party) of 90 days.
- The insurance policy has no exclusions or limitations which are triggered by supervisory actions.

After the expression of initial consternation, many of these requirements were addressed in such a fashion that they were acceptable to all the parties, including reinsurers.

In addition to addressing the above framework requirements, the parties had to turn to mapping in risk scenarios into insurance coverages. The framework has identified seven event type categories:

- Internal acts – insider trading, theft, computer crime
- Employment practices and workplace safety – accident coverage for employees, workers' compensation, harassment
- Clients, products and business practices – breach of contract, negligence, E&O, D&O, product defects
- Execution, delivery and management process – miscommunication, negligent loss or damage to client assets
- It and utilities – hardware/software breakdown, computer viruses
- Damage or loss to assets – national disasters, human threats, war and expropriation
- External acts – robbery, computer crime

Many of these events will be familiar to Finance Institutions (FI) underwriters and are likely to be covered under standard market wordings (although some events are habitually excluded, e.g. breach of contract or covered at a price/unauthorised trading). The framework identified other risk activities which impact oprisk which, to date,

may not be addressed by established coverages, for example lender liability, aggressive sales, organised labour activities, money laundering and acts of God. Overlying these events categories are the business lines (in perceived order of risk) from corporate finance (highest – and where cover is unlikely to be extended (at least on broader terms given the worldwide investment banking losses)) to retail brokerage (lowest).

A multitude of solutions were proposed to these multi layered risks/activities ranging from the complete rewriting of the underlying policies which map directly into the framework events (and cover the totality of risks save for those which are deemed to be uninsurable or insurance is precluded by public policy considerations) or providing additional coverage extensions, for example, the costs of the mitigation of losses, to the provision of endorsements which overlap established covers, e.g. Bankers Blanket Bond, Computer Crime, Civil Liability/Professional Indemnity, EPL, D&O, Property and BI. Nevertheless, it should be noted that where the banks' oprisk capital requirements are in effect transferred to insurers (by a policy of insurance) the corollary is that it is insurers' capital which is then exposed.

It is fair to say that the emphasis (at present) is now on not what insurers need to deliver in terms of coverage (albeit certain covers will have to be 'tweaked' to map in to the underlying risk scenarios recognised within the framework (insofar as they can be)), but on the methodologies employed by the banks both from a quantitative and qualitative aspect (and such information needs to be collated at insurers' attachment points and below them too i.e. on the bank's retained losses). Thus, the production of the portfolio of policies to the bank's regulator will not be sufficient to obtain the sought after oprisk capital 'haircut' (and it is highly unlikely that, at present, any bank would achieve the full 20% haircut in any event). It is likely that the relevant supervising authority will closely examine the methodologies employed by the banks in determining whether such policies may be utilised in reducing oprisk capital requirements, the nature of the coverages proffered and the strength of the insurers involved in providing such cover, given that it is their balance sheet carrying the bank's oprisk. It is also incumbent on the insurers to understand (and address) the asymmetry of information between banks and insurers.

It is at this juncture that it is also fair to say that while the responsiveness of traditional coverages can deliver certainty to banks, untested new coverages which over-lie traditional coverages or replace such coverages remain untested (both from the perspective of the banks and the insurers/reinsurers). Certainly some new coverages have thrown up completely unexpected results which in the usual scheme of matters would not have resulted in positive policy responses and which can only, in the author's view, lead to delay and uncertainty in settling claims. There still remain issues as to the payment of premiums on renewal, the effect of which may be to preclude an insured bank from failing to renew cover (and the punitive nature of such payments may have a capital impact). Further, the economics of renewing policies, particularly where there are significant premium hikes is something which the regulators and, no doubt the purchasing bank, will scrutinise.

Whilst policies will be integrated into a bank's risk management programme, nevertheless a bank may choose to self-insure (i.e. manage its own risks) (after all the framework does not require insurance to be obtained). Thus, a mixed basket of managed risks and insurances can be presented to regulators and the cost effectiveness of the solutions can be considered. For example, a bank may choose to insure certain risks or to insure certain risks within the upper layers of its insurance programme.

## Conclusion

It is probably too early to say whether the methodologies employed by banks will be sufficient to assuage the concerns of regulators which in turn permits the transfer of the risks to insurers' balance sheets (although operational losses are increasing in frequency and quantum). However it would be fair to say that the insurance community have produced products to address the basic coverage issues and the next phase is for the banks to gather the necessary loss experiences together with policy responses in order to give the necessary comfort to their regulators. It is likely, given the multitude of triggers (first and third party policies) which exist and the accumulation of such information, that this process will take some time to work through the system in order that considered responses may be given to the regulatory authorities.

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## Third Parties (Rights Against Insurers) Act 2010

### Introduction

The Third Parties (Rights Against Insurers) Act 1930 provides an injured party with access to the insurance policy of the insolvent liable party, provided certain conditions are met. If access is provided a statutory transfer of the insured's rights against the insurer is made to the third party and, as a result, the insurance proceeds do not become part of the insolvent estate available to all the insured's creditors.

However, the conditions which insureds had to comply with under the 1930 Act were considered to disproportionately favour insurers, such that third parties faced considerable difficulties in order to successfully access insurance proceeds. In addition, since the 1930 Act came into force, changes were made to insolvency law, which meant that the 1930 Act was no longer up-to-date and, in particular, it did not cover some of the new methods by which companies can be dissolved.

Therefore, in 1998, the Law Commission of England and Wales commenced a review of the 1930 Act and concluded that changes had to be made to the legislation. It, therefore, drafted proposals for reforming the 1930 Act, which have largely been reproduced in the new act.

The Third Parties (Rights Against Insurers) Act 2010 is designed to make it simpler, faster and less costly for third parties to recover compensation from the insurers of insolvent companies. The 2010 Act received royal assent on 25 March 2010 and is expected to come into force in April 2011. However, the 1930 Act will continue to apply in cases where both the insured's insolvency and the liability to the third party occurred before the commencement date of the 2010 Act.

### Transfer of rights under the 2010 Act

As soon as the insured becomes a "relevant person" under the 2010 Act, the insured's rights are transferred to the third party. However, the third party cannot enforce the rights until the insured's liability is established. The insured becomes a "relevant person" when one of the specified insolvency

procedures takes place as listed at sections 4 to 7 of the 2010 Act; the list of procedures is in line with current insolvency practice and the definition of insolvency has been widened to include companies subject to a Company Voluntary Arrangement or a Scheme of Arrangement. Consequently, the statutory transfer of rights to the third party is now quicker than under the 1930 Act.

Previously, the rights were only transferred if the third party had first: (i) established the insured was liable by obtaining a judgment in its favour; (ii) taken steps to restore the dissolved insured company to the Companies House register; and (iii) given notice to the insurer in accordance with the terms of the relevant policy.

### Discovery quicker and easier

As soon as the insured becomes a "relevant person", the third party can seek information as to the existence of any insurance policy and the request for information can be made not just to the insured but to any person who might be able to provide the information (e.g. brokers, insurance companies). Section 1(3) of schedule 1 of the 2010 Act sets out the information which the third party can request and if there is a contract of insurance covering the alleged liability, or might reasonably be regarded as covering it, the third party can ask:

- who the insurer is;
- what the terms of the contract are;
- whether the insured has been informed that the insurer has claimed not to be liable under the contract in respect of the supposed liability;
- whether there are or have been any proceedings between the insurer and the insured in respect of the supposed liability and, if so, relevant details of those proceedings;
- in a case where the contract sets a limit on the fund available to meet claims in respect of the supposed liability and other liabilities, how much of it (if any) has been paid out in respect of other liabilities; and
- whether there is a fixed charge to which any sums paid out under the contract in respect of the supposed liability would be subject.

Under the 1930 Act the third party had to establish that the insured was liable before it could request any insurance information. Consequently, the 2010 Act makes it easier for a third

party to find out about the existence of any insurance policy, in advance of bringing any proceedings against the insured and/or its insurer. This also allows the third party to consider whether it is feasible and worthwhile bringing any proceedings, before it incurs any substantial time and costs in doing so.

A person who receives a request for information from a third party must respond within 28 days from the date of receipt of the notice (in accordance with section 2(1) of Schedule 1 of the 2010 Act). If the information cannot be provided then the person must state why and give details of any other person who might be able to supply it. Failure to comply allows the third party to apply to court for an order compelling compliance (in accordance with section 2(3) of Schedule 1 of the 2010 Act). Previously, under the 1930 Act, there was no time limit in which a request must be complied with and it was not clear what material the third party had a right to request.

### Proceedings streamlined

The 2010 Act provides that once the insured becomes a "relevant person" the third party can litigate its substantive cause of action against the insured, in conjunction with an action for a declaration/order that the insurer pay any damages awarded.

Therefore, the 2010 Act allows the third party to establish the liability of the insured and sue the insurer in the same proceedings, instead of having to bring two sets of proceedings as previously under the 1930 Act (in accordance with sections 2(2) and 2(10) of the 2010 Act).

Further, the third party no longer has to first restore the insolvent insured to the register of companies at Companies House, before it can bring proceedings against the insured. Under the 1930 Act this requirement often acted as

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a deterrent to the third party bringing proceedings, as it could take up to three months and cost in the region of £1,500.

Now the third party has a choice, it can either use the new procedure and bring one set of proceedings against the insured and insurer or, as previously under the 1930 Act, it can solely sue the insurer (it is not obliged to join the insured to the proceedings) but in order to enforce its rights against the insurer it must then establish that the insured is liable.

### Insurers' technical defences limited

Insurers may rely on any defence on which they could rely if the proceedings had been brought by the insured, in order to prevent the third party from being in a better position against the insurer than the insured would have been. In short, the statutory transfer of rights means that the third party's claim can only be as good as the insured's claim would have been against the insurer. Consequently, the third party has no right to recover from an insurer any amounts in excess of the insured's liability

However, under the 2010 Act, insurers can no longer rely on certain technical defences to avoid paying third parties. For example, under the 1930 Act insurers could rely on late notice even where the insured no longer existed and the claim had been notified by the third party. In addition, the failure of an insured to provide continuing information and assistance to the insurer will not defeat a third party claim if the insured was incapable, due to its insolvency, of providing such assistance.

### Provision for international claims

The 1930 Act did not include any provisions for claims involving a cross-border element, whereas section 18 of the 2010 specifically addresses this issue and provides that as long as the insured is a "relevant person" under section 1 of the 2010 Act, then the insured's rights are transferred to the third party regardless of where the liability of the insured to the third party was incurred or whether it was incurred under the laws of England and Wales.

Further, the 2010 Act will apply irrespective of (i) the place of residence or domicile of the parties; (ii) the governing law of the insurance policy; or (iii) the place where sums due under the insurance policy are payable. Consequently, the scope of insurers' liability is potentially much wider under the 2010 Act than under the 1930 Act.

### Other issues

Under section 10 of the 2010 Act, the insurers' right remains, as under the 1930 Act, to set off any sums owed to it by the insured (eg. the excess or unpaid premium) from any sums payable to the third party.

The 2010 Act does not apply to cases where the liability of the "relevant person" is covered by reinsurance, therefore the third party has no right to access reinsurance proceeds.

In accordance with section 17 of the 2010 Act, prohibition on contracting out of the act remains, as found in the 1930 Act.

### Conclusion

As a result of the 2010 Act it is now: (i) quicker and easier for third parties to discover the particulars of any available liability insurance; (ii) permitted for third parties to sue the insured and its insurers in a single set of proceedings; (iii) prohibited for insurers to rely on technical defences to deny liability to third parties; and (iv) possible for international claims to fall within the scope of the act. Consequently, insurers are likely to be faced with an increased amount of claims from third parties, in cases where the insured has become insolvent (i.e. the insured has become a "relevant person" under the 2010 Act).

However, the increased access to information earlier should mean that third parties give serious consideration to whether the insured is liable, before they commence proceedings.

Insurers' risks are also potentially greater as third parties can bring proceedings against them without first proving the insured's liability. Therefore, insurers may be faced with defending claims where it is later discovered that the insured is not liable.

However, as insurers are more likely to become parties to the proceedings brought by third parties, they can now ensure that proper defences are made to the claim that the insured is liable to the third party, whereas previously, due to the requirement to bring two sets of proceedings under the 1930 Act, they did not have control of the defence of the claim, which the third party brought against the insured and as such these claims were often poorly defended by the insolvent entity.

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## About Hill Dickinson

The Hill Dickinson Group offers a comprehensive range of legal services from offices in Liverpool, Manchester, London, Chester, Sheffield, Piraeus and Singapore. Collectively the firms have more than 1,300 people, including 190 partners.

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