



LAW REFORM
COMMISSION/COIMISIÚN UM
ATHCHÓIRIÚ AN DLÍ

REPORT

CONSUMER INSURANCE CONTRACTS

[LRC 113 - 2015]



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Law Reform Commission

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Part-time Commissioner:

Donncha O'Connell, Professor of Law

Part-time Commissioner:

Ms Justice Marie Baker, judge of the High Court

Part-time Commissioner:

Tom O'Malley, Barrister-at-Law

LAW REFORM RESEARCH STAFF

Director of Research:

Raymond Byrne BCL, LLM (NUI), Barrister-at-Law

Legal Researchers:

Owen Garvey BA, LLB (NUI), Barrister-at-Law

Kerri McGuigan LLB (Dub), LLM (UCL), Attorney-at-Law (New York)

Michael O'Sullivan BCL (NUI), Dip IT (DCU), Solicitor

Fiona O'Regan BCL, LLM, PhD (NUI)

Tara Smith BCL, LLM, PhD (NUI), Attorney-at-Law (New York)

ACCESS TO LEGISLATION

Project Manager:

Alma Clissmann, BA (Mod), LLB, Dip Eur Law (Bruges), Solicitor

Deputy Project Manager:

Jane Murphy LLB (UL), LLM (NUI), Barrister-at-Law

ADMINISTRATION STAFF

Head of Administration:

Deirdre Fleming

Executive Officer:

[Currently vacant]

Staff Officer:

Annmarie Cowley

Clerical Officers:

Liam Dargan

Brian Purcell

Library and Information Manager:

Órla Gillen, BA, MLIS

PRINCIPAL LEGAL RESEARCHER FOR THIS REPORT

Denise Roche BCL (Int.), Solicitor

CONTACT DETAILS

Further information can be obtained from:

Head of Administration
Law Reform Commission
35-39 Shelbourne Road
Ballsbridge
Dublin 4

Telephone:

+353 1 637 7600

Fax:

+353 1 637 7601

Email:

info@lawreform.ie

Website:

www.lawreform.ie

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Michael Corrigan, Corrigan & Corrigan, Solicitors

Bill Cox, Department of Jobs, Enterprise and Innovation

Deirdre Fagan, Solicitor, AXA Legal Services Solicitors

Kevin Fingleton, Marsh Ireland

Robert Fitzpatrick, Barrister-at-Law

April Gilroy, Solicitor, Matheson, Solicitors

Emer Gilvarry, Solicitor, Mason Hayes & Curran

Brian Hunt, Solicitor, Head of Government & Industry Affairs, Zurich Insurance Ireland plc

Julie K Hutchison, Head of International Technical Insight, Standard Life

Mr Justice Ronan Keane

Mike Kemp, Insurance Ireland

John Larkin, Solicitor, William Fry Solicitors

Mary-Michelle O'Connor, Aviva insurance Europe SE

Pauly Marrinan Quinn, Senior Counsel, former Insurance Ombudsman of Ireland

Bernie Mooney, Consumer Protection, Banking & Policy, Central Bank of Ireland

Liam Reidy, Senior Counsel

Emma Roche-Cagney, Barrister-at-Law

Bernard Sheridan, Director of Consumer Protection, Central Bank of Ireland

Full responsibility for this publication lies, however, with the Commission.

TABLE OF CONTENTS

Table of Key of Acronyms	xv	
Table of Legislation	xvii	
Table of Cases	xxi	
SUMMARY	1	
CHAPTER 1	SCOPE OF THE REPORT: CONSUMER INSURANCE CONTRACTS	11
A	Scope of the Report	11
	(1) A single regime that applies to consumers and businesses	11
	(2) Separate regimes for individual consumers and businesses	12
	(3) The status of statutory and non-statutory codes in litigation	16
	(4) General application to life and non-life insurance; and exclusion of certain insurance-related matters	18
B	Note on Use of “Consumer” rather than “Proposer”, “Policyholder” or “Insured” in the Report	19
CHAPTER 2	PRE-CONTRACTUAL DUTIES: UTMOST GOOD FAITH AND THE DUTY OF DISCLOSURE	21
A	Current Law on Utmost Good Faith and Pre-Contractual Disclosure	21
	(1) Utmost good faith and the duty of disclosure: from Carter v Boehm to the Marine Insurance Act 1906	21
	(2) The duty of disclosure, the prudent insurer and the objective test of materiality: the Chariot Inns case	24
	(3) The duty of disclosure, the prudent insurer and a test of reasonableness in determining materiality: the Aro Road case and applying the good faith principle to both parties	26
	(4) Judicial activity since Aro Road: good faith applies to both parties and the insurer must make reasonable enquiries in a professional manner	29
	(5) Impact of the Financial Services Ombudsman	31
	(6) Impact of the Consumer Protection Code 2012	31
	(7) Impact of Insurance Ireland’s voluntary codes	32
B	Comparative Developments	32
	(1) United Kingdom	32

	(2) Australia	35
C	Good Faith and the Duty of Disclosure: General Conclusions and Recommendations	37
	(1) The principle of utmost good faith (uberrima fides)	37
	(2) The duty of disclosure	39
CHAPTER 3	PRE-CONTRACTUAL DISCLOSURE: SPECIFIC RECOMMENDATIONS AND PROPORTIONATE REMEDIES	43
A	Reformulated duty of disclosure: the consumer's duties	43
	(1) No general requirement to volunteer information	43
	(2) Duty to answer questions honestly and with reasonable care	44
	(3) Exceptions to the duty of disclosure	48
B	Reformulated duty of disclosure: the insurer	49
	(1) Types of Questions	49
	(2) Materiality	52
	(3) Whether the answers "induce" the insurer to enter into the contract	58
	(4) Duty to explain the consequences of non-disclosure	60
C	Proportionate Remedies: Avoidance, Rescission and Damages	60
	(1) The penalty for misrepresentations	60
	(2) From the "all-or-nothing" approach of repudiation towards proportionality	61
	(3) Categories of misrepresentations: innocent, negligent and fraudulent	63
D	Renewal of Insurance Contracts	74
CHAPTER 4	WARRANTIES AND TERMS THAT DESCRIBE THE RISK	79
A	Defining Warranties	79
	(1) Types of insurance warranties	80
	(2) No specific form of words required for warranty (general rules for interpretation of contracts apply)	81
	(3) Non-compliance with warranty may be excused (a) where circumstances change, (b) where compliance would be unlawful or (c) through waiver	82
	(4) Codification of general rules on warranties in Marine Insurance Act 1906	83
	(5) Insurance Ireland Codes on warranties	84

	(6) Consumer Protection Code 2012 and warranties	85
	(7) The Unfair Terms Regulations 1995 and warranties	85
	(8) Conclusions and recommendation on general reform of insurance warranties	85
B	Specific Reforms to Replace Warranties of Fact and Warranties of Opinion (Including “Basis Of Contract” Clauses)	86
C	Specific Reforms to Replace Warranties as to the Future (Continuing or Promissory Warranties)	90
	(1) Distinction between “warranties as to the future” and other contract terms	90
	(2) Substance over form	91
	(3) Causal connection between the contract term and the breach	92
	(4) Causal connection test coupled with the proportionality rule	93
	(5) Fault based approach	94
	(6) Suspensive conditions	94
	(7) Terms descriptive of the risk	96
	(8) Conclusions and recommendations	97
CHAPTER 5	INSURABLE INTEREST	101
A	Overview of the Law on Insurable Interest	101
	(1) Insurable interest is a mandatory requirement for life insurance and non-life indemnity insurance	101
	(2) The nature and extent of the required insurable interest is not clear	102
B	Insurable interest: Reform or Abolish	107
	(1) United Kingdom	108
	(2) Australia	110
	(3) Insurable interest is not a necessary part of the general definition of an insurance contract	111
	(4) Insurable interest is not a requirement of the statutory insurance licensing regime, and is not required to distinguish insurance contracts from other types of financial services	112
	(5) Insurable interest and indemnity insurance	115
	(6) How public policy on gambling has changed between the 18th and 21st century, and why insurable interest is not required to distinguish insurance contracts from gambling and wagering	116

	(7) Insurable interest is not necessary to deter moral hazard risks	117
	(8) Conclusions and recommendations	120
CHAPTER 6	PRIVITY OF CONTRACT AND THIRD PARTY RIGHTS	123
A	The Privity Rule and Third Party Rights: General	123
	(1) Section 76 of the Road Traffic Act 1961	124
	(2) Section 62 of the Civil Liability Act 1961	125
	(3) Reform of Third Party Rights in Insurance Contracts in Other Jurisdictions	127
	(4) Conclusions	129
B	Specific Recommendations on Third Party Rights	130
	(1) Definition of third party	130
	(2) Definition of insured person	130
	(3) Transfer of rights to third parties	130
	(4) Third party's rights should apply in specific circumstances	131
	(5) A right to proceed directly against the insurer before establishing liability	134
	(6) A right to the disclosure of certain information	135
	(7) Conditions affecting transferred rights	138
	(8) Voluntarily-incurred liabilities	139
	(9) Two or more claimants	140
CHAPTER 7	SUBROGATION	141
A	Overview of subrogation	141
B	Specific reforms of subrogation	141
	(1) Family relationship settings	141
	(2) Employer-employee setting: Lister v Romford Ice	143
	(3) Distribution of recovered funds	147
	(4) Contractual provisions	149
	(5) Third parties	150
CHAPTER 8	POST-CONTRACTUAL DUTIES	151
A	The Post-Contractual Duty of Good Faith	151
B	The Duties Prior to the Manifestation of the Claim	151
	(1) Payment of the premium	152
	(2) Aggravation or reduction of the risk	152
C	Duties During Claims Handling	157
	(1) The policyholder's obligations	157

	(2) Insurer's Obligations: Processing a claim and offer of settlement	160
D	Disputed Claims	164
	(1) Investigating a disputed claim	164
	(2) Reports prepared and information discovered after a claim is made	166
	(3) Late Payment of Claims	168
	(4) Fraudulent Claims	173
	(5) Innocent co-insureds	178
CHAPTER 9	UNFAIR AND OTHERWISE ONEROUS TERMS	185
A	Case law and legislation on unfair and otherwise onerous terms	185
	(1) Case law in Ireland and the United Kingdom on unfair terms	185
	(2) Sale of Goods and Supply of Services Act 1980	188
	(3) European Communities (Unfair Terms in Consumer Contracts) Regulations 1995	190
	(4) Consumer Protection Act 2007	195
	(5) Conclusions and recommendations	199
	(6) Clarifying the scope of the "main subject matter" of insurance contracts	201
CHAPTER 10	FORM OF THE CONTRACT	207
A	Current Law on the Form of a Contract of Insurance	207
B	Specific Matters Concerning Form of the Contract	214
	(1) Provision of Pre-Contractual and Post-Contractual Information	214
	(2) Contractual material in writing or other durable form	222
	(3) How information is to be provided	223
	(4) How information is to be interpreted	225
	(5) Prescribed notices, notification and forms	226
	(6) The right to cancel or the "cooling-off" period	228
	(7) Cancelling outside the "cooling-off" period	231
	(8) Renewal of the insurance contract	232
	(9) Issuing reasons for adverse underwriting decisions	234
	(10) Consequences of non-compliance with duties	237
APPENDIX A	LIST OF RECOMMENDATIONS IN THE REPORT	239
APPENDIX B	DRAFT CONSUMER INSURANCE CONTRACTS BILL 2015	251
APPENDIX C	DEVELOPMENT OF INSURANCE REGULATION IN IRELAND AND IN COMPARABLE JURISDICTIONS	283

A	Scale and Nature of Insurance Business in Ireland	283
	(1) Insurance constitutes an important financial services sector in Ireland	283
	(2) Financial value of life and non-life insurance in Ireland	283
	(3) Increasing movement towards online insurance activity	285
B	The Limited Regulation of Insurance Contract Law and the Need for Further Reform	286
	(1) Insurance contracts, asymmetric information and the need for statutory regulation	286
	(2) General principles and rules of contract law apply to insurance contracts	287
	(3) Specific principles and rules of contract law apply to insurance contracts	287
	(4) The current limited statutory regulation of insurance contract law	288
	(5) Non-statutory industry Codes of Practice	290
	(6) Previous recommendations for further reform of insurance contract law in Ireland	292
	(7) The EU influence on reform of insurance contract law, including the Principles of European Insurance Contract Law (PEICL)	294
	(8) Reform of insurance contract law in other common law jurisdictions, including Australia and the United Kingdom	298
C	Regulatory Oversight	298
	(1) Central Bank of Ireland and the Consumer Protection Code	299
	(2) Role of the Financial Services Ombudsman	300
	(3) Data Protection Acts and Code of Practice for Insurance	303
	(4) The status of statutory and non-statutory codes	305

TABLE OF KEY ACRONYMS

ADR	Alternative Dispute Resolution
ALI	American Law Institute
ALRC	Australian Law Reform Commission
ASIC	Australian Securities and Investments Commission
DCFR	Draft Common Frame of Reference
EEA	European Economic Area
EESC	European Economic and Social Committee
EIOPA	European Insurance and Occupational Pensions Authority
EU	European Union
FOS	Financial Ombudsman Service
FCA	Financial Conduct Authority
FSA	Financial Services Authority
FSO	Financial Services Ombudsman
ICOBS	Insurance Conduct of Business Sourcebook
IFSRA	Irish Financial Services Regulatory Authority
MAT	Marine, Aviation and Transport
MABS	Money Advice and Budgeting Service
PRIPs	Packaged Retail Investment Products
PECL	Principles of European Contract Law
PEICL	Principles of European Insurance Contract Law
PRA	Prudential Regulation Authority
SSM	Single Supervisory Mechanism
ULC	Uniform Law Commission
CJEU	Court of Justice of the European Union
OFT	Office of Fair Trading

TABLE OF LEGISLATION

Adoption Act 2010	No 21/2010	Irl
Air Navigation (International Conventions) Act 2004	No 11/2004	Irl
Assurance Companies Act 1909	9 Edw 7, c.49	Irl
Central Bank Act 1942	No 22/1942	Irl
Central Bank Act 1942 (Financial Services Ombudsman Council) Regulations 2005	SI 190/2005	Irl
Central Bank Act 1942 (Financial Services Ombudsman Council) (Amendment) Regulations 2014	SI 164/2014	Irl
Central Bank Act 1989	No 16/1989	Irl
Central Bank and Financial Services Authority of Ireland Act 2003	No 12/2013	Irl
Central Bank and Financial Service Authority of Ireland Act 2004	No 21/2004	Irl
Central Bank Reform Act 2010	No 23/2010	Irl
Central Bank (Supervision and Enforcement) Act 2013	No 26/2013	Irl
Children and Family Relationships Act 2015	No 9/2015	Irl
Civil Liability Act 1961	No 41/1961	Irl
Civil Partnership and Certain Rights and Obligations of Cohabitants Act 2010	No 24/2010	Irl
Collecting Societies and Industrial Assurance Companies Act 1896	59 & 60 Vict, c.26	Irl
Companies Act 2006	2006, c.46	UK
Companies Act 2014	No 34/2014	Irl
Companies (Amendment) Act 1990	No 27/1990	Irl
Competition Act 1991	No 24/1991	Irl
Competition Act 2002	No 14/2002	Irl
Competition and Consumer Protection Act 2014	No 29/2014	Irl
Consumer Credit Act 1995	No 24/1995	Irl
Consumer Information Act 1978	No 1/1978	Irl
Consumer Insurance (Disclosure and Representations) Act 2012	2012, c. 6	UK

Consumer Protection Act 2007	No 19/2007	Irl
Contracts (Rights of Third Parties) Act 1999	1999, c. 31	UK
Corporations Act 2001	No 50/2001	Aus
Courts Act 1981	No 11/1981	Irl
Criminal Justice (Theft and Fraud Offences) Act 2001	No 50/2001	Irl
Data Protection Act 1988	No 25/1988	Irl
Data Protection (Amendment) Act 2003	No 6/2003	Irl
Debtors (Ireland) Act 1840	3 & 4 Vict, c.105	Irl
European Communities (Certain Aspects of the Sale of Consumer Sales and Associated Guarantees) Regulations 2003	SI 11/2003	Irl
European Communities (Directive 2000/31/EC) Regulations 2003	SI 68/2003	Irl
European Communities (Distance Marketing of Consumer Financial Services) Regulations 2004	SI 853/2004	Irl
European Communities (Distance Marketing of Consumer Financial Services) (Amendment) Regulations 2005	SI 63/2005	Irl
European Communities (Fourth Motor Insurance Directive) Regulations 2003	SI 651/2003	Irl
European Communities (Late Payment in Commercial Transactions) Regulations 2002	SI 388/2002	Irl
European Communities (Late Payment in Commercial Transactions) Regulations 2012	SI 580/2012	Irl
European Communities (Life Assurance) Framework Regulations 1994	SI 360/1994	Irl
European Communities (Misleading Advertising) Regulations 1988	SI 134/1988	Irl
European Communities (Misleading and Comparative Marketing Communications) Regulations 2007	SI 774/2007	Irl
European Communities (Non-Life Insurance) Framework Regulations 1994	SI 359/1994	Irl
European Communities (Undertakings for Collective Investment in Transferable Securities) Regulations 2011	SI 352/2011	Irl
European Communities (Unfair Terms in Consumer Contracts) Regulations 1995	SI 27/1995	Irl
European Union (Consumer Information, Cancellation and Other Rights) Regulations 2013	SI 484/2013	Irl

Friendly Societies Act 1896	59 & 60 Vict, c.25	Irl
Gaming Act 1845	8 & 9 Vict, c.109	Irl
Gaming and Lotteries Act 1956	No 2/1956	Irl
Health Insurance (Amendment) Act 2012	No 45/2012	Irl
Health Insurance (Miscellaneous Provisions) Act 2009	No 25/2009	Irl
Health Insurance Act 1994	No 16/1994	Irl
Insurance Act 1936	No 45/1936	Irl
Insurance Act 1953	No 7/1954	Irl
Insurance Act 1989	No 3/1989	Irl
Insurance Act 2000	No 42/2000	Irl
Insurance Act 2015	2015, c.4	UK
Insurance Amendment Act 2009	SBC 2009 c.16	Can
Insurance Contracts Act 1984	No 80/1984	Aus
Insurance Contracts Amendment Act 2013	No 75/2013	Aus
Insurance Law Reform Act 1977	No 14/1977	NZ
Insurance Laws Amendment Act 1998	No 35/1998	Aus
Investment Intermediaries Act 1995	No 11/1995	Irl
Life Assurance Act 1774	14 Geo 3, c.48	UK
Life Assurance Companies Act 1870	33 & 34 Vict, c.61	Irl
Life Assurance (Insurable Interest) Act 2004	AT 3/2004	IoMan
Life Assurance (Provision of Information) Regulations 2001	SI 15/2001	Irl
Life Assurance (Provision of Information) (Amendment) Regulations 2002	SI 161/2002	Irl
Life Insurance (Consequential Amendments and Repeals) Act 1995	No 5/1995	Aus
Life Insurance (Ireland) Act 1866	29 & 30 Vict, c.42	Irl
Malicious Injuries (Amendment) Act 1986	No 27/1986	Irl
Marine Insurance Act 1906	6 Edw 7, c.41	UK
Married Women's Property Act 1882	47 & 48 Vict, c.14	Irl
Married Women's Status Act 1957	No 5/1957	Irl

Merchandise Marks Act 1887	50 & 51 Vict, c.28	Irl
Merchandise Marks Act 1891	54 & 55 Vict, c.15	Irl
Merchandise Marks Act 1911	1 & 2 Geo 5, c.31	Irl
Merchandise Marks Act 1931	No 48/1931	Irl
Misrepresentation Act 1967	1967, c.7	Eng/W
Misrepresentation Act (Northern Ireland) 1967	1967, c.14	NI
Motor Insurance (Provision of Information) (Renewal of Policy of Insurance) Regulations 2002	SI 389/2002	Irl
National Lottery Act 1986	No 28/1986	Irl
Non-Life Insurance (Provision of Information) (Renewal of Policy of Insurance) Regulations 2007	SI 74/2007	Irl
Personal Insolvency Act 2012	No 44/2012	Irl
Prices Act 1958	No 4/1958	Irl
Prices (Amendment) Act 1972	No 20/1972	Irl
Proceeds of Crime Act 1996	No 30/1996	Irl
Proceeds of Crime (Amendment) Act 2005	No 1/2005	Irl
Pyramid Selling Act 1980	No 27/1980	Irl
Road Traffic (Compulsory Insurance) (Amendment) Regulations 1992	SI 346/1992	Irl
Road Traffic Act 1933	No 11/1933	Irl
Road Traffic Act 1961	No 24/1961	Irl
Sale of Goods Act 1893	56 & 57 Vict, c.71	Irl
Sale of Goods and Supply of Services Act 1980	No 16/1980	Irl
Supply of Goods (Implied Terms) Act 1973	1973, c.13	UK
Third Parties (Rights against Insurers) Act 1930	1930, c.25	UK
Third Parties (Rights against Insurers) Act 2010	2010, c.10	UK
Trade Descriptions Act 1968	1968, c.29	UK
Unfair Contract Terms Act 1977	1977, c.50	UK
Unfair Terms in Consumer Contracts Regulations 1999	SI 1999/2083	UK

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Anderson v Fitzgerald	(1853) 10 ER 551	Irl
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Antaios Compania Naviera SA v Salen Rederierna AB	[1985] AC 191	Eng
Aro Road and Land Vehicles Ltd v Insurance Corporation of Ireland Ltd	[1986] IR 403	Irl
Assicurazioni General Spa v Arab Insurance Group (BSC)	[2002] EWCA Civ 1642; [2003] Lloyd's Rep IR 131	Eng
Asturcom Telecomunicaciones SL v Maria Cristina Rodríguez Nogueira	Case C-40/08, [2009] ECR I-9579	EU
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Bank of Ireland v Smith	[1996] IR 658	Irl
Baxendale v Harvey	(1859) 157 ER 913	Eng
Bennett v Axa Insurance Plc	[2003] EWHC 86 (Comm); [2004] Lloyd's Rep IR 615	Eng
Brady v Irish National Insurance Co Ltd	[1986] IR 698	Irl
Bupa Ireland Ltd v Health Insurance Authority	[2008] IESC 42; [2009] 1 ILRM 81	Irl
Capemel Ltd v Lister	[1989] IR 319	Irl
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Carna Foods Ltd v Eagle Star Insurance Co	[1997] 2 IR 193	Irl
Carroll v An Post National Lottery Company	[1996] IEHC 50; [1996] 1 IR 443	Irl
Carter v Boehm	(1766) 3 Burr 1905	Eng
Carey v Independent Newspapers (Ireland) Ltd	[2003] IEHC 67	Irl
Castellain v Preston	(1883) 11 QBD 380	Eng
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Coleman v New Ireland Assurance Plc	[2009] IEHC 273	Irl
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Connors v London and Provincial Assurance Co	(1913) 47 ILTR 148	Irl
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Cunningham v Woodchester Investments	[1984] IEHC 1	Irl
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Douglas v Kinger	(2008) 94 DLR (4th) 267	Can
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Driscoll v Driscoll	[1918] 1 IR 152	Irl
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Emo Oil Ltd v Sun Alliance Insurance plc	[2009] IESC 2	Irl
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Hu v Duleek Formwork Ltd and Aviva Direct Ltd	[2013] IEHC 50	Irl
Hussain v Brown (No.2)	[1995] EWCA Civ J0628-6; [1996] 1 Lloyd's Rep 627	Eng
Irish Life and Permanent plc v Dunne and Dunphy	[2015] IESC 46	Irl
Irish Life and Permanent plc v Financial Services Ombudsman	[2012] IEHC 367	Irl
Interfoto Picture Library Ltd v Stiletto Visual Programs Ltd	[1987] EWCA Civ J1112-6; [1989] QB 433	Eng
International Commercial Bank Plc v Insurance Corporation of Ireland Plc	[1991] ILRM 726	Irl
Investors Compensation Scheme Ltd v West Bromwich Building Society	[1998] 1 WLR 896; [1999] Lloyd's Rep PN 496	Eng
Joel v Law Union and Insurance Co.	[1908] 2 KB 863	Eng
Justice (decd) v St Paul Ireland	Circuit Court, 25 November 2004	Irl
Kausar v Eagle Star Insurance Co Ltd	[2000] Lloyd's Rep IR 154	Irl
Keating v New Ireland Assurance Company Plc	[1990] 2 IR 383	Irl
Keenan v Shield Insurance Co	[1988] IR 89	Irl
Keith v The Protection Marine Insurance Company of Paris	(1882) 10 LR I 51	Irl
Kennedy v London Express Newspapers	[1931] IR 532	Irl
Kerry Tree (Technology) Ltd v Sun Alliance and London Insurance	[2001] IEHC 144	Irl
Kelleher v Irish Life Assurance Company Ltd	[1993] 3 IR 393	Irl
Kosmopoulos v Constitution Insurance Co	[1987] 1 SCR 2	Can
Lambert v Co-Operative Insurance Society Ltd	[1975] EWCA Civ J0122-2; [1975] 2 Lloyd's Rep 485	Eng
Latham v Hibernian Insurance Co Ltd	High Court, 22 March 1991	Irl
Layher Ltd v Lowe	58 Con LR 42	Eng
Lister v Romford Ice and Cold Storage Co Ltd	[1957] AC 1955	Eng
Lonrho Exports Ltd v Exports Credits Guarantee Department	[1999] Ch 158	Eng
Lucena v Craufurd	(1808) 1 Taut 325, 127 ER 630	Eng
Lyons and Murray v Financial Services Ombudsman	[2011] IEHC 454	Irl
McAleenan v AIG (Europe) Ltd	[2010] IEHC 128	Irl
McCarron v Modern Timber Homes Ltd	[2012] IEHC 530	Irl

McCarthy v Joe Walsh Tours Ltd	[1991] ILRM 813	Irl
McKenna v Best Travel Ltd	[1995] 1 IR 577	Irl
Macaura v Northern Assurance Co Ltd	[1925] AC 619	Eng
Manifest Shipping Co. Ltd v Uni-Polaris Shipping Co. Ltd (The Star Sea)	[2001] UKHL 1; [2003] 1 AC 469	Eng
Manor Park Homebuilders Ltd v AIG Europe (Ireland) Ltd	[2008] IEHC 174; [2009] 1 ILRM 190	Irl
Matei v Volksbank Romania SA	CJEU, 26 February 2015	EU
Maulder v National Insurance Company of New Zealand	[1993] 2 NZLR 351	NZ
Michovsky v Allianz Ireland plc	[2010] IEHC 43	Irl
Geo Mitchell Ltd v Finney Lock Seeds Ltd	[1983] 2 AC 803	Eng
Mostazo Claro v Centro Móvil Mileneum	Case C-168/05, [2006] ECR 1-1042	EU
Morris v Ford Motor Co Ltd	[1973] EWCA Civ J0327-1; [1973] 1 QB 792	Eng
Murphy v ARB Underwriting and Ors	High Court 9 May 2012	Irl
Murphy and Thers v Bower	(1866) 2 IR CL 506	Irl
Murray v Scottish Automobile and General Insurance Co	1929 SC 48	Sco
Napier and Ettrick (Lord) v R F Kershaw Ltd and Others	[1993] AC 713	Eng
New Hampshire Ins Co v Mirror Group Newspaper	[1996] CLC 1692	Eng
Norsworthy v SGIC	[1999] SASC 496	Aus
Oceano Grupo Editorial SA v Rocio Murciano Qintero	Cases C-240/98-C244/98, [2000] ECR 1-4941	EU
O'Donovan v Cork County Council	[1967] IR 173	Irl
O'Reilly v Irish Life Assurance Plc	[2005] IEHC 449	Irl
Office of Fair Trading v Abbey National Plc and others	[2009] UKSC 6; [2010] 1 AC 696	Eng
Pan Atlantic Insurance Co. Ltd v Pine Top Insurance Co. Ltd	[1995] 1 AC 501	Eng
Parker v National Farmers Union Mutual Insurance Society Ltd	[2012] EWHC 2156 (Comm); [2013] Lloyd's Rep IR 253	Eng
Portage La Prairie Mutual Insurance Co v MacLean	2012 NSSC 341	Can
President of India v Lips Maritime Corp	[1988] AC 395	Eng
Prudential Insurance Co v Commissioners of Inland Revenue	[1904] 2 KB 658	Eng
Quin v National Assurance Co	(1839) Jo & Car 316	Irl
PJ Carrigan Ltd v Norwich Union Fire Society Ltd	[1987] IR 618	Irl
R (on the application of T) v Secretary of State for the Home Department and another	[2013] EWCA Civ 25; [2014] UKSC 35	Eng
Rhatigan & Ors v Eagle Star Life Assurance Co	[2013] IEHC 139	Irl
Roberts v Avon Insurance Co	[1956] 2 Lloyd's Rep 240	Eng
Roche v Peilow	[1985] IR 232	Irl

Rohan Construction Ltd v Insurance Corporation of Ireland Ltd	[1986] ILRM 419; [1988] ILRM 373	Irl
Ross v Bradshaw	(1761) 1 Wm BI 312	Eng
Ryanair Ltd v Billigfluege. De GmbH	[2010] IEHC 47	Irl
Sadlers Company v Badcock and Others	(1743) 26 ER 733	Eng
Seaton v Heath	(1899) 1 QB 782	Eng
Scott v Wawanesa Mutual Insurance Co	[1989] 1 SCR 1445	Can
Scottish Amicable Heritable Securities Association, &c. v Northern Assurance Co &c.	(1883) 11 R 287	Sco
Sprung v Royal Insurance	[1999] 1 Lloyd's Rep IR 111	Eng
Sinnott v Quinnsworth Ltd	[1984] ILRM 523	Irl
Simcock v Scottis Imperial Ins Co	(1902) 10 SLT 286	Sco
Silver Hill Duckling Ltd and Steele v Minister of Agricultural	[1987] IR 289	Irl
Siu Yin Kwan and Another v Eastern Insurance Co Ltd	[1994] 2 AC 199	Eng
Stepstone Mortgage Funding Ltd v Fitzell	[2012] IEHC 142; [2012] 2 IR 318	Irl
Stewart v McKenna & Ors	[2014] IEHC 301	Irl
St Alban's Investment Co v Sun Alliance Insurance Ltd	[1983] IR 362	Irl
Strachan v Scottish Boatowner's Mutual Insurance Association	[2010] SC 367	Sco
Smith v Lynn	(1951) 85 ILTR 57	Irl
Suisse Atlantique Société d'Armement Maritime SA v NV Rotterdamsche Kolen Centrale	[1967] 1 AC 361	Eng
Superwood Holdings plc v Sun Alliance & London Insurance Plc	[1995] 3 IR 303	Irl
In re Sweeney and Kennedy's Arbitration	[1950] IR 85	Irl
Swiss Reinsurance Co v United India Insurance Co Ltd	[2005] EWHC 237 (Comm); [2005] 2 All ER (Comm) 367	Eng
Tarbuck v Avon Plc	[2001] 2 All ER 503	Eng
US Trading Ltd v AXA Insurance Co Ltd	[2010] Lloyd's Rep IR 505	Eng
Ulster Bank v Financial Services Ombudsman	[2006] IEHC 323	Irl
Wainwright v Bland	(1835) 1 Moo & R 481; 174 ER 165	Eng
Waugh v British Railways Board	[1980] AC 521	Eng
Woolfall & Rimmer Ltd v Moyle	[1942] 1 KB 66	Eng
Vandepitte v Preferred Accident Insurance Corporation of New York	[1933] AC 70	UK
Van Hove v CNP Assurances SA	CJEU, 23 April 2015	EU
Ventouris v Mountain (The Italia Express) (No.2)	[1992] 2 Lloyd's Rep 281	Eng
Yorkshire Insurance Co Ltd v Nisbet Shipping Co Ltd	[1962] 2 QB 330	Eng
Zurich Bank v McConnon	[2011] IEHC 75	Irl

Zurich General Accident and Liability Insurance Co Ltd v Morrison	[1942] 2 KB 53	Eng
Zurich Insurance Co v Shield Insurance Co Ltd	[1988] IR 174	Irl

SUMMARY

A Overview of the project on insurance contract law

1. Insurance contracts (or policies) are important because they often concern and affect the health, homes, property and even the lives of ordinary people.

Every person travelling in a motor vehicle on a public road in Ireland at any time will have an interest in the existence (or absence) of an insurance contract.

All responsible Irish employers, homeowners and many holidaymakers enter into or continue insurance contracts in order to protect their employees, their homes, their property, their health and the wellbeing of loved ones in the event of death.

2. As part of its *Third Programme of Law Reform*¹ the Commission has undertaken and completed a review of the laws that govern and regulate the insurance contracts that affect ordinary people and small businesses in Ireland in order to determine whether they are working properly or are in need of reform.²

The Commission has concluded that, while recent EU and domestic legislation on the regulation of insurance contracts has benefited ordinary people and small businesses in Ireland, there is a need for further reform and that the relevant provisions should also be consolidated in a single statutory framework. The draft *Consumer Insurance Contracts Bill* in Appendix B of the Report is intended to give effect to this.

B Insurance contract law principles and rules developed in 18th and 19th centuries should be reformed to reflect bargaining powers of insurers and consumers in 21st century

3. Many of the laws that govern insurance contracts in Ireland today have their origins in 18th and 19th century English court cases.³

The case law reflected an 18th and 19th century society in which the concept of insurance was at an early stage and its transaction was often concluded in London ale or coffee houses such as that owned in 1680 by a Mr Edward Lloyd. This would later become the insurance market Lloyd's of London.

Many of the principles identified and developed by English judges such as Lord Mansfield in cases reported as long ago as 1766⁴ and 1786⁵ still apply to insurance contracts in Ireland.

4. Some of the principles identified in those early cases were codified in subsequent legislation, some also dating from the 18th century but still applicable in Ireland.⁶

¹ *Report on Third Programme of Law Reform* (LRC 86-2007), Project 34. This Report follows the publication of the Commission's *Consultation Paper on Insurance Contracts* (LRC CP 65-2011).

² In Chapter 1, the Commission also explains why the Report does not review or make specific recommendations concerning the laws governing insurance intermediaries, reinsurance, or marine, air or transport insurance (MAT insurance).

³ The leading text in Ireland is Buckley, *Insurance Law* 3rd ed (Round Hall Thomson, 2012), and one of the leading texts on English insurance contract law is Birds, Lynch and Milnes (eds), *MacGillivray on Insurance Law* 12th ed (Sweet & Maxwell, 2012). Both texts describe the origins and development of insurance contract law from the 18th century, including relevant case law and legislation.

⁴ *Carter v Boehm* (1766) Burr 1905.

⁵ *De Hahn v Hartley* (1786) 1 Term Rep 343.

⁶ For example the *Life Assurance Act 1774*, the *Life Assurance (Ireland) Act 1866* and the *Marine Insurance Act 1906*.

Most were fair, reasonable, sensible, carefully argued, constructive and appropriate for 18th and 19th century British society, when most insurance contracts were concluded between insurers like Edward Lloyd and ship-owners or wealthy landowners.

5. But are these principles appropriate for Ireland in the 21st century when most insurance contracts are concluded between large (often multinational) corporate bodies or conglomerates with very large financial, technical, actuarial and human resources⁷ and consumers with very limited financial, technical and other resources?

Are they appropriate and do they provide sufficient protection for all Irish consumers, including individuals and small businesses with differing levels of negotiating ability?

Do the laws accommodate consumers who wish to buy insurance contracts online and/or at short notice?

6. The Commission has concluded that many of the principles and resultant laws that govern contracts between insurers and consumers in Ireland are no longer appropriate and it recommends the abolition of some of those principles and laws and their replacement with specific legislative measures.

The Report is wide ranging. It reviews Irish law, the laws and Directives of the EU and comparable laws in other countries.

The Report's 105 recommendations for reform and statutory consolidation (as set out in the draft *Consumer Insurance Contracts Bill* in Appendix B) include the following.

C Recommendation that reforms should apply to consumers as defined for purposes of Financial Services Ombudsman and under *Consumer Protection Code 2012*

7. In **Chapter 1** the Commission explains why its recommendations should apply to consumers, defined to include individuals and small businesses with a turnover of less than €3 million. This definition of consumer is that used to define the statutory jurisdiction of the Financial Services Ombudsman, which provides a mediation service on consumer insurance complaints, and in the Central Bank's *Consumer Protection Code 2012*, which contains important requirements on insurance contracts.

D Recommendation to replace the current pre-contractual duty of disclosure imposed on consumers with a statutory duty to answer carefully and honestly specific questions posed by an insurer that identify the material risks and the relevant information actually relied on by the insurer

8. In the 18th century a duty was imposed on both parties to an insurance contract to disclose to each other "material" facts likely to influence a "prudent insurer" in deciding to accept a risk or fix a premium (the price charged).

The duty is based upon the principle that the relationship between the parties to an insurance contract is one of the "utmost good faith" ("*uberrimae fidei*") and differs from the relationship between the parties to most other contracts in that respect.

The duty extends even to information that a consumer *ought* to know *might* influence a hypothetical "prudent" insurer.

Failure by a consumer to discharge this duty permits an insurer to avoid paying the claim and this may occur in circumstances where a consumer has acted innocently and in good faith.

⁷ The insurance industry is an important financial services sector in Ireland, with insurance companies and insurance broker firms employing over 20,000 people: see Appendix C, below.

Although a Supreme Court judge observed in 1986⁸ that the use of the word “utmost” as an additional epithet preceding “good faith” did not add anything to this principle, it is undeniable that good faith is a desirable and necessary factor for the parties to an insurance contract.

9. However, insurers today are far better resourced and equipped than consumers to identify facts that will be “material” to insurers in deciding to accept risks or fix premiums. The Commission has therefore concluded that the onus should rest on insurers to identify such facts for consumers by asking them specific questions.

This will allow insurers to identify all of the facts which insurers consider “material” to the risk to be insured and to the price to be fixed. A corresponding obligation should be imposed on consumers to answer those questions honestly and with reasonable care.

The reasons for these recommendations are discussed in detail in **Chapters 2 and 3** of this Report.

E Recommendation that there should be proportionate remedies for innocent or negligent mistakes by a consumer, but that insurers should continue to be able to repudiate liability completely in cases of fraud

10. Under our current law, an innocent or negligent non-disclosure by a consumer enables insurers to refuse to indemnify and pay claims made honestly under the insurance contract. This has resulted in injustice, and the Commission therefore recommends that, where a consumer’s non-disclosure, misrepresentation or other breaches of contract are innocent or due to negligence, insurers should not be able to repudiate all liability under the insurance contract but should be required to make proportionate payments to the consumer.

Any such payments would be proportionately adjusted to take account of the presence or absence of carelessness by the consumer and whether the breach of contract actually affected the specific risk undertaken by the insurer.

11. The Commission recommends, however, that where a consumer’s non-disclosure, misrepresentation or other breaches of contract are fraudulent (that is, where made intentionally or recklessly), the insurer’s right to completely repudiate liability should remain. There must be clear provisions within our laws which will deter fraudulent insurance claims.

The reasons for these recommendations are discussed in detail in **Chapter 3** of this Report.

F Recommendation that the concept of insurance warranties should be replaced with statutory provisions allowing insurers to include provisions that precisely identify or define the risk insured but which also protect consumers from unfair and unjust outcomes

12. “Warranties” in insurance contracts are special terms or conditions that permit a party to an insurance contract (usually the insurer) to repudiate the contract and refuse to meet the claim if the particular provision (the warranty) is breached.

This means for example that if a policyholder wrongly “warrants” that a particular type of burglar alarm has been installed and the premises subsequently burns down as a result of faulty electrical wiring, the insurer will probably be entitled to repudiate liability under the policy even though there has been no connection between the breach of warranty (the absence of a burglar alarm) and the event giving rise to the claim (a fire).

13. The strictness of the rule that a warranty must be “literally” complied with is illustrated by the facts of the 18th century case *De Hahn v Hartley*.⁹

⁸ McCarthy J in *Aro Road and Land Vehicles Ltd v Insurance Corporation of Ireland Ltd* [1986] IR 403, discussed in Chapter 2, below.

⁹ (1786) 1 Term Rep 343.

In that case the plaintiff had warranted that a ship would have a complement of 50 crewmen. Although on departure from port only 46 were on board, a further six crewmen boarded at a subsequent port.

The ship capsized in a storm and all 52 crew on board died. The insurer repudiated liability under the insurance contract on the grounds that the plaintiff was in breach of the warranty from the time the ship first departed port with a crew of less than 50. Although this had been remedied before the loss occurred, and could not be regarded as directly related to the risk undertaken, the Court held that the defendant was entitled to repudiate liability.

14. Declarations that particular provisions of the contract are “basis of contract” have been held to make those conditions “warranties.”

For example, in *Keenan v Shield Insurance Co Ltd*¹⁰ the plaintiff had declared that his answers were “true and complete in every respect” and were subject to the “basis of contract” warranty.

The High Court held that the plaintiff had included a relatively unimportant inaccuracy in an answer to a question in the proposal form. However, because of the “warranty” that his answers were “true and complete in every respect” the Court had to dismiss the claim “with considerable regret.”¹¹

15. There have been many other cases highlighted by the courts where reliance by insurers on breaches of “warranties” has appeared to be unfair and unjust and has failed to provide satisfactory protection to consumers.

The Commission is therefore recommending the abolition of the concept of warranties in insurance contracts and their replacement with statutory rules that will enable insurers to continue to include provisions within contracts that (a) precisely identify or define the risk insured and (b) protect consumers from the unfair and unjust effects of the current law.

The reasons for these and other related recommendations are provided in detail in **Chapter 4** of this Report.

G Recommendation to abolish the requirement that a consumer must have an “insurable interest” in the risk insured and to replace it with legislation that (a) requires a consumer, when making a claim, to prove actual loss and (b) applies the principle of indemnity (that is, that a policyholder cannot make a profit on any claim)

16. Since the 18th century insurance contract law has provided that a consumer may not recover a benefit from an insurance contract unless he or she has some identifiable interest or expectation in the risk insured: this is called an “insurable interest.”

This means that an insurer may enter into a contract purporting to insure a particular property, life or risk but will not have to compensate the consumer/policyholder if he or she does not own or has no interest in that property, life or risk.

17. This was not a legal requirement when insurance began to develop in England in the 16th and 17th centuries but it became so during the 18th century because of concern that some insurance contracts involved a high degree of moral hazard and smacked of gambling or wagering (which at that time was regarded as a significant social evil).

It was suggested that some marine insurance contracts were being concluded by persons with more interest in making claims for the failure of ships to arrive in port than in trading their cargo, and that, in life insurance, an insurable interest was needed to prevent the risk of criminal activity.¹²

¹⁰ [1987] IR 113.

¹¹ *Ibid* at 119 (Blayney J).

¹² This included the risk of committing murder in order to recover under a life policy but, as discussed in Chapter 5 below, there is no evidence to support that contention.

As a result the law prohibited both gambling and any insurance contract that resembled gambling.

Regulated gambling is now permitted by law in Ireland but the “insurable interest” requirement (described authoritatively as “a confusing and illogical mess”¹³) remains in force for life insurance and non-life indemnity insurance.

18. Insurance contracts are, of course, intended to compensate for loss, not to provide profit for the consumer based on speculation.

However, in some circumstances (for example, cohabitants who wish to take out life insurance contracts on one another, or family members who wish to insure premises owned by an elderly parent who has failed to do so) insurers may refuse to pay claims because the consumer has no “insurable interest” in the risk.

Modern insurers have sufficient technical and other resources to enable them to distinguish between genuine insurance consumers and speculators or gamblers. These resources enable them to make informed decisions before entering into insurance contracts.

19. The Commission acknowledges that an insurance contract should, in principle, indemnify a consumer against an identified and proven loss and should not provide a means or mechanism that would enable a consumer to profit from the outcome of a particular event.

However, no compelling reason has been advanced for the retention of the historical concept of insurable interest in consumer insurance contracts and the Commission recommends its abolition and replacement with legislative provisions that apply the principle of indemnity but protect the interests of the parties to the contracts.

The reasons for these recommendations are discussed in detail in **Chapter 5** of this Report.

H Recommendation to permit third parties intended to benefit under an insurance contract to make a direct claim against the insurer

20. In general, a person who is not party to a contract (a “third party”) does not have enforceable legal rights under the contract even where the contract is intended to benefit him or her.

Subject to a few exceptions, this general rule (called the “privity rule”) applies to insurance contracts.

The exceptions include statutory provisions for motor insurance policies that indemnify motorists against claims made by third parties who are not party to the contract. These enable those third parties to bring claims and recover compensation from insurers with whom they have no contract.¹⁴

21. However, the privity rule can make it difficult (and sometimes impossible) for third parties to obtain the benefits to which they should be entitled under certain insurance contracts (such as public or employer’s liability contracts).

This means that a (perhaps) seriously injured person cannot directly recover compensation from the insurer of an employer or other person who has paid for and holds a valid insurance policy expressly intended to benefit the injured person.

This can happen where the policyholder is a corporate body in liquidation, receivership or examinership, or an individual who has died, is missing or whose decision-making capacity is in question.

¹³ Merkin *Reforming Insurance Law: Is there a Case for Reverse Transportation? A Report for the English and Scottish Law Commissions on the Australian Experience of Insurance Law Reform* (Law Commission of England and Wales and Scottish Law Commission, 2007) at 78.

¹⁴ Similar statutory provisions enable injured parties to recover compensation from the Motor Insurers Bureau of Ireland in the context of claims made against uninsured drivers.

Third parties in such circumstances find that they cannot bring a claim against the insurer to recover compensation to which they are entitled.

Moreover, they cannot discover (a) the terms of the insurance contract, (b) if the terms of the contract have been complied with by the parties, (c) if the insurer has agreed or refused to indemnify or (d) the reasons for any refusal or departure from the terms of the contract.

22. Limited relief is provided to some third parties by section 62 of the *Civil Liability Act 1961* but, in light of the case law on its application in practice,¹⁵ the Commission considers that relief to be inadequate.

The Commission recommends that legislative provisions should be enacted that would enable third parties affected in this way to obtain relevant documentary and other information directly from insurers and to bring claims directly against insurers where that is necessary and appropriate.

The reasons for these recommendations are set out in detail in **Chapter 6** of this Report.

I Recommendation to modify the subrogation rights of insurers in respect of some family, personal and employer-employee relationships

23. In insurance contract law, subrogation (which means substitution) entitles an insurer to “step into the shoes” of its policyholders in order to provide indemnity and secure its own rights as insurer.

In road traffic claims subrogation allows insurers to defend or settle claims made against their policyholders and then to initiate claims in the names of those policyholders in order to recover some or all of the compensation.

If an insured house-owner recovers compensation under a house fire policy, the insurer may reclaim any sum that the house-owner would be entitled to recover from a third party.

24. This can give rise to difficulty in family relationships, in employer-employee relationships and in the control of litigation.

Where a homeowner makes an insurance claim for damage to a dwelling caused by the carelessness of a visiting relative, subrogation entitles the insurer to bring a claim against the offending (and possibly uninsured) relative in the name of the insured homeowner.

This may result in unfair pressure being placed on the insured homeowner by an insurer not to make an otherwise perfectly valid claim for compensation.

Some cases¹⁶ have demonstrated that, where a number of insurance contracts apply to the same event, subrogation may have unintended consequences such as claims by insurers against the employees of its policyholders.

25. The Commission believes that the current laws governing subrogation should be reformed and modified in order to avoid unintended consequences for family and employer-employee relationships.

The reasons for these recommendations concerning subrogation are contained in **Chapter 7** of this Report.

¹⁵ *Dunne v PJ White Construction Co Ltd and Payne* [1989] ILRM 803 and *Hu v Duleek Formwork Ltd and Aviva Direct Ltd* [2013] IEHC 50.

¹⁶ *Lister v Romford Ice and Cold Storage Co Ltd* [1957] AC 1955, *Sinnott v Quinnsworth Ltd and Durning* [1984] ILRM 523 and *Zurich Insurance Co v Shield Insurance Co Ltd* [1988] IR 174.

J Recommendation to replace the post-contractual duty of good faith with specific statutory duties, including a duty on consumers to pay premiums within a reasonable period and a duty on insurers to handle claims and complaints promptly and fairly

26. The duty to act with “utmost good faith” continues throughout the term of an insurance contract and during the period while a claim made by a consumer is being processed by an insurer.

As noted above, the Commission has recommended the abolition of the pre-contractual duty of utmost good faith and, for similar reasons, recommends its abolition at the post-contractual stage.

The Commission recommends that it should be replaced by a number of specific statutory obligations or duties, including a duty on consumers to pay premiums within a reasonable time and a duty on insurers to handle claims and complaints promptly and fairly.

The reasons for these and other related recommendations are provided in detail in **Chapter 8** of this Report.

K Recommendation to adapt existing legislation on unfair terms to insurance contracts

27. Existing legislation¹⁷ contains generally applicable rules on the enforceability (or otherwise) of unfair contract terms. This legislation forms part of the “general good requirements” with which insurers must comply.¹⁸

While these rules apply to insurance contracts, the Commission recommends that (a) there should be a specific statutory duty on insurers to draw attention to terms that are unfair or otherwise onerous and (b) that the general statutory provisions concerning unfair contract terms should be suitably adapted to insurance contracts.

The Commission also recommends that the law needs to be clarified so that insurance contract terms will not be deemed unfair where they have actually been considered by the insurer in the calculation of the premium and where they have been drawn to the attention of the consumer.

The reasons for these recommendations are set out in **Chapter 9** of this Report.

L Recommendation to consolidate and reform existing legislation to ensure that policyholders receive clearly written information on the essential terms of the insurance contract, including policy documents

28. Currently, insurers are required by legislation to provide policyholders with various written notices and policy documents both at the pre-contractual stage and the post-contractual stage (for example, at renewal).

However, these requirements are scattered in a disparate collection of primary and secondary legislation,¹⁹ some of which apply only when insurance contracts are entered into at a distance, including online, while others apply to both online and traditional forms of insurance provision.

¹⁷ *Sale of Goods and Supply of Services Act 1980; European Communities (Unfair Terms in Consumer Contracts) Regulations 1995* (SI No.27 of 1995), as amended, which implemented Directive 93/13/EEC, the 1993 Directive on Unfair Terms in Consumer Contracts; and *Consumer Protection Act 2007*, which implemented Directive 2005/29/EC, the 2005 Directive on Unfair Commercial Practices, and also consolidated other consumer protection legislation.

¹⁸ The EU-derived law that regulates insurance undertakings, discussed in Appendix C, below, imposes on insurers “general good requirements” which require them to comply with the general principles and rules of contract law, notably the statutory rules concerning supply of services, unfair terms and unfair commercial practices discussed in Chapter 9, below. See Article 24 of the *European Communities (Non-Life Insurance) Framework Regulations 1994* (SI No.359 of 1994) and Article 43 of the *European Communities (Life Assurance) Framework Regulations 1994* (SI No.360 of 1994).

29. The Commission recommends that these provisions on the form of the consumer insurance contract should be consolidated into a single piece of legislation, together with important reforms, including: (a) a general statutory duty on insurers to provide consumers with plainly written documents containing the essential terms of the contract (subject to the proviso that not all insurance contract terms need necessarily be in writing), (b) a duty to provide clear warnings of the consequences of non-compliance with the statutory duties proposed in this Report and (c) a duty to provide the policyholder with policy documents as soon as is practicable after the contract has been completed.

The Commission recommends that more detailed requirements, such as the precise content of warnings, should be set out in Regulations, or in a statutory Code of Practice (along the lines of the Central Bank's *Consumer Protection Code 2012*).

The Commission's detailed recommendations on this consolidation and reform of pre-contractual and post-contractual information to consumers are set out in **Chapter 10**.

M The Report takes account of previous reviews of insurance contract law in Ireland, and of EU and comparative developments

30. The Commission's review of the current law, and the consequent recommendations in this Report, have taken into account previous reviews of insurance law carried out in Ireland in recent decades, some of which have led to important, though limited, reforms.²⁰ Those previous reviews also called for a wide-ranging review of insurance contract law, such as that encompassed in this Report.

Insurance undertakings are not only an important part of the financial services sector in Ireland,²¹ but also form part of an increasingly international insurance sector.

31. At EU level, there has been significant harmonisation of aspects of the insurance market, notably in the areas of freedom of establishment of insurance undertakings and on related matters such as solvency requirements, but there has been relatively modest regulation of insurance contracts.²²

The European Commission has acknowledged that detailed reform of insurance contract law is likely to remain a matter for each Member State to pursue rather than a matter for EU

¹⁹ This includes: the *Life Assurance Act 1774*, the *Life Assurance (Ireland) Act 1866*, the *Marine Insurance Act 1906*, the *Insurance Act 1989*, the *Insurance Act 2000*, the *European Communities (Non-Life Insurance) Framework Regulations 1994* (SI No.359 of 1994), the *European Communities (Life Assurance) Framework Regulations 1994* (SI No.360 of 1994), the *Life Assurance (Provision of Information) Regulations 2001* (SI No.15 of 2001), the *European Communities (Distance Marketing of Consumer Financial Services) Regulations 2004* (SI No.853 of 2004) and the *Non-Life Insurance (Provision of Information) (Renewal of Policy of Insurance) Regulations 2007* (SI No.74 of 2007).

²⁰ These include the *Report of the Committee of Inquiry into the Insurance Industry* (Prl. 5530, 1976) (the O'Donoghue Report), available at oireachtas.ie (in the digitised library of documents laid before the Houses of the Oireachtas); the *Report of the Motor Insurance Advisory Board* (2002) (the MIAB Report), available at djei.ie; and *Competition Issues in the Non-Life Insurance Market: Final Report and Recommendations* (in two volumes, 2005), published by the Competition Authority (in 2014 amalgamated with the National Consumer Agency into the Competition and Consumer Protection Commission, the CCPC), available at ccpc.ie. See Appendix C for discussion of these Reports and resultant statutory reforms.

²¹ See Appendix C regarding the number of people directly employed in the insurance sector, the value of premiums written annually and the value of payments made under life and non-life insurance policies in Ireland.

²² As noted in Appendix C, below, the principal focus of the 2009 "Solvency II" Framework Directive, 2009/138/EC (which consolidates with amendments 13 EU Life and Non-Life Directives), is on general regulatory issues such as the right of establishment and solvency requirements for insurance undertakings. The 2009 Directive comprises 312 Articles, of which only Articles 183 to 186 impose contract-related provisions under the Heading "Information for Policyholders" in respect of life and non-life insurance.

harmonisation measures. However, it has also pointed out that differences in the respective insurance contract laws of Member States can constitute a significant barrier to the further development of the insurance sector in the EU.²³

32. In preparing this Report, therefore, the Commission has borne in mind that its recommendations should take account of developments in important centres of financial services with which Ireland has close ties, notably the United Kingdom. In this respect, since 2006 the Law Commission of England and Wales and the Scottish Law Commission have been engaged in a joint review of insurance contract law,²⁴ which has already resulted in the enactment of the UK *Consumer Insurance (Disclosure and Representations) Act 2012* and the UK *Insurance Act 2015*. These significant statutory reforms are likely to affect insurance undertakings operating in this State, and the Commission's recommendations in this Report have paid particular attention to them.
33. The Law Commission of England and Wales and the Scottish Law Commission were in turn influenced by the analysis contained in the Australian Law Reform Commission's seminal 1982 *Report on Insurance Contracts*,²⁵ which led to the enactment of the Australian *Insurance Contracts Act 1984*. That Report and the Australian experience of the reforms enacted in the 1984 Act also feature prominently in the analysis in this Report.
34. While further reform of insurance contract law is unlikely to occur at EU level, the Commission has also had the benefit of the publication in 2009 of *Principles of European Insurance Contract Law (PEICL)*, which contains a "model" Act of European insurance contract law drawn from the national laws of EU Member States, together with detailed commentary by leading European writers on insurance law.²⁶ Although the PEICL does not provide a suitable model for reform of all aspects of insurance contract law in the State, the accompanying commentary provides extremely helpful analysis of key insurance law principles.
35. Appendix A contains the full list of 105 recommendations made in this Report.
36. Appendix B contains a draft *Consumer Insurance Contracts Bill* to give effect to the recommendations in the Report, including that the main provisions on consumer insurance contracts should be consolidated, with reforms, in a single Act.
37. Appendix C contains an overview of the development of the regulation of insurance in Ireland. This includes the regulation of insurance undertakings, now largely derived from EU law and forming part of the wider regulation of financial services generally, notably the more stringent regulatory system put in place in the wake of the financial crisis that emerged in 2008.

²³ *Final Report of the Commission Expert Group on European Insurance Contract Law* (European Commission, 2014).

²⁴ The Law Commission of England and Wales and Scottish Law Commission have, since 2006, published 10 Issues Papers, three Consultation Papers and two Reports related to their insurance law project. The two Reports are *Consumer Insurance Law: Pre-contract Disclosure and Misrepresentation* (Law Com No.319/Scot Law Com No.219, 2009), which led to the UK *Consumer Insurance (Disclosure and Representations) Act 2012*; and *Insurance Contract Law: Business Disclosure, Warranties, Insurers' Remedies for Fraudulent Claims, and Late Payment* (Law Com No.353/Scot Law Com No.238, 2014), which led to the UK *Insurance Act 2015*. A third Report, which will include final recommendations on insurable interest and which will complete the Commissions' joint project, is in preparation at the time of writing (June 2015).

²⁵ Australian Law Reform Commission *Report on Insurance Contracts* (Report No.20, 1982).

²⁶ Basedow et al (eds) *Principles of European Insurance Contract Law (PEICL)* (Sellier, 2009), whose membership includes two English members who thus represent a common law tradition, including Professor John Birds, University of Manchester, co-editor of *MacGillivray on Insurance Law*, 12th ed (Sweet & Maxwell, 2012). See further Appendix C on the relationship between the PEICL and a possible proposal from the European Commission for an "Opt-In" Regulation on Insurance Contract Law.

This Appendix also discusses the relatively limited reform of insurance contract law to date in Ireland, while also noting previous recommendations for more significant reform in a number of reports on the Irish insurance industry.

The Appendix notes the importance of recent reform of insurance contract law in the United Kingdom, particularly because of the growing international nature of insurance undertakings. In addition, the Appendix refers to proposals being developed at EU level, including the development of the *Principles of European Insurance Contract Law* (PEICL), which contain an important analysis of the key principles of law in this area.

CHAPTER 1 SCOPE OF THE REPORT: CONSUMER INSURANCE CONTRACTS

A Scope of the Report

1.01 Comparable reviews of insurance contract law have considered whether proposed reforms should apply to consumers and businesses alike or whether differential regimes should apply. In this respect, three general approaches can be discerned.

- First, a single statutory regime that would apply to consumers and businesses alike, subject to some exclusions.¹
- Second, two separate statutory regimes: one for consumers (often defined as individuals) acting outside their trade or profession, with mandatory requirements and no opting out; and another for businesses with some mandatory requirements, but with the possibility of opting out of other requirements.²
- Third, two separate regimes: (a) a statutory regime for consumers, defined to include individuals acting outside their trade or profession and small businesses with bargaining powers similar to individuals; and (b) large businesses, with significant bargaining power, to be governed by the existing insurance contract law.

1.02 In the Consultation Paper the Commission provisionally recommended that the reforms being recommended for insurance contract law in this jurisdiction should adopt the third approach, so that the legislative framework proposed would apply to consumers as defined for the purposes of the jurisdiction of the Financial Services Ombudsman (FSO) and within the *Consumer Protection Code 2012*, namely natural persons and businesses with an annual turnover not exceeding €3 million.³ For the reasons outlined below, the Commission affirms that approach in this Report.

(1) *A single regime that applies to consumers and businesses*

1.03 The argument for a single insurance regime for consumers and businesses is that it would allow for one legal regime to apply regardless of the nature of the insurance contract. This would create certainty for insurers, consumers and business policyholders as to their respective rights and obligations under an insurance contract and would avoid demarcation between consumer and business insurance contracts.

1.04 The Australian Law Reform Commission (ALRC) recommended this approach because:

“If the general law of insurance is unfair to individuals, why is it not also unfair to individuals when they are in business? Most businessmen are not legal experts. Nor are they insurance

¹ This is the general approach in the Australian *Insurance Contracts Act 1984*, subject to some limitations: see fn5, below.

² Thus, the UK *Consumer Insurance (Disclosure and Representations) Act 2012*, which reformed the duty of disclosure, applies to consumers only, defined as an individual who enters into the contract wholly or mainly for purposes unrelated to the individual's trade, business or profession. The UK *Insurance Act 2015*, which contains further major reforms, including concerning insurance warranties, applies to both consumers as defined in the 2012 Act (that is, individuals) and also to businesses who take out insurance. The 2015 Act retains a distinction between the two categories by providing that in an insurance contract with a business the insurer may contract out of most of the 2015 Act, provided it states clearly in writing that it is doing this and draws specific attention to any disadvantageous terms (which the 2015 Act describes as transparency requirements): see further paragraph 1.06, below.

³ Law Reform Commission *Consultation Paper on Insurance Contracts* (LRC CP 65-2011) at paragraph 1.70.

experts. The cost to business of employing solicitors and brokers to avoid the difficulties to which existing law gives rise might well be reduced by a simpler and fairer set of rules applying to all insurance contracts. It could be added to by the creation of two sets of rules and by attendant difficulties of demarcation.”⁴

1.05 This general analysis was implemented in the Australian *Insurance Contracts Act 1984*, which in general does not differentiate between consumers and businesses. Nonetheless, a need to maintain a distinction between consumers and businesses in certain circumstances has arisen.⁵

(2) Separate regimes for individual consumers and businesses

1.06 Some jurisdictions, in response to concerns that a single insurance regime may impede the market in business-to-business transactions, have enacted separate regimes in which strict provisions apply in an insurer-to-consumer setting but which, in an insurer-to-business setting, allow for the legislative provisions to be varied by express agreement between contracting parties.

This is the approach of the United Kingdom where the *Consumer Insurance (Disclosure and Representations) Act 2012* is limited in application to consumers⁶ while the *Insurance Act 2015* applies to both consumers and non-consumers alike depending on the section of the 2015 Act in question.⁷

The insurer is prevented from contracting out of the provisions of the 2012 and 2015 Acts in an insurer-to-consumer setting.⁸ By contrast, the 2015 Act provides that insurers may contract out of most of the Act’s provisions in an insurer-to-business context⁹ (with the exception of the absolute prohibition upon “basis of contract” clauses),¹⁰ provided the insurer complies with the “transparency requirements” contained in the 2015 Act, that is, by drawing specific and clear attention to the contracting out terms.¹¹

This approach has the benefit of (a) providing insurers with the freedom to contract on an equal negotiating footing with large well resourced businesses and (b) providing consumers with some protections and certainty as to the applicable rules if a contract is challenged in the courts.

1.07 Whilst acknowledging this benefit, the Commission nonetheless takes the view that private individuals in today’s society require clear and unambiguous rights and protections against possible exploitation and that the bargaining powers of many small businesses are no greater than those of private individuals.

⁴ Australian Law Reform Commission *Report on Insurance Contracts* (Report No. 20,1982) at paragraph 26.

⁵ Certain aspects of the *Insurance Contracts Act 1984*, in particular reforms affecting the duty of disclosure (see Chapter 3 below), are limited to “eligible contracts,” defined as contracts where one of the parties is a natural person and the contract is wholly one or more of the following types: motor vehicle, home buildings, home contents, accident and sickness, consumer credit or travel insurance.

⁶ Section 1 of the 2015 Act defines a consumer as “an individual who enters into the contract wholly or mainly for purposes unrelated to the individual’s trade, business or profession.”

⁷ For example Part 1 of the 2015 Act which concerns the duty of fair representation (a reformulated duty of disclosure) is limited in application to non-consumer contracts, while sections 10 and 11, regarding warranties, apply to both.

⁸ Section 15 of the 2015 Act.

⁹ Section 16 of the 2015 Act.

¹⁰ Section 9 of the 2015 Act, which prohibits basis of contract clauses and converts them (and warranties with which they are closely connected) into representations, provides that an insurer is not permitted, even in an insurance contract with a business, to contract out of this important reform. The Commission discusses reform of basis of contract clauses and warranties in Chapter 4, below.

¹¹ Section 17 of the 2015 Act.

(a) A Single Regime for individual consumers and SMEs

1.08 The Financial Services Ombudsman (FSO), which was established under the *Central Bank and Financial Services Authority of Ireland Act 2004*,¹² independently and impartially investigates and resolves disputes between consumers and financial service providers. Insurance contract disputes account for half of all the complaints received by the FSO.¹³

1.09 Significantly, the 2004 Act defines a consumer for the purposes of the FSO's jurisdiction as: (a) a natural person when not acting in the course of, or in connection with, carrying on a business, or (b) a person, or group of persons, of a class prescribed in Regulations made by the Financial Services Ombudsman Council.¹⁴

1.10 As envisaged by the 2004 Act the FSO's jurisdiction was extended in 2005¹⁵ to include a person or group of persons (including limited companies and unincorporated bodies such as partnerships, charities, clubs, trusts and sole traders) having an annual turnover¹⁶ of €3 million or less in the financial year preceding the year in which a complaint is made to the FSO.¹⁷ The inclusion of such small and medium-sized enterprises within the FSO's jurisdiction was affirmed in 2014 in amending Regulations made by the Financial Services Ombudsman Council.¹⁸

Similarly, the Central Bank's *Consumer Protection Code 2012*,¹⁹ which has created enforceable standards for financial services contracts, including insurance contracts, and which in many respects amounts to a statutory statement of key contractual obligations, applies to both individual consumers and small and medium-sized enterprises.

The general principles of the 2012 Code apply to all "customers," which are defined as²⁰ any person to whom a regulated entity provides or offers to provide a product or service the subject of this Code, and

¹² Part VIIB of the *Central Bank Act 1942*, inserted by section 16 of the *Central Bank and Financial Services Authority of Ireland Act 2004*.

¹³ FSO *Bi-Annual Review January to June 2013* (2013) at 4.

¹⁴ The Council was established under section 57BF of the 1942 act, also inserted by the 2004 Act.

¹⁵ *Central Bank Act 1942 (Financial Services Ombudsman Council) Regulations 2005* (SI No.190 of 2005).

¹⁶ The 2005 Regulations, as amended by the *Central Bank Act 1942 (Financial Services Ombudsman Council) (Amendment) Regulations 2014* (SI No.164 of 2014), provide that the "turnover" of the person or group of persons is: (a) determined by calculating the income received from the person's or group of persons' sales and services falling within the person's or group of persons' ordinary activities after deduction of sales rebates; and (b) calculated in respect of the financial year prior to the year in which the complaint is made to the FSO and not the year or years in which the conduct complained of occurred.

¹⁷ In *Hooper Dolan v Financial Services Ombudsman* [2011] IEHC 296 the High Court (MacMenamin J) upheld the ability of the Financial Services Council to expand the definition under section 57BA of the 1942 Act. In *Lyons and Murray v Financial Services Ombudsman* [2011] IEHC 454, the High Court (Hogan J) without referencing *Hooper* queried if this expanded definition would survive a constitutional challenge in the light of Article 15.2.1° of the Constitution. At the time of writing (June 2015) the *Lyons and Murray* case is under appeal.

¹⁸ *Central Bank Act 1942 (Financial Services Ombudsman Council) (Amendment) Regulations 2014* (SI No.164 of 2014).

¹⁹ The 2012 Code replaced the 2006 *Consumer Protection Code*. Like the 2006 Code, the 2012 Code was issued under the following statutory powers: (a) section 117 of the *Central Bank Act 1989*; (b) sections 23 and 37 of the *Investment Intermediaries Act 1995*; (c) section 8H of the *Consumer Credit Act 1995*; and (d) section 61 of the *Insurance Act 1989*. The *Consumer Protection Code 2012* is more detailed than the previous *Consumer Protection Code* published in 2006. This reflects a more robust "principles and rules" approach to regulation introduced in the wake of the financial crisis that emerged in 2008.

²⁰ Central Bank of Ireland *Consumer Protection Code 2012* at 73.

any person who requests such a product or service.” Under the Code, a person means “a natural person or a legal person.”²¹

1.11 The other chapters of the 2012 Code apply to customers who fall within the definition of a consumer²² as defined for the purposes of the FSO, that is, individuals and small businesses with a turnover not exceeding €3 million.

1.12 The aspects of the Code that focus on insurance, and which incorporate and supersede the comparable provisions of the non-statutory Insurance Ireland Codes,²³ predominantly adopt the broader FSO definition of a consumer rather than being limited to personal, individual consumers.

1.13 In summary, existing financial services legislation in Ireland (which includes insurance undertakings) recognises that individual consumers and small businesses should have comparable legal protections because of their comparable bargaining powers, and whereas large commercial enterprises can use commercial power to negotiate tailored contract terms, small businesses and private individuals are often restricted to standardised insurance contracts offered on a “take it or leave it” basis.

(b) Consideration of the UK approach

1.14 The Law Commission of England and Wales and Scottish Law Commission,²⁴ in their 2007 Consultation Paper, remarked that many small businesses are in a similar position to individual consumers and in their 2009 Issues Paper No.5 proposed that “micro-businesses” should be treated in the same way as individual consumers. However in their 2012 Consultation Paper, they decided not to provide additional protection to “micro-businesses”, instead proposing to include them in the general insurance regime for business insurance.

1.15 As a result, the UK has limited the definition of the consumer in both the *Consumer Insurance (Disclosure and Representations) Act 2012* and the *Insurance Act 2015* to an “individual who enters into the contract wholly or mainly for purposes unrelated to the individual’s trade, business or profession”.²⁵

1.16 This change of opinion by the Commissions occurred for a number of reasons.²⁶

1.17 First, they stated that there was difficulty in creating a definition of a micro-business which could apply at the time when the contract was formed. They considered that the UK’s Financial Ombudsman Service definition, based on EU Recommendation 2003/361, was too complicated for most small businesses to understand when they took out insurance.

²¹ Central Bank of Ireland *Consumer Protection Code 2012* at 75.

²² Some provisions of the 2012 Code are specifically restricted to a personal consumer, that is, a consumer who is a natural person acting outside his or her business, trade or profession. The 2012 Code also defines a “vulnerable consumer” as a natural person who: (a) has the capacity to make his or her own decisions but who, because of individual circumstances, may require assistance to do so (for example, hearing impaired or visually impaired persons); and/or (b) has limited capacity to make his or her own decisions and who requires assistance to do so (for example, persons with intellectual disabilities or mental health difficulties). The *Assisted Decision-Making (Capacity) Bill 2013* uses the term “relevant person” rather than “vulnerable person.” On the terminology challenges in this context (often referred to as the “euphemism treadmill”) see also the Commission’s *Report on Sexual Offences and Capacity to Consent* (LRC 109-2013), Introduction, paragraphs 2-11.

²³ The specific provisions of these Codes are discussed in relevant Chapters of this Report. The origins and non-enforceable nature of the Insurance Ireland Codes are discussed in Appendix C, below.

²⁴ The Law Commission of England and Wales and Scottish Law Commission joint project on insurance law, which began in 2006, is discussed in Appendix C, below.

²⁵ See the definitions of consumer in section 1 of the *Consumer Insurance (Disclosure and Representations) Act 2012* and section 1 of the *Insurance Act 2015*.

²⁶ Law Commission of England and Wales and Scottish Law Commission *Consultation Paper on Insurance Contract Law: The Business Insured’s Duty of Disclosure and the Law of Warranties* (Law Com. No.204/Scot Law Com. No.155, 2012), Appendix A.

1.18 Second, the Commissions identified some problems with a “turnover based” test, including the date of calculation of the turnover. In Ireland, the FSO has not encountered this difficulty in applying the turnover test, because it is assessed on the basis of the financial year prior to the making of the complaint. Similarly, in the context of an insurance contract, the turnover test can be based on the financial year prior to entering into the insurance policy.

1.19 Some insurers voiced concerns that they would need to ask additional questions and re-programme their systems to distinguish between micro-businesses and others which would impose additional costs. It was accepted that while many insurers already adhere to this there is little consistent practice across the industry.²⁷ The Commission does not consider that this will be unduly burdensome because insurers already must obtain business details from small commercial clients in order to assess and determine risk.

1.20 Finally, it was suggested that in cases of hardship the UK Financial Ombudsman Service provides the necessary protection for micro-businesses. The Irish FSO similarly alleviates hardship, but a standardised approach rather than the individualist nature of the FSO approach may well be appropriate.

(c) Conclusion: reforms should apply to consumer as defined for the FSO

1.21 In the Consultation Paper, the Commission recognised that not all businesses are sophisticated commercial entities with specialist knowledge of insurance law and that the business sector in Ireland consists of a large number of entities of varying size, sophistication and expertise.

The benefit of the FSO’s turnover test – notwithstanding that the Law Commission of England and Wales and Scottish Law Commission have stated that this can be a rather crude method of determining which regime a policy will fall under – is that it is easily understood and requires information that businesses already have.

As to a difficulty with the delay between the turnover figure being calculated and bringing a claim under the policy, this is addressed by the FSO jurisdiction, by requiring the turnover to be that of the financial year prior to the complaint being made, which for insurance contract purposes means the financial year prior to the insurance policy being completed.

As to any difficulty in determining a turnover figure for start-up businesses, the Commission has not identified this as a major point of difficulty for the FSO, which has been in operation for over a decade.

1.22 The Commission’s 2010 *Report on Personal Debt Management and Debt Enforcement*, which proposed a new non-judicial personal insolvency regime, recommended that this should apply to personal debt, including where relevant debt connected with the debtor’s employment or business.²⁸ It was therefore designed to be of use to persons who were or are involved in the small and medium-sized enterprise sector.

The inclusion in the 2010 Report of business-related debts was also derived from the jurisdiction of the FSO.²⁹ The *Personal Insolvency Act 2012*, which implemented the key elements of the 2010 Report, also adopted this wider FSO-related definition of consumer debt.

1.23 Admittedly, limiting the scope of the Report to consumers as natural persons entering into contracts not connected to a business would have the benefit of clarity, and is also the approach used in the *European Communities (Unfair Terms in Consumer Contracts) Regulations 1995* and the *Consumer Protection Act 2007*.³⁰ However, legislation such as the *Sale of Goods and Supply of Services Act 1980* also provide for enforceable statutory contract rules in the business-to-business setting, and these are

²⁷ Law Commission of England and Wales and Scottish Law Commission *Consultation Paper on Insurance Contract Law: The Business Insured’s Duty of Disclosure and the Law of Warranties* (Law Com. No.204/Scot Law Com. No.155, 2012), Appendix A.67.

²⁸ Law Reform Commission *Report on Personal Debt Management and Debt Enforcement* (LRC 100-2010), Introduction, paragraph 20, fn16.

²⁹ *Ibid.*

³⁰ See generally Chapter 10, below.

being maintained in place while its provisions on “natural person consumers” are being reformed in the proposed *Consumer Rights Bill*.³¹ Many small businesses in Ireland purchase insurance in much the same way as individuals (“natural persons”), and often there is little distinction between those two categories in this specific type of contract with which this Report is concerned.

The fact is that small business owners are often no more sophisticated or experienced than their individual counterparts (“natural persons”). This reality has been recognised in the scope of the jurisdiction of the FSO which includes business entities with an annual turnover of up to €3 million, as affirmed in 2014,³² and by the Central Bank which in its *Consumer Protection Code 2012* includes in the definition of “consumer” incorporated entities with an annual turnover of up to €3 million.

1.24 The Commission recommends that the legislative framework proposed in this Report should apply to consumers as defined for the purposes of the jurisdiction of the Financial Services Ombudsman and in the Central Bank’s *Consumer Protection Code 2012*, namely, natural persons and a person or group of persons (including limited companies and unincorporated bodies such as partnerships, charities, clubs, trusts and sole traders) having an annual turnover of €3 million or less in the preceding financial year.

(3) The status of statutory and non-statutory codes in litigation³³

1.25 In the Consultation Paper, the Commission provisionally recommended that codes of practice setting out standards of best practice in insurance contracts should be admissible in evidence in any litigation or other dispute resolution process.

1.26 Currently there is an anomaly in the law, because, whereas statutory codes of practice such as the Central Bank’s *Consumer Protection Code 2012* may not be admissible in legal proceedings, non-statutory or voluntary codes of conduct such as Insurance Ireland’s Codes of Practice on Insurance (which the Commission discusses in detail in the succeeding chapters of this Report) or voluntary codes made under the *Consumer Protection Act 2007* may be admissible in legal proceedings.³⁴

³¹ In May 2015, the Department of Jobs, Enterprise and Innovation published the *Scheme of a Consumer Rights Bill* (following the Department’s 2014 *Consultation Paper on Reform of the Law on Consumer Contract Rights*, both available at djei.ie). If enacted, the Bill would repeal, with significant reforms, the *Sale of Goods Act 1893* and the *Sale of Goods and Supply of Services Act 1980* insofar as those Acts deal with consumer contracts. To the extent that those Acts deal with business-to-business contracts, they are being retained pending the introduction by the Department of an updated and reformed *Sale of Goods and Supply of Services Bill*: see the Explanatory Note to Head 6 of the *Scheme of a Consumer Rights Bill*. In the draft Bill in Appendix B, below, the Commission has followed the definition given to an individual consumer in the *Scheme of a Consumer Rights Bill*, namely “a natural person who is acting for purposes that are wholly or mainly outside his or her trade, business, craft or profession.”

³² *Central Bank Act 1942 (Financial Services Ombudsman Council) (Amendment) Regulations 2014* (SI No.164 of 2014).

³³ The development of non-statutory codes, such as Insurance Ireland’s Codes of Practice, and statutory codes, such as the Central Bank’s *Consumer Protection Code 2012*, is discussed in more detail in Appendix C of the Report, below.

³⁴ Section 89 of the *Consumer Protection Act 2007* provides that the relevant provisions of any voluntary codes of practice may be taken into account by a court where this is of assistance and relevant to determine whether there has been a breach of the 2007 Act. Section 2 of the 2007 Act defines a code of practice as “any code, agreement or set of rules or standards that is not imposed by or under an enactment but purports to govern or define commercial practices of one or more traders, whether generally or in respect of a particular trade, business or professional sector or one or more commercial practices who agree, commit or undertake to abide or be bound by such rules or standards.” The definition of a “code of practice” appears to be limited to voluntary codes and therefore would not appear to be applicable to statutory codes of practice such as the *Consumer Protection Code 2012*.

This is especially important in insurance contract law because some insurers have successfully sought in litigation to avoid the application of the provisions of the voluntary Insurance Ireland Codes.³⁵ It is also important because, in a number of areas, the *Consumer Protection Code 2012* has superseded the Insurance Ireland Codes and therefore its status should be clear.

1.27 The 2012 Code is enforceable by the Central Bank acting in its regulatory capacity. Therefore the 2012 Code contains important and significant consumer protection requirements which financial service providers, including insurers, must take seriously at the risk of enforcement action by the Central Bank.³⁶

1.28 In *Irish Life and Permanent plc v Dunne and Dunphy*³⁷ the Supreme Court held that while non-compliance with a statutory Code issued by the Central Bank, in that case the *Code of Conduct on Mortgage Arrears*, was not intended to render illegal a loan agreement, nonetheless, a breach of the terms of the Code could have some important effects where the lender sought to enforce the terms of a contract. In the *Dunne* case, the defendants sought to resist the plaintiff lender's application for repossession of their property on the ground that the plaintiff had not complied with the provisions of the Code. The Supreme Court held where a breach of the Code involves a failure by a lender to abide by the moratorium on repossession referred to in the Code (although in no other circumstances), non-compliance with the Code affects, as a matter of law, a relevant lender's entitlement to obtain an order for possession. The Court added that it is a matter for the relevant lender to establish by appropriate evidence in any application before the Court that compliance with that aspect of the Code has occurred.

1.29 The Supreme Court decision in *Irish Life and Permanent plc v Dunne and Dunphy* affirmed the approach that had been taken in a number of High Court decisions.

Thus, in *Stepstone Mortgage Funding Ltd v Fitzell*³⁸ the High Court (Laffoy J) had refused to make an order for possession of a family home where the lender was in breach of the Code of Conduct on Mortgage Arrears.

Similarly, in *Irish Life and Permanent plc v Financial Services Ombudsman*,³⁹ the High Court (Hogan J) suggested that the Consumer Protection Code could be taken into account in an individual case. While the Court acknowledged that the legislative provisions under which the Code was made are silent on the enforceability of a contract found to be in breach of its provisions,⁴⁰ the Court rejected the view that the Code was to be regarded as entirely a species of "soft" law, that is, not susceptible to legal enforcement. This analysis was approved by the Supreme Court in *Irish Life and Permanent plc v Dunne and Dunphy*.

1.30 The Commission considers that any code of practice that contains practical guidance which would assist a court or other adjudicatory body such as the FSO in determining any issue before it should be admissible for that purpose and capable of being taken into account by the court.

1.31 This should apply regardless of whether this assistance is provided by an entirely voluntary code of practice (such as the original Insurance Ireland Codes of Practice); by a code of practice agreed under a statutory regime which does not have statutory effect (such as a code agreed under section 13(2) of the *Data Protection Act 1988*); by a statutory code which appears to be enforceable only by the relevant regulator (for example the 2012 Code subject to comments in the *Irish Life and Permanent* case, above);

³⁵ See the discussion of *Justice (decd) v St Paul Ireland*, Circuit Court, 25 November 2004, in Appendix C, below, cited in Buckley "Insurers' Self Regulation does not work" [2005] CLP 10 and Buckley *Insurance Law* 3rd ed (Thomson Round Hall, 2012), paragraph 1-19.

³⁶ Section 48 of the *Central Bank (Supervision and Enforcement) Act 2013* empowers the Central Bank to make Regulations for the proper and effective regulation of regulated financial service providers, including insurers. Such Regulations could include matters currently contained in the *Consumer Protection Code 2012*.

³⁷ [2015] IESC 46.

³⁸ [2012] IEHC 142; [2012] 2 IR 318.

³⁹ [2012] IEHC 367. See also *Zurich Bank v McConnon* [2011] IEHC 75 and Donnelly "Banking and Security Law Update" (2011) 18 CLP 114.

⁴⁰ *Ibid* at paragraph 55.

or by a code that has the same status as a statutory instrument (such as a code made under section 13(3) of the *Data Protection Act 1988*).

1.32 **The Commission recommends that a code of practice, whether made under statutory authority or otherwise, which contains practical guidance that would assist a court or other adjudicatory body such as the FSO in determining any issue before it in connection with a consumer insurance contract, should be admissible and may be taken into account for that purpose.**

(4) General application to life and non-life insurance; and exclusion of certain insurance-related matters

1.33 Except where otherwise provided, this Report applies to an insurance contract, whether life insurance or non-life insurance, entered into between a consumer, as defined above, and an insurer (that is, an insurance undertaking licensed by the Central Bank of Ireland to provide life insurance or non-life insurance in the State or an undertaking otherwise lawfully carrying on the business of an insurance undertaking in the State). The proviso “except where otherwise provided” allows for the specific situations in the Report where provisions apply only to life insurance or, as the case may be, non-life insurance: see for example the different periods related to notice of renewal of life and non-life contracts discussed in Chapter 10 of the Report.

1.34 The Report does not consider or make any recommendations that would alter or affect any contractual rights or other obligations concerning:

- insurance brokers or insurance intermediaries,
- a contract of reinsurance, or
- a contract of marine, air or transport insurance (MAT insurance).

1.35 Thus, insurance brokers and intermediaries are regulated by the *Investment Intermediaries Act 1995*, and in the context of insurance contracts their role may give rise to civil liability in contract or in tort.⁴¹ Similarly, contracts of reinsurance are separately regulated, including under EU-derived legislation such as the *European Communities (Reinsurance) Regulations 2006*.⁴² MAT insurance is regulated in part by, for example, the *Marine Insurance Act 1906* and in part by international conventions. In the case of air travel, insurance cover and related liability provisions are regulated by the 1999 Convention for the Unification of Certain Rules for International Carriage by Air (the Montreal Convention), which was implemented in the *Air Navigation (International Conventions) Act 2004*; and by Regulation (EC) No.2027/97 on air carrier liability in the event of accidents, which includes compulsory insurance requirements for EU air carriers. These matters are excluded from the scope of the Report because of these separate regulatory arrangements, and any reforms concerning them would require separate review (and are, in some instances, a matter for regulation at EU or international level).

1.36 The succeeding chapters of this Report make extensive references to the *Marine Insurance Act 1906*. This is because the 1906 Act contains a number of provisions that have codified some common law principles and rules of insurance contract law and these have therefore been applied by the courts outside the marine context in which they appear in the 1906 Act. For this reason, the Commission has concluded that it would be prudent, in order to remove any doubt on the matter, to provide that nothing in the 1906 Act is to apply to the insurance contracts with which the recommendations made in this Report are concerned. It remains for separate consideration whether the 1906 Act, to the extent that it applies to marine insurance and to insurance contracts that fall outside the scope of the proposals in this Report, should be reviewed with a view to its reform.

⁴¹ The decision of the Supreme Court in *Chariot Inns Ltd v Assicurazioni Generali Spa and Coyle Hamilton Hamilton Phillips Ltd* [1981] IR 199, discussed in Chapter 2 in the context of the pre-contractual duty of disclosure, also considered the liability in tort of the second defendant, an insurance broker.

⁴² SI No.380 of 2006, which implemented Directive 2005/68/EC, the 2005 EU Directive on Reinsurance.

1.37 The Commission recommends that, except where otherwise provided, the legislative framework proposed in this Report applies in general to contracts of insurance, both life and non-life, made between a consumer and an insurer (that is, an insurance undertaking licensed by the Central Bank of Ireland to provide life insurance or non-life insurance in the State, or an undertaking otherwise lawfully carrying on the business of an insurance undertaking in the State).

1.38 The Commission recommends that the legislative framework proposed in this Report does not alter or affect any rights or obligations concerning or arising from: (a) the duties of an insurance broker or insurance intermediary, (b) contracts of reinsurance, or (c) contracts of marine, air or transport (MAT) insurance.

1.39 The Commission recommends that no provision of the *Marine Insurance Act 1906* should apply to a contract of insurance with which this Report is concerned.

B Note on Use of “Consumer” rather than “Proposer”, “Policyholder” or “Insured” in the Report

1.40 In the textbooks and literature on insurance the term “proposer” is, in general, used to refer to a person who applies for insurance cover, which may be done by completing a proposal form supplied by the insurer. The term “policyholder” is, in general, used to refer to a person who has obtained insurance cover, that is, who has agreed an insurance contract. The term “insured” is also used in reference to a policyholder. Consequentially these terms are found in the Report, in particular when quoting from other sources.

1.41 Nonetheless, in order to underline the application of the recommendations in this Report to consumers, as defined above, the Commission has where possible used the term “consumer” in the text of the Report, rather than “proposer”, “policyholder” or “insured”. This includes its use in the draft *Consumer Insurance Contracts Bill* in Appendix B of the Report, which is intended to implement the recommendations in the Report.

CHAPTER 2 PRE-CONTRACTUAL DUTIES: UTMOST GOOD FAITH AND THE DUTY OF DISCLOSURE

A Current Law on Utmost Good Faith and Pre-Contractual Disclosure

(1) *Utmost good faith and the duty of disclosure: from Carter v Boehm to the Marine Insurance Act 1906*

2.01 The principle of utmost good faith (*uberrima fides*)¹ in insurance contracts and the related duty of disclosure were first identified in the 18th century case *Carter v Boehm*.² The plaintiff (Mr Carter) was the Governor of Fort Marlborough in Sumatra which at that time was under the control of the British East India Company. He had agreed a one year policy of property insurance with the defendant (Mr Boehm), who underwrote the risk of property loss in the event that the fort was attacked and overrun.

After the contract had been concluded, a French warship attacked and overran the fort and the plaintiff claimed under the policy for his losses. The defendant repudiated liability, primarily on the ground that the plaintiff had not disclosed the contents of a letter given to him which had indicated that the port might be attacked. Having heard the evidence in the case, a jury concluded that the defendant was not entitled to repudiate.

2.02 The defendant then applied to the Court of King's Bench for a retrial of the action. Delivering the Court's judgment, Lord Mansfield CJ (whose judgments in a number of cases developed key principles of English mercantile or commercial law) rejected the application, and the plaintiff's claim therefore succeeded. Lord Mansfield stated that the case turned on the principle of good faith, which he explained as follows:³

"The governing principle is applicable to all contracts and dealings. Good faith forbids either party by concealing what he privately knows, to draw the other into a bargain, from his ignorance of the fact, and his believing the contrary. But either party may be innocently silent, as to grounds open to both, to exercise their judgment upon. *Aliud est celare; aliud, tacere; neque enim id est celare quicquid reticeas; sed cum quod tuscias, id ignorare emolumenti tui causa velis eos, quorum intersit id scire.* Cicero, *De Off*, lib. 3, c.12, 13...⁴ The reason of the

¹ For an overview of the principle of utmost good faith in insurance contracts, see Buckley *Insurance Law* 3rd ed (Thomson Round Hall, 2012), Chapter 3.

² (1766) 3 Burr 1905.

³ *Ibid* at 1910-11.

⁴ This quotation from Cicero's *De Officiis* (*Of Duties*, written in 44 BC, Book 3 of which is titled *The Conflict between the Right and the Expedient*) can be translated as follows: "It is one thing to conceal, not to reveal is quite a different thing... The fact is that merely holding one's peace about a thing does not constitute concealment, but concealment consists in trying for your own profit to keep others from finding out something that you know, when it is for their interest to know it." Cicero's *De Officiis* was a widely prescribed text in English universities in the 18th century and, as indicated by its citation in *Carter v Boehm*, it also influenced key principles in the emerging English mercantile and commercial law of that time. Cicero's views on "concealment" in *De Officiis* were also cited by the 18th century French jurist Robert Pothier in his textbook on sale of goods law, *Traité du Contrat de Vente*. Pothier was one of the "founding fathers" of the Napoleonic *Code Civil des Français*. Pothier's work also influenced the drafting of the *Sale of Goods Act 1893*. In addition, both Cicero and Pothier were quoted extensively by Joseph Story, Professor of Law in Harvard University and a US Supreme Court Justice, in Story, *Commentaries on Equity Jurisprudence, as Administered in England and America* (the leading early 19th century textbook on equity, first published in 1835). It is thus clear that

rule which obliges parties to disclose is to prevent fraud and to encourage good faith. It is adapted to such facts as vary the nature of the contract which one privately knows, and the other is ignorant of and has no reason to suspect.”

2.03 As this quotation clearly indicates, Lord Mansfield considered that the principle of good faith was “applicable to all contracts and dealings” but subsequent English case law from the 19th century onwards largely confined its application to the insurance contract setting and to link the principle to a specific duty of disclosure in insurance.

The Commission discusses elsewhere in this Report⁵ the emergence since the second half of the 20th century both in case law and legislation of a separate, though related, requirement of “good faith” in contract law generally. This emergence is derived, in part, from common law principles and rules concerning onerous or unfair contract terms and, in part, from EU (and civil law) principles concerning unfair contract terms.

This more recent, and generally applicable, concept of “good faith” now forms part of the statutory regime aimed at providing greater consumer protection in contracts for the supply of services, which includes insurance contracts.

It is important to bear in mind, therefore, that regardless of any reforms proposed in this Report concerning “utmost good faith” as it applies in insurance contract law, the separate “good faith” principle that now forms part of general contract law, and in particular the statutory consumer protection regime, will continue to apply to insurance contracts.

2.04 Returning to *Carter v Boehm*, Lord Mansfield declared that the good faith principle applied to both proposer and insurer, pointing out that a proposer often has exclusive access to specific information and an insurer relies on a proposer to disclose that information. He stated that the withholding of such information, even without any fraudulent intention, would be contrary to the good faith principle and would render the policy void.

Equally, however he held that an insurer might have specific information that a proposer did not have, for example, that a ship had already safely arrived at its destination. If an insurer agreed to insure the ship in those circumstances, a policyholder would be entitled to recover the insurance premium from the insurer.⁶

2.05 Lord Mansfield listed situations where proposers are not required to disclose information and can remain “innocently silent” (for example, matters about which the insurer actually knows or “ought to know”, matters of speculation, or the risks arising from natural perils such as lightning, or “political perils from the ruptures of States from war and the various operations of it”).⁷ These and other exceptions to the duty of disclosure were subsequently codified in the *Marine Insurance Act 1906*, discussed below.

The exceptions listed by Lord Mansfield were of direct relevance to the plaintiff’s successful claim under the insurance policy. The Court concluded that the letter that had not been disclosed to the defendant amounted to nothing more than speculation and therefore could not, even if disclosed, have influenced or affected the insurer’s decision to underwrite the risk or the premium charged. Furthermore, the defendant insurer was himself in breach of the good faith principle by asserting, after the event, that the non-disclosure entitled him to repudiate the policy.

important principles in modern commercial law and equity can be traced to Cicero, even if he is rarely cited in 21st century case law. For an example of the continuing influence of Cicero’s political speeches in an extra-judicial context in Northern Ireland in 2003, see Gillen “*O Tempore, O Mores*” (2004) 55 NILQ 55, cited in the Commission’s *Report on Children and the Law: Medical Treatment* (LRC 103-2011), at paragraph 2.91, fn118.

⁵ See Chapter 9, on Unfair Terms.

⁶ (1766) 3 Burr 1905, at 1910.

⁷ *Ibid* at 1911.

2.06 The mutual nature of the principle of good faith, as described and applied in *Carter v Boehm*, was recognised in the codifying⁸ section 17 of the *Marine Insurance Act 1906* which provides:

“A contract of marine insurance is a contract based upon the utmost good faith, and, *if the utmost good faith be not observed by either party*, the contract may be avoided by the other party.” (emphasis added)

While framed as a mutual obligation between the proposer and the insurer, and appearing fair and equal, the principle has often favoured the insurer and in *Carter v Boehm*⁹ Lord Mansfield observed that:¹⁰

“the special facts, upon which the contingent chance is to be computed, lie most commonly in the knowledge of the insured only.”

2.07 Although in *Carter v Boehm* the insurer was in possession of better knowledge of the risk than the proposer, the dictum of Lord Mansfield indicating that the good faith principle should, in general, translate into a duty of disclosure on the proposer, was codified in section 18(1) of the 1906 Act in the following terms:

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

Furthermore, section 18(2) of the 1906 Act provides that a “material circumstance” is one:

“which would influence the judgment of a prudent insurer on fixing the premium, or determining whether he will take the risk.”¹¹

There is no duty to disclose circumstances that the proposer did not know nor could not reasonably be expected to have known¹² but “wilful ignorance” may be sufficient to constitute actual knowledge.¹³ It is also important to note that section 18(2) of the 1906 Act refers to material circumstances that “would influence” the judgment of a prudent insurer. This is a much wider concept than circumstances that actually influence the judgment of a particular insurer in a specific contract.

2.08 Section 18(3) of the 1906 Act also codifies the exceptions to the duty of disclosure, some of which were identified by Lord Mansfield in *Carter v Boehm*. Others were added in later cases. Section 18(3) provides that, in the absence of inquiry by the insurer, the following circumstances need not be disclosed:

⁸ The Long Title to the 1906 Act provides that it is “[a]n Act to codify the Law relating to Marine Insurance”. Thus, as intended by its drafter Sir Mackenzie Chalmers (who also drafted the codifying *Sale of Goods Act 1893*, discussed in Chapter 9, below), the 1906 Act is a codification of the common law principles and rules on marine insurance contracts developed by the end of the 19th century. While many provisions of the 1906 Act apply exclusively to marine insurance, section 17 is recognised as being among a number of codifying sections in the 1906 Act that can be applied to other forms of insurance, such as the non-life fire insurance at issue in *Chariot Inns Ltd v Assicurazioni Generali Spa and Coyle Hamilton Hamilton Phillips Ltd* [1981] IR 199, discussed below.

⁹ (1766) 3 Burr 1905.

¹⁰ *Ibid* at 1909-10.

¹¹ Section 18(4) of the 1906 Act provides: “Whether any particular circumstance, which is not disclosed, be material or not is, in each case, a question of fact.” Section 18(5) of the 1906 Act provides: “The term ‘circumstance’ includes any communication made to, or information received by, the assured.”

¹² See *Joel v Law Union and Crown Insurance Co* [1908] 2 KB 863. This case concerned a proposer who had experienced headaches that later transpired to be the result of a brain tumour.

¹³ See *Keating v New Ireland Assurance Co plc* [1990] 2 IR 383 and *Coleman v New Ireland Assurance plc* [2009] IEHC 273, at paragraph 4.7 of the judgment, which refers to “wilful ignorance or deliberate or culpable forgetfulness.”

“(a) any circumstance which diminishes the risk;¹⁴

(b) any circumstance which is known or presumed to be known to the insurer. The insurer is presumed to know matters of common notoriety or knowledge, and matters which an insurer in the ordinary course of his business, as such, ought to know;¹⁵

(c) any circumstances as to which information is waived by the insurer;¹⁶

(d) any circumstance which it is superfluous to disclose by reason of any express or implied warranty.”¹⁷

(2) The duty of disclosure, the prudent insurer and the objective test of materiality: the Chariot Inns case

2.09 In the 1981 decision *Chariot Inns Ltd v Assicurazioni Generali Spa and Coyle Hamilton Hamilton Phillips Ltd*,¹⁸ which concerned a claim under a fire insurance policy, the Supreme Court confirmed that section 18 of the 1906 Act had codified the test of disclosure for insurance generally. The Court also applied an objective test of materiality, that is, that the non-disclosure could have affected the decision to take on the insurance risk, and not a subjective test, that it actually affected the decision-making of the insurer. More recent Supreme Court decisions have modified this approach in favour of a subjective test of materiality.

2.10 In *Chariot Inns*, a director of the plaintiff company, which owned a premises called the Chariot Inn, was also the director of another company, Consolidated Investment Ltd, which had stored in its premises some furniture from the Chariot Inn. The furniture was subsequently destroyed there in a fire, and Consolidated Investment Ltd successfully made a claim under its fire insurance policy with its insurance company, Sun Alliance. Two years later, the plaintiff company sought fire insurance for the Chariot Inn from the first defendant insurance company, with the advice and assistance of the second defendant, an insurance broker.

The defendant company’s proposal form required the plaintiff to state its claims experience for loss over the previous 5 years. The director of the plaintiff company, who completed and signed the proposal form, asked the broker whether he should refer to the fire claim made two years previously by Consolidated Investment Ltd. The second defendant advised him that, as that had involved a claim by a different company, he should not, and on this advice he entered “none” in the proposal form in answer to this question. The proposal form also stated that the plaintiff warranted that the statements made on the proposal form were “true and complete.”

2.11 The Chariot Inn was subsequently completely destroyed in a fire and the plaintiff made a claim under the policy. The defendant company repudiated the claims on the basis of non-disclosure, and the plaintiff then brought proceedings against the first defendant to enforce the policy, and claimed damages from the second defendant broker in negligence because of the advice given to the plaintiff. In the High Court, the plaintiff was successful against both defendants. On appeal, the Supreme Court dismissed the claim against the first defendant but held that the broker had been negligent and awarded damages in the

¹⁴ See *Manor Park Homebuilders Ltd v AIG Europe (Ireland) Ltd* [2008] IEHC 174; [2009] 1 ILRM 190, discussed below.

¹⁵ An insurer may not invoke non-disclosure of a material fact where the fact is one that an insurer is deemed to know. An insurer who is active in a specific trade or industry will be deemed to know what the characteristics of the sector are, the kind of goods used and activities that are undertaken respectively. See the decision of the Supreme Court in *Brady v Irish National Insurance Ltd* [1986] IR 698.

¹⁶ See *Aro Road and Land Vehicles Ltd v Insurance Corporation of Ireland Ltd* [1986] IR 403, discussed below.

¹⁷ See *Ross v Bradshaw* (1761) 1 Wm BI 312.

¹⁸ [1981] IR 199. The only judgment was delivered by Kenny J, with whom the other members of the Supreme Court, Henchy and Griffin JJ, concurred.

plaintiff's favour on that account. The Court described the principle of utmost good faith and the duty of disclosure in the following terms:¹⁹

"A contract of insurance requires the highest standard of accuracy, good faith, candour and disclosure by the insured when making a proposal for insurance to an insurance company."

2.12 The Court also held that the standard to be applied to materiality is the objective test of constructive knowledge:²⁰

"It is not what the person seeking insurance regards as material, nor is it what the insurance company regards as material. It is a matter or circumstance which would reasonably influence the judgment of a prudent insurer in deciding whether he would take the risk, and, if so, in determining the premium which he would demand. The standard by which materiality is to be judged is objective and not subjective."

2.13 A strictly objective test holds that the duty of disclosure does not depend on the proposer's awareness of its existence. The question of what is a material circumstance requires the proposer to have an awareness of the factors that would be relevant to an insurer, even if the insurer has not explained its business or prompted the proposer in any way. The onus of proof is on the insurer to establish that the undisclosed information was material to a prudent insurer, but the Supreme Court in the *Chariot Inns* case also confirmed the English case law that the insurer need not establish that this had *actually* affected its judgment. The Court cited with approval the following observations of MacKinnon LJ in the English Court of Appeal decision in *Zurich General Accident and Liability Insurance Ltd v Morrison*:²¹

"Under the general law of insurance an insurer can avoid a policy if he proves that there has been misrepresentation or concealment of a material fact by the assured. What is material is that which would influence the mind of a prudent insurer in deciding whether to accept the risk or fix the premium, and if this be proved it is not necessary further to prove that the mind of the actual insurer was so affected. In other words, the assured could not rebut the claim to avoid the policy because of a material misrepresentation by a plea that the particular insurer concerned was so stupid, ignorant, or reckless, that he could not exercise the judgment of a prudent insurer and was in fact unaffected by anything the assured had represented or concealed."

2.14 That analysis influenced the outcome of *Chariot Inns* because the defendant brokers had contended that, firstly, the onus of establishing that the matter not disclosed was material to the risk undertaken rested on the defendant insurers and, secondly, that, in order to discharge this onus, the defendant insurers had to establish that the matter not disclosed did actually affect, and not merely might have affected, their judgement.

2.15 The Supreme Court accepted the first part of this proposition but held that the second part "contains the error which MacKinnon LJ condemned"²² and that, even though it had not been established that the non-disclosure actually affected the first defendant's judgement – a subjective test – it was sufficient that it could have – an objective test. The Court therefore concluded that the first defendant was entitled to repudiate liability.

¹⁹ *Ibid* at 225.

²⁰ *Ibid* at 226.

²¹ [1942] 2 KB 53, at 60, quoted with approval in *Chariot Inns Ltd v Assicurazioni Generali Spa and Coyle Hamilton Hamilton Phillips Ltd*[1981] IR 199, at 226.

²² *Chariot Inns Ltd v Assicurazioni Generali Spa and Coyle Hamilton Hamilton Phillips Ltd*[1981] IR 199, at 231.

(3) The duty of disclosure, the prudent insurer and a test of reasonableness in determining materiality: the Aro Road case and applying the good faith principle to both parties

2.16 The objective nature of the test of materiality identified in *Chariot Inns* continues to form part of Irish insurance law,²³ but subsequent cases have added an important element, namely, a test of reasonableness on the part of the insurer. Whereas the almost exclusive focus on the duty of the proposer in *Chariot Inns* operates primarily for the benefit of the insurer, the additional requirement of reasonableness on the part of the insurer involves in some respects confirmation of the dicta of Lord Mansfield in *Carter v Boehm* holding that the duty of good faith applies to both parties to an insurance contract.²⁴

2.17 In *Aro Road and Land Vehicles Ltd v Insurance Corporation of Ireland Ltd*.²⁵ the plaintiff company was transporting machinery from the State to Northern Ireland in four loads, using a road freight company. The machinery was being transported at the plaintiff's own risk and the freight company's representative suggested to the plaintiff company's managing director that the plaintiff should take out insurance cover. The freight company had a standing arrangement with the defendant insurance company, which included having blank insurance certificates on hand. The freight company's representative read out over the telephone the basic terms of the insurance certificate, which covered property damage, and loss due to fire and theft.

The plaintiff's managing director agreed to take out this cover (reluctantly, as similar loads had previously been transported without difficulty), and the freight company filled out the insurance certificates as agent of the defendant insurance company.

2.18 The freight company did not require the plaintiff to complete a proposal form and only required the plaintiff to state the value of the machinery being transported and the name of the consignee company to which it was being transported in Northern Ireland. The freight company also required payment of the insurance premium, which it collected from the plaintiff on the same date that it completed the insurance certificates.

Three of the loads were delivered to their destination, but the truck carrying the fourth load was hijacked in Northern Ireland, set on fire by the hijacker and its contents destroyed. The plaintiff company then sought payment under the policy, but the defendant repudiated liability on the ground that the managing director of the plaintiff company had not disclosed that, 19 years previously, he had been convicted on 10 counts of receiving stolen goods and had been sentenced to 21 months' imprisonment.

The plaintiff accepted that the convictions and sentences had occurred, and the defendant company equally accepted that the plaintiff's managing director had nothing to do with the load's hijacking and destruction.

2.19 In the High Court, Carroll J applied the test of materiality in the *Chariot Inns* case and considered that the non-disclosure of the managing director's conviction 19 years prior to the insurance cover was not material. She nonetheless noted that the expert witness for the defendant company had expressed the opinion that a reasonable and prudent insurer would have regarded it as material and she held that she should defer to this opinion. The Court therefore concluded that the defendant company was entitled

²³ The general thrust of the approach in the *Chariot Inns* case has been followed in the cases discussed below, including *Aro Road and Land Vehicles Ltd v Insurance Corporation of Ireland Ltd* [1986] IR 403; *Kelleher v Irish Life Assurance Company Ltd* [1993] 3 IR 393; *Manor Park Homebuilders Ltd v AIG Europe (Ireland) Ltd* [2008] IEHC 174, [2009] 1 ILRM 190; *Coleman v New Ireland Assurance plc (t/a Bank of Ireland Life)* [2009] IEHC 273; and *McAleenan v AIG (Europe) Ireland Ltd* [2010] IEHC 128. See Buckley *Insurance Law* 3rd ed (Thomson Round Hall 2012) at paragraph 3-27.

²⁴ The *Chariot Inns* decision, to the extent that it discussed inducement, may also require reconsideration in the light of subsequent case law in other jurisdictions. This includes the UK House of Lords decision in *Pan Atlantic Insurance Co Ltd v Pine Top Insurance Co Ltd* [1995] 1 AC 501 and the other decisions discussed in Chapter 3, below.

²⁵ [1986] IR 403.

to repudiate liability and she dismissed the plaintiff's claim. On appeal, the Supreme Court reversed this decision.

McCarthy J, delivering the leading judgment of the Court,²⁶ stated that Carroll J had not been correct in deferring to the views of the expert witness, because in determining what was material the Court was "the sole and final arbiter."²⁷ In this respect, the Supreme Court considered that the question of what is material to a prudent insurer must also involve a test of reasonableness. McCarthy J declared that:²⁸

"if the judgment of an insurer is such as to require disclosure of what he thinks is relevant but which a reasonable insured, if he thought of it at all, would not think relevant, then, in the absence of a question directed towards the disclosure of such a fact, the insurer, albeit prudent, cannot properly be held to be acting reasonably."

Indicating clearly that insurers must expect to be judged by professional standards of competence and reasonableness he added:²⁹

"A contract of insurance is a contract of the utmost good faith on both sides; the insured is bound to disclose every matter which might reasonably be thought to be material to the risk against which he is seeking indemnity; that test of reasonableness is an objective one not to be determined by the opinion of underwriter, broker or insurance agent, but by, and only by, the tribunal determining the issue. Whilst accepted standards of conduct and practice are of significance in determining issues of alleged professional negligence, they are not to be elevated into being an absolute shield against allegations of malpractice — see *O'Donovan v Cork County Council*³⁰ and *Roche v Peilow*.³¹ In disputes concerning professional competence, a profession is not to be permitted to be the final arbiter of standards of competence. In the instant case, the insurance profession is not to be permitted to dictate a binding definition of what is reasonable."

2.20 The Court also considered that the use of the word "utmost" as an additional epithet preceding "good faith" did not add anything to the principle of good faith, and held that:³²

"Good faith is not raised in its standard by being described as the utmost good faith; good faith requires candour and disclosure, not, I think, accuracy in itself, but a genuine effort to achieve the same using all reasonably available sources... If the duty is one that requires disclosure by the insured of all material facts which are known to him, then it may well require an impossible level of performance."

McCarthy J pointed out that in *Carter v Boehm*³³ Lord Mansfield had stated "in terms free from exaggeration"³⁴ that the duty of disclosure is intended to "prevent fraud and to encourage good faith"³⁵ and did not consider it necessary to add the word "utmost" to the principle of good faith.

"If the determination of what is material were to lie with the insurer alone, I do not know how the average citizen is to know what goes on in the insurer's mind, unless the insurer asks him

²⁶ Walsh and Hederman JJ agreed with the judgment of McCarthy J. As noted below, Henchy J delivered a separate concurring judgment, with which Griffin J concurred.

²⁷ [1986] IR 403 at 411.

²⁸ *Ibid* at 412.

²⁹ *Ibid* at 412.

³⁰ [1967] IR 173.

³¹ [1985] IR 232.

³² [1986] IR 403, 414.

³³ (1766) 3 Burr 1905.

³⁴ [1986] IR 403, 414.

³⁵ (1766) 3 Burr 1905, at 1910-1911, quoted by McCarthy J in the *Aro Road* case [1986] IR 403, 414.

by way of the questions in a proposal form or otherwise. I do not accept that he must seek out the proposed insurer and question him as to his reasonableness, his prudence and what he considers material.”³⁶

McCarthy J commented that even if the plaintiff’s managing director had been given the opportunity to complete a proposal form in that case “there is no reason to think that he would have recounted petty convictions from about 20 years before”.

The Supreme Court concluded that the defendant insurer had “failed to discharge the onus of proof that lay on them” to establish that the non-disclosure was material, having regard to the reasonableness standard already mentioned.

2.21 Separately from this analysis, the Court concluded that the general law of insurance was materially affected by “over-the-counter” insurance such as found in this case and in other forms of transit and in personal travel, including holiday insurance. McCarthy J stated:³⁷

“If no questions are asked of the insured, then, in the absence of fraud, the insurer is not entitled to repudiate on grounds of non-disclosure. Fraud might arise in such an instance as where an intending traveller has been told of imminent risk of death and then takes out life insurance in a slot machine at an airport. Otherwise, the insured need but answer correctly the questions asked; these questions must be limited in kind and number; if the insurer were to have the opportunity of denying or loading the insurance one purpose of the transaction would be defeated. Expedition is the hallmark of this form of insurance.”

He noted that counsel for the defendant insurer had suggested that the whole basis of insurance could be seriously damaged if there was any weakening in the rigidity (and “severity”) of the duty of disclosure. McCarthy J dismissed this suggestion observing that “[t]he force of such an argument as a proposition of law is matched by the improbability of the event.”³⁸

2.22 Henchy J, delivering a separate and concurring minority judgment,³⁹ noted that since it was accepted that the plaintiff’s managing director had had nothing to do with the hijacking and destruction of the insured load, the basis for the defendant’s repudiation of liability under the policy “was entirely a technical one under the law of insurance.”⁴⁰ He also agreed that, in the specific circumstances the defendant had, in effect engaged in “over-the-counter insurance.”

He noted that, even at that time in the 1980s, many concerns such as airlines, shipping companies and travel agents, acting as agents for an insurance company “and usually under the umbrella of a master policy” were prepared to sell insurance “in circumstances in which full disclosure is neither asked for nor could reasonably be given effect to.”⁴¹ He added:⁴²

“The time factor, if nothing else, would rule out the requirement of full disclosure in many instances: an air traveller who buys insurance of his luggage in an airport just before boarding an aeroplane could not be expected to have time to make disclosure of all material circumstances. Insurance sold in that way obviously implies a willingness on the part of the insurer to provide the cover asked for without requiring disclosure of *all* material circumstances.” (emphasis in original)

2.23 Henchy J believed that the key question was whether the defendant had waived the duty of disclosure and was thus precluded from asserting that full disclosure was a prerequisite of the contract of

³⁶ [1986] IR 403, 414.

³⁷ *Ibid* at 415.

³⁸ *Ibid*.

³⁹ As noted above, Griffin J agreed with the judgment of Henchy J.

⁴⁰ [1986] IR 403, 408.

⁴¹ *Ibid* at 409.

⁴² *Ibid*.

insurance.⁴³ Waiver is one of the exceptions to the duty of disclosure identified by Lord Mansfield in *Carter v Boehm*. He stated that the circumstances in which the road freight company had arranged the insurance indicated “an indifference... as to matters such as the personal circumstances of the managing director” of the plaintiff company.

Henchy J. accepted that even in those circumstances “certain types of information may not be knowingly withheld” but emphasised that the issue in the case was whether “an innocent non-disclosure of an incident in the past life of the managing director” entitled the insurer to avoid the policy. Henchy J stated it did not, and forcefully concluded:⁴⁴

“Insurers who allow agents such as shippers, carriers, airlines, travel agents and the like to insure on their behalf goods being carried, and to sell that insurance to virtually all and sundry who ask for it, with minimal formality or inquiry, and with no indication that full disclosure is to be made of any matter which the insurers may *ex post facto* deem to be material, cannot be held to contract subject to a condition that the insured must furnish *all* material information.” (emphasis in original)

2.24 The decision of the Supreme Court in *Aro Road* reiterated some long-established principles and also recognised the changed circumstances in which insurance products were being sold by the 1980s. It held that, as originally set out in *Carter v Boehm*, the principle of good faith applies to the insurer as well as the proposer/policyholder; that the principle of good faith is not affected by the addition of the word “utmost” before “good faith”; that the duty of disclosure remains one based essentially on an objective test of what a prudent insurer would regard as material; that the test of materiality should also be judged according to an objective standard of reasonableness by the insurer (comparable to the test that applies in determining liability in professional negligence claims); that circumstances may indicate that the duty of disclosure has been waived by the insurer; and that this is more likely where insurance is sold “over-the-counter” as a mass market product.

(4) *Judicial activity since Aro Road: good faith applies to both parties and the insurer must make reasonable enquiries in a professional manner*

2.25 The decision in *Aro Road* signalled what has been described as “a significant shift”⁴⁵ in the application of the principle of utmost good faith and the degree to which an insurer can rely exclusively upon a policyholder’s compliance with the obligation of the duty of disclosure.

Judicial activity since *Aro Road* has included the consideration of two important factors:

- changes in the regulatory context since the 18th century; and
- how insurance products are sold and waiver of the duty of disclosure.

2.26 In *Manor Park Homebuilders Ltd v AIG Europe (Ireland) Ltd*,⁴⁶ the High Court (McMahon J) applied both the objective test of disclosure laid down in *Chariot Inns* and the analysis in *Aro Road* that the principle of good faith applies to both parties. In *Manor Park*, there was poor documentation management by the insurer and no pre-contractual insistence on disclosure. McMahon J summarised the position as follows:⁴⁷

“The insured’s duty is balanced by a reciprocal duty on the insurer to make its own reasonable inquiries, to carry out all prudent investigations and to act at all times in a professional manner. In fact the onus to do this, because of its experience and expertise, lies primarily on the insurer. Where... the full extent of the risk can readily be defined without the insured’s participation, the law does not insist on full disclosure. That is why the authorities do not

⁴³ *Ibid* at 410.

⁴⁴ *Ibid*.

⁴⁵ Corrigan in *Landmarks in Insurance 1985-2010* (Insurance Institute of Ireland, 2010), Chapter 9, at 50.

⁴⁶ [2008] IEHC 174; [2009] 1 ILRM 190.

⁴⁷ *Ibid* at 213.

recognise any responsibility in this regard in over-the-counter or slot-machine policies such as travel policies sold at airports.”

He quoted with approval the following comment from a leading English textbook:⁴⁸

“Neither party is obliged to make such enquiries for the purposes of their respective duty of disclosure to the other, other than those enquiries which are required in the ordinary course of business. In this respect, the insurer should not use the duty of the utmost good faith as a crutch or an excuse not to carry out his own investigations which form part and parcel of the profession.”

He added that:⁴⁹

“It would be strange indeed if the Court placed such a heavy onus on the insured without also insisting on the insurer to look out for its own interests. *Uberrimae fidei* is not a charter for indolent insurers.”

2.27 Where insurance contracts are clearly based on information from proposers in response to precise questions from insurers, such questions require careful and truthful disclosure by proposers of facts identified by insurers as those that are material to the relevant risk. While the failure to ask a question directed at a particular subject or risk does not necessarily amount to a waiver of the duty of disclosure, the key issue in this respect is the form of the questions and their context. Some questions may, depending on their content and context, serve to broaden the duty by reminding the proposer of it. Nonetheless, the leading English text *MacGillivray on Insurance Law* summarised in the following passage that, in general, the effect of questions asked will be to limit the duty of disclosure:⁵⁰

“It is more likely, however, that the questions asked will limit the duty of disclosure, in that, if questions asked on particular subjects and the answers to them are warranted, it may be inferred that the insurer has waived his right to information, either on the same matters but outside the scope of the questions, or on matters kindred to the subject-matter of the questions. Thus, if an insurer asks, ‘How many accidents have you had in the last three years?’ it may well be implied that he does not want to know of accidents before that time, though these would still be material. If an insurer asks whether individual proposers have ever been declared bankrupt, he waives disclosure of the insolvency of companies of which they have been directors. Whether or not such a waiver is present depends on a true construction of the proposal form, the test being, would a reasonable man reading the proposal form be justified in thinking that the insurer had restricted his right to receive all material information, and consented to the omission of the particular information in issue?”

2.28 In *Kelleher v Irish Life Assurance Company Ltd*⁵¹ the Supreme Court expressly approved the analysis quoted above in *MacGillivray* and held that:⁵²

“the true and acid test must be as to whether a reasonable man reading the proposal form would conclude that information over and above it which is in issue was not required.”

Additionally the Court emphasised that the manner in which the insurance product in that case was sold (health cover offered exclusively to doctors) may well serve to limit the duty of disclosure:

“it is not without importance that what was described as the ‘special promotional offer’ being offered by the assurance company after negotiation through the brokers to all the members of the [Irish Medical Organisation] constitutes a very sound and probable commercial manner in

⁴⁸ Eggers, Picken and Foss *Good Faith and Insurance Contracts*, 2nd ed (Informa Lloyd’s List Publishing, 2004) at 291, quoted in *Manor Park* [2008] IEHC 174; [2009] 1 ILRM 190, at 213.

⁴⁹ [2008] IEHC 174; [2009] 1 ILRM 190, 213.

⁵⁰ Legh-Jones, Birds, Owen *MacGillivray on Insurance Law* 11th ed (Sweet & Maxwell 2008), paragraph 17-019.

⁵¹ [1993] 3 IR 393.

⁵² *Ibid* at 404 (Finlay CJ, with whom Blayney and Denham JJ agreed).

which to attract a very substantial quantity of new business by one single project. That fact constitutes a probable reason why the defendant should significantly limit the disclosure required from proposers for that insurance.”⁵³

2.29 Similarly, in *Coleman v New Ireland Assurance plc*⁵⁴ the proposal form contained a declaration to the effect that the proposer had disclosed all relevant facts and that all statements made on the application form were true and complete “to the best of my knowledge.” The High Court (Clarke J) held that:⁵⁵

“insofar as the answers to questions raised in a proposal form is concerned, a party will only be exposed to the risk of the contract of insurance being voided where the party fails to answer such questions to the best of the party’s ability and truthfully. This would be so even where an answer is inaccurate as a result of ignorance or even, in the words of McCarthy J [in *Keating v New Ireland Insurance Co Ltd*],⁵⁶ the ‘obtuseness which may be sometimes due to a mental block on matters affecting one’s health’... It is clear, therefore, that any material non-disclosure or any materially inaccurate answer to a question on the proposal form are to be judged by reference to the knowledge of the proposer, and whether answers given were to the best of the proposer’s ability and truthful.”

(5) Impact of the Financial Services Ombudsman

2.30 Because the Financial Services Ombudsman (“the FSO”) has a statutory discretion to make determinations based on the justice of an individual case, it is not bound by precedent and its decisions concerning the duty of disclosure have ranged from the traditional prudent insurer test to something less stringent.⁵⁷ There are a number of situations in which the FSO has held that the non-disclosure relied upon was based on illegal or improper inferences drawn by the insurer,⁵⁸ or that, despite non-disclosure, other mitigating circumstances were present.⁵⁹

2.31 Arising from the FSO’s statutory discretion, where those decisions are appealed the courts will not be required to apply the current general law on disclosure and will therefore allow the FSO a great degree of leeway in its decision-making. However, a scheme operating independently of a system of precedent presents obvious difficulties, in particular because previous decisions of the FSO cannot provide a definitive guide to the outcome of similar disputes in the future.⁶⁰

(6) Impact of the Consumer Protection Code 2012

2.32 Paragraph 4.35 of the Central Bank’s *Consumer Protection Code 2012* provides:

“A regulated entity must explain to a consumer, at the proposal stage, the consequences for the consumer of failure to make full disclosure of relevant facts, including:

- a) the consumer’s medical details or history; and
- b) previous insurance claims made by the consumer for the type of insurance sought.

The explanation must include, where relevant,

⁵³ *Ibid.*

⁵⁴ [2009] IEHC 273. See also *FBD Insurance v Financial Services Ombudsman and Mongan* [2011] IEHC 315.

⁵⁵ *Ibid* at paragraph 3.7.

⁵⁶ [1990] 2 IR 383.

⁵⁷ See Dockery “Insurance Policies and the Duty to Disclose ‘Material Facts’” (2012) 17 Bar Review 50.

⁵⁸ See Case Study 3 in the FSO Annual Report 2010.

⁵⁹ Buckley *Insurance Law* 3rd ed (Thomson Round Hall 2012), paragraph 3.86, comments that the FSO has taken a “different and, sometimes inconsistent, approach” to materiality in its decisions (and discusses these in detail).

⁶⁰ See, for example, *FBD Insurance PLC v Financial Services Ombudsman and Mongan* [2011] IEHC 315.

- i) that a policy may be cancelled;
- ii) that claims may not be paid;
- iii) the difficulty the consumer may encounter in trying to purchase insurance elsewhere; and,
- iv) in the case of property insurance, that the failure to have property insurance in place could lead to a breach of the terms and conditions attaching to any loan secured on that property.”

This is a clear and important statement on the need to draw attention to the consequences of non-disclosure but does not, of course, alter or affect the existing law.

(7) Impact of Insurance Ireland's voluntary codes

2.33 Although Insurance Ireland's voluntary industry codes of practice lack binding legal status,⁶¹ the Commission considers that they are useful indicators of what the insurance industry itself considers best practice.

The Insurance Ireland *Code of Practice on Life Assurance: Duty of Disclosure* states:⁶²

“In relation to those issues upon which insurers wish to base their underwriting decisions, clear questions should be included in proposal forms on those matters which have been commonly found to be material... Insurers will continue to develop clearer and more explicit proposal forms.”

The *Code of Practice on Non-Life Insurance* similarly states:

“Those matters which insurers have commonly found to be material should, as far as practicable, be the subject of clear questions in proposal forms.”⁶³

Both the *Code of Practice on Life Assurance: Duty of Disclosure* and the *Code of Practice on Non-Life Insurance* state:⁶⁴

“Insurers should avoid asking questions which would require knowledge beyond that which the signatory could reasonably be expected to possess.”

2.34 These voluntary and legally unenforceable statements of good practice reflect awareness on the part of the insurance industry that proposers and insurers should engage in dialogue and an exchange of information at the pre-contractual stage.

The Commission welcomes movements away from traditional disclosure principles for consumers, which various events including modern communications and technologies have overtaken, but they are not a substitute for legislative reform.

B Comparative Developments

2.35 Reforms in other jurisdictions indicate movement away from onerous disclosure requirements and towards a recognition of mutual obligations on the consumer and the insurer. The United Kingdom and Australia provide such examples.

(1) United Kingdom

(a) Utmost good faith retained as an interpretive principle only in the Insurance Act 2015

2.36 In 2014 the Law Commission of England and Wales and Scottish Law Commission recommended abolition of the duty of good faith as a substantive principle of insurance contract law and

⁶¹ See the discussion of *Justice (decd) v St Paul Ireland*, Circuit Court, 25 November 2004, in Appendix C, below, cited in Buckley “Insurers’ Self Regulation does not work” [2005] CLP 10 and Buckley *Insurance Law* 3rd ed (Thomson Round Hall, 2012), paragraph 1-19.

⁶² Paragraph 1(c) and 2(a) of the Code of Practice.

⁶³ Paragraph 1(c) of the Code of Practice.

⁶⁴ Paragraph 1(d) in both Codes of Practice.

that it should instead become an interpretive principle⁶⁵ and this was implemented in the UK *Insurance Act 2015*, which also included a “duty of fair presentation” to replace the pre-contractual duty of disclosure in non-consumer insurance contracts. The reforms in the 2015 Act complemented the related reforms for consumer contracts enacted in the *Consumer Insurance (Disclosure and Representations) Act 2012*, which replaced the pre-contractual duty of disclosure with a duty to take reasonable care not to make a misrepresentation.

Section 14(1) of the 2015 Act⁶⁶ provides that any rule of law permitting a party to a contract of insurance to avoid the contract on the ground that the utmost good faith has not been observed by the other party “is abolished.” Section 14(2) provides that any rule of law to the effect that a contract of insurance is a contract based on the utmost good faith “is modified” to the extent required by the 2015 Act itself and by the *Consumer Insurance (Disclosure and Representations) Act 2012*.

Section 14(3) of the 2015 Act also amended section 17 of the *Marine Insurance Act 1906*, which had codified the common law duty of utmost good faith. The 2015 Act retained the first part of section 17 of the 1906 Act, which provides that “a contract of marine insurance is a contract based upon the utmost good faith” but repealed the second part, which had provided: “and, if the utmost good faith be not observed by either party, the contract may be avoided by the other party.” Section 14(3) also expressly provides that the amended section 17 is subject to the provisions of the 2012 and 2015 Acts.

2.37 The effect of the 2015 Act is that the duty of good faith remains as an “interpretative principle” with section 17 of the 1906 Act and the common law continuing to provide that insurance contracts remain contracts of utmost good faith, but subject to the significant amendments to the duty of disclosure made by the 2012 and 2015 Acts. In their 2014 Report the Law Commission of England and Wales and Scottish Law Commission referred to a number of uses for the duty of utmost good faith as an “interpretative principle.”⁶⁷ These include:

- to support the application of judicial discretion, because the mutual nature of the duty could provide a solution to an especially hard case or emerging difficulty and the courts could develop the concept to prevent an insurer from relying on a right to deny a claim where it would be manifestly unfair to do so;⁶⁸
- to assist in determining whether it would be necessary to imply a term into a contract in line with the traditional “business efficacy” test;⁶⁹ and
- to interpret the duty of fair presentation of the risk, which was enacted in the 2015 Act.

(b) *Duty of disclosure for consumer contracts replaced in 2012 Act with duty to take reasonable care not to make a misrepresentation*

2.38 As noted above, the *Consumer Insurance (Disclosure and Representations) Act 2012* had already abolished the common law duty of disclosure in consumer contracts and replaced it with specific duties on the insurer and the consumer (limited in the 2012 Act to an individual consumer).

The 2012 Act provides that consumer proposers are no longer required to volunteer information, as previously required by the common law duty of disclosure. Instead, the onus is on insurers to ask clear

⁶⁵ Law Commission of England and Wales and Scottish Law Commission Report *Insurance Contract Law: Business Disclosure; Warranties; Insurers’ Remedies for Fraudulent Claims; and Late Payment* (Law Com No.353/Scot Law Com No.238, 2014).

⁶⁶ Section 14 of the 2015 Act applies to consumer and non-consumer contracts, but in the case of non-consumer contracts the insurer may contract out of the 2015 Act, subject to the “transparency requirements”: see paragraph 1.06, above.

⁶⁷ Law Commission of England and Wales and Scottish Law Commission *Report on Insurance Contract Law: Business Disclosure; Warranties; Insurers’ Remedies For Fraudulent Claims; and Late Payment* (Law Com No.353/Scot Law Com No.238, 2014), paragraph 30.23.

⁶⁸ *Ibid* paragraph 30.23(3).

⁶⁹ *Ibid* paragraph 30.23(2) and paragraphs 30.57 to 30.61.

and specific questions, with the consumer proposer required to take reasonable care not to make a misrepresentation. When deciding whether a consumer has taken “reasonable care,” the 2012 Act requires the courts to consider a number of factors.

Insurers cannot avoid policies for honest or reasonable misrepresentations and they are to be honoured in full. They have a compensatory (proportionate) remedy for “careless” misrepresentations based on what they would have done had the consumer answered the questions with reasonable care. Insurers can avoid the policy and retain premiums if the misrepresentation was “deliberate or reckless”.

(c) *Duty of disclosure for non-consumer contracts replaced in 2015 Act with duty of fair presentation of the risk*

2.39 The *Insurance Act 2015* contains corresponding reforms to the duty of disclosure for non-consumer insurance contracts, that is, those not covered by the 2012 Act.⁷⁰ Section 3(1) of the 2015 Act provides for a “duty of fair presentation,” which requires the non-consumer to make a “fair presentation of the risk” to the insurer before entering into the contract of insurance. This replaces the common law duties of disclosure and representations, as codified in sections 18, 19 and 20 of the *Marine Insurance Act 1906*.

(i) *Duty of fair presentation*

2.40 Section 3(3) of the 2015 Act defines a fair presentation of the risk as one: (a) which makes the disclosure required by section 3(4) of the 2015 Act (discussed below); (b) which makes that disclosure in a manner which would be reasonably clear and accessible to a prudent insurer;⁷¹ and (c) in which every material representation as to a matter of fact is substantially correct, and every material representation as to a matter of expectation or belief is made in good faith.⁷²

The non-consumer’s disclosure required under section 3(4) of the 2015 Act is to either: (a) disclose every material circumstance which it knows or ought to know;⁷³ or (b) failing that, disclosure which gives the insurer sufficient information to put a prudent insurer on notice that it needs to make further enquiries for the purpose of revealing those material circumstances.⁷⁴ As to what the non-consumer “ought to know” this includes what should reasonably have been revealed by a reasonable search of information available to the insured, whether the search is conducted by making enquiries or by any other means.⁷⁵

(ii) *The state of knowledge of the insurer*

2.41 Section 3(5) of the 2015 Act provides that if the insurer does not make any further enquiries, the duty of disclosure in section 3(4) does not require the non-consumer to disclose a circumstance if: (a) it diminishes the risk; (b) the insurer knows it; (c) the insurer ought to know it; (d) the insurer is presumed to know it; or (e) it is something as to which the insurer waives information.

⁷⁰ The reforms in the 2015 Act on the duty of disclosure come into effect 18 months after enactment, in August 2016. This transitional period was to allow the insurance market to adjust relevant practices.

⁷¹ This relates to the form of presentation rather than the substance and is designed to discourage “data-dumping,” that is, circumstances where the insurer is presented with an overwhelming amount of undigested information. Equally, this requirement would not be “satisfied by an overly brief or cryptic presentation.” See paragraph 47 of the Explanatory Notes to the Insurance Bill as passed by the House of Lords and introduced in the House of Commons on 15 January 2015 (the House of Commons made no amendments to the Bill as passed by the House of Lords so that these Explanatory Notes refer, in effect, to the 2015 Act as enacted).

⁷² This third element mirrors the common law duty not to make misrepresentations, as codified in section 20 of the 1906 Act.

⁷³ Section 3(4)(a) of the 2015 Act. This mirrors the common law duty, as codified in section 18 of the 1906 Act, to disclose every material circumstance known to them, including everything which “in the ordinary course of business, ought to be known” to them.

⁷⁴ Section 3(4)(b) of the 2015 Act.

⁷⁵ Section 4(6) of the 2015 Act.

Of these five matters, (a) and (b) replicate similar provisions from the common law duty as codified in the 1906 Act. As to (b), the insurer “knows” what is known to the individuals within the insurer who are involved in that particular underwriting decision.⁷⁶ As to (c), the insurer “ought to know” information which is readily available to the underwriters or is known by an employee or agent of the insurer who ought reasonably to have passed it on.⁷⁷ As to (d), the insurer is “presumed to know” matters it ought to know in the ordinary course of its business, such as industry knowledge (but only to the extent that the industry knowledge is relevant to the type of insurance provided by the insurer).⁷⁸

The 2015 Act also provides that references to the knowledge of an individual within the insurer include not only actual knowledge, but also matters which the individual suspected, and of which the individual would have had knowledge but for deliberately refraining from confirming them or enquiring about them.⁷⁹

(d) Proportionate remedies in the 2015 Act

2.42 The 2015 Act, like the 2012 Act, also provides for a range of proportionate remedies, by contrast with the common law position under which the insurer had the right to avoidance of the contract.

Thus, where the breach of duty by the non-consumer is deliberate or reckless the remedy of avoidance is still available.

Where the breach is neither deliberate nor reckless, the onus is on the insurer to show what it would have done had it received a fair presentation of the risk.

A major difference between the 2015 Act and the 2012 Act is that whereas, under the 2012 Act, “innocent” breaches of the duty are not actionable,⁸⁰ under the 2015 Act “innocent” breaches of the duty also provide an insurer with a remedy if the insurer can show inducement.

(2) Australia

(a) Utmost good faith

2.43 In its 1982 Report, the Australian Law Reform Commission (ALRC) concluded that the principle of utmost good faith should remain the “touchstone” of contracts of insurance, but that it should be made clear that utmost good faith applies just as much to the insurer as the insured.⁸¹ It also recommended that:⁸²

“[l]egislation should make it clear that the duty of good faith applied to all aspects of the relationship between insurer and insured, including the settlement of claims.”

This recommendation was implemented in section 13 of the Australian *Insurance Contracts Act 1984*, which provides:

“A contract of insurance is a contract based on the utmost good faith and there is implied in such a contract a provision requiring each party to it to act towards the other party, in respect of any matter arising under or in relation to it, with the utmost good faith”.

The 1984 Act does not define utmost good faith so that the long-established case law continues to have relevance, subject to section 12 of the 1984 Act which provides that the principle of good faith “does not have the effect of imposing on an insured, in relation to the disclosure of a matter to the insurer, a duty other than the duty of disclosure,” which is set out in section 21 of the 1984 Act.

⁷⁶ Section 5(1) of the 2015 Act.

⁷⁷ Section 5(2) of the 2015 Act.

⁷⁸ Section 5(3) of the 2015 Act.

⁷⁹ Section 6 of the 2015 Act.

⁸⁰ Schedule 1 of the 2015 Act contains the relevant detail concerning the proportionate remedies.

⁸¹ Australian Law Reform Commission *Report on Insurance Contracts* (Report No. 20,1982) at xxi-xxii (executive summary).

⁸² *Ibid* at paragraph 328.

2.44 The ALRC had also recommended in 1982 that if an insurer's reliance on a specific term in a contract of insurance would involve acting contrary to the principle of utmost good faith, the insurer should not be entitled to rely on such a provision. The 1982 Report stated this was intended as a "sufficient inducement to insurers that their advisers be careful in drafting their policies and to act fairly in relying on their strict terms."⁸³ Section 14(1) of the 1984 Act implemented this analysis and provides:

"If reliance by a party to a contract of insurance on a provision of the contract would be to fail to act with the utmost good faith, the party may not rely on the provision."

(b) The duty of disclosure: general

2.45 The ALRC's 1982 Report concluded that the common law duty of disclosure required reform in order to achieve an appropriate balance between the insurer and policyholder. The ALRC considered that, if a proposer was obliged to disclose all information concerning risks, this was at odds with the core requirement of the principle of good faith, and it concluded that an insurer should only be entitled to redress in the event of deliberate concealment or culpable indifference on the part of the policyholder.⁸⁴

This analysis is reflected in section 21 of the *Insurance Contracts Act 1984*, which requires all insurance policyholders to "disclose to the insurer, before the relevant contract of insurance is entered into, every matter that is known" to them. These are matters that a policyholder (a) "knows to be a matter relevant to the decision of the insurer whether to accept the risk and, if so, on what terms;" or (b) "a reasonable person in the circumstances could be expected to know to be a matter so relevant."

2.46 In a 2004 Review of the 1984 Act,⁸⁵ it was recommended that a list of non-exclusive factors should be taken into account when identifying such a "reasonable person." Consequently, section 21(1)(b) of the 1984 Act was amended by the *Insurance Contracts Amendment Act 2013* to provide that, in determining what a reasonable person in the circumstances could be expected to know to be relevant, regard is to be had to (but not limited to): (a) the nature and extent of the insurance cover to be provided under the relevant contract of insurance; and (b) the class of persons who would ordinarily be expected to apply for insurance cover of that kind.

Additionally the duty of disclosure does not require the disclosure of a matter:

- that diminishes the risk;
- that is of common knowledge;
- that the insurer knows or in the ordinary course of the insurer's business as an insurer ought to know; or
- as to which compliance with the duty of disclosure is waived by the insurer.

2.47 Section 21(3) of the 1984 Act, as amended in 2013, also provides that where a person (a) failed to answer, or (b) gave an obviously incomplete or irrelevant answer to a question included in a proposal form about a matter, the insurer is deemed to have waived compliance with the duty of disclosure in relation to the matter. This is supported by section 27 of the 1984 Act which provides:

"A person shall not be taken to have made a misrepresentation by reason only that the person failed to answer a question included in a proposal form or gave an obviously incomplete or irrelevant answer to such a question."

(c) Duty of disclosure: specific application to "eligible" contracts of insurance

2.48 Section 21A of the 1984 Act, inserted by the *Insurance Laws Amendment Act 1998*, provides that, in connection with an "eligible" consumer insurance contract, the insurer will be taken to have waived

⁸³ *Ibid* at paragraph 51.

⁸⁴ *Ibid* at 175, 180 and 183.

⁸⁵ Review Panel *Report on the Review of the Insurance Contracts Act 1984 Final Report on second stage: Provisions other than section 54* (Australian Treasury, 2004) paragraphs 4.5 to 4.16.

the duty of disclosure unless it asks the consumer specific questions.⁸⁶ The “eligible” contracts to which section 21A applies are motor vehicle, home buildings, home contents, accident and sickness, consumer credit and travel insurance (consumer insurance contracts).⁸⁷

Section 21A(2) provides that “an insurer is taken to have waived compliance with the duty of disclosure in relation to the contract unless the insurer complies with either subsection (3) or (4).” Section 21A(3) covers the circumstances where the insurer asks the consumer specific questions relevant to the risk.

Section 21A(4) allows the insurer to ask the consumer to disclose an “exceptional circumstance” provided the specific questions were also asked.

An “exceptional circumstance” is something which is known to the consumer and the consumer “knows, or a reasonable person in the circumstances could be expected to know, is a matter relevant to the decision of the insurer whether to accept the risk and, if so, on what terms” and it “is not a matter that the insurer could reasonably be expected to make the subject” of a specific question.

2.49 If the insurer complies with 21A(3) or 21A(4) of the 1984 Act but then asks the consumer to disclose “any other matters that would be covered by the duty of disclosure in relation to the contract; the insurer is taken to have waived compliance with the duty of disclosure in relation to those matters.” This discourages vague and open-ended questions.

The consumer, in answering specific questions or those regarding an “exceptional circumstance”, must disclose “each matter that is known” to them and what “a reasonable person in the circumstances could be expected to have disclosed in answer to that question.”⁸⁸ In circumstances where consumers fail to discharge their duty under section 21A, they are governed by the general disclosure duty in section 21 of the 1984 Act: see above.

2.50 Section 21A, as amended by the *Insurance Contracts Amendment Act 2013*, removes the ability of insurers to ask “catch all” questions and applies enhanced rules for the duty of disclosure. An insurer “may request the insured to answer one or more specific questions that are relevant to the decision of the insurer whether to accept the risk and, if so, on what terms”. If the insurer does not make such a request, they are taken to have “waived compliance with the duty of disclosure in relation to the contract.”

It also provides that, in circumstances where the insurer makes such a request but “requests the insured to disclose to the insurer any other matter that would be covered by the duty of disclosure in relation to the contract; then the insurer is taken to have waived compliance with the duty of disclosure in relation to that other matter”.

Where an insurer makes such a request and “in answer to each specific question included in the request”, the consumer discloses each matter that: “(a) is known to the insured; and (b) a reasonable person in the circumstances could be expected to have disclosed in answer to that question,” then the consumer “is taken to have complied with the duty of disclosure in relation to the contract”.

C Good Faith and the Duty of Disclosure: General Conclusions and Recommendations

(1) The principle of utmost good faith (*uberrima fides*)

2.51 In the Consultation Paper the Commission provisionally recommended that the concept that contracts of insurance are based on the principle utmost good faith (*uberrima fides*), as codified in section

⁸⁶ See Merkin *Reforming Insurance Contract Law: Is there a case for Reverse Transportation? A Report for the English and Scottish Law Commissions on the Australian Experience of Insurance Law Reform* (Law Commission of England and Wales and Scottish Law Commission, 2007), at paragraph 4.18, available at lawcommission.justice.gov.uk.

⁸⁷ Section 21A(9) of the 1984 Act defines an eligible contract of insurance as one specified in Regulations made under the 1984 Act. At the time of writing (June 2015) the relevant Regulations are the *Insurance Contracts Regulations 1985* (Australian Statutory Rules 1985, No.162), as amended.

⁸⁸ Section 21A(6) and 21A(7) sets the conditions that the policyholder must meet in order to comply with the duty of disclosure.

17 of the 1906 Act, should be retained and should continue to be the basis on which the pre-contractual duty of disclosure, codified in section 18 of the 1906 Act, is founded.⁸⁹

However, having carefully considered the submissions which it has received and having further reflected on this, the Commission has reconsidered this recommendation in respect of consumer insurance contracts. The Commission has concluded that, while the principle of utmost good faith has its origins in the nature of the indemnities which insurers provide and the potential paucity of information available to insurers about the risks against which they intend to insure, the emergence of statutory corporate governance and risk management requirements,⁹⁰ allied to modern communications, technology and information-gathering sources have fundamentally altered the foundations of the principle⁹¹ in favour of insurers and to the detriment of consumers.

2.52 The Irish judiciary has drawn attention to this fact in *Aro Road*⁹² and other cases and has taken into account the modern realities of insurance contracts, including the fact that insurance is now written by large (usually international) undertakings with significant internal governance and risk assessment resources, as required by the relevant statutory licensing regimes.

In *Manor Park Homebuilders Ltd*⁹³ the High Court (McMahon J) was at pains to point out that:

“Properly understood, the principle contains an equitable element which will be informed by the facts of each case. In taking this position, the law is not being harsh and unreasonable on the insurer, who at the end of the day can easily secure its legal and commercial position by drafting appropriate conditions and warranties and inserting them into the contract if it so desires. If it chooses not to do so, however, it cannot expect too much sympathy from the courts for not adhering to prudent and professional business practices in assessing the risk for itself.”

2.53 While the “utmost good faith” principle has possibly curtailed some unfair aspects of insurance contract law for consumers, it is an evolving doctrine predicated on the “facts of each case” and can therefore be unpredictable. Historically the courts considered that application of the principle heavily favoured insurers leading Butcher to remark:⁹⁴

“the application of the rules to ensure good faith have placed in the hands of insurers a weapon which may be wielded in a way which produces a result which is the opposite of that which would, in ordinary parlance, be regarded as what good faith would demand.”

2.54 In the United Kingdom, the Special Public Bill Committee parliamentary debates on the *Consumer Insurance (Disclosure and Representations) Act 2012* queried the practical implications of abolishing utmost good faith when so few legal cases appeared to turn on it alone.⁹⁵

It was explained that it was not the number of cases that had been decided on the principle that mattered but rather that it placed insurers in “a very strong negotiating position and the consumer, faced with an argument on the law, will not necessarily give up right at the beginning but will readily accept a

⁸⁹ Law Reform Commission *Consultation Paper on Insurance Contracts* (LRC CP 65-2011) paragraph 3.27.

⁹⁰ The relevant statutory and regulatory requirements, including those arising under EU Directives and under the Central Bank’s statutory corporate governance codes, are discussed in Appendix C.

⁹¹ Law Commission of England and Wales and Scottish Law Commission *Insurance Contract Law Issues Paper 1 on Misrepresentation and Non-Disclosure* (September 2006) paragraph 2.9. See also Hasson “The Doctrine of *Uberrima Fides* in Insurance Law - A Critical Evaluation” (1969) 32 MLR 615, 620.

⁹² [1986] IR 403, discussed above.

⁹³ [2008] IEHC 174; [2009] 1 ILRM 190 at 213.

⁹⁴ Butcher “Good Faith in Insurance Law: A Redundant Concept?” [2008] JBL 375, 379.

⁹⁵ Lord Davis of Stamford.

compromise offered by the insurers, so the courts do not see such cases". This was termed the "submarine effect."⁹⁶

2.55 The remedy of avoidance weighs heavily in favour of the insurer. The ability of a policyholder to avoid the policy for failure on the part of the insurer to act with utmost good faith is not analogous to an insurer terminating the policy for the same reason.

Australia retained the principle of utmost good faith on a modified statutory footing with specific provisions imposed on the duty of disclosure. For the reasons discussed below, the advantages provided by this measure are debatable.

The Law Commission of England and Wales and Scottish Law Commission recommended that the principle of utmost good faith should remain as a general interpretative principle, so that the common law (as codified in section 17 of the 1906 Act) could continue to provide that insurance contracts are contracts of good faith although a breach of such "good faith" would no longer entitle the insurer to avoid the policy. As noted above this was enacted in the UK *Insurance Act 2015*.

One of the reasons⁹⁷ advanced by the Law Commissions for its retention was that it would "leave some room for judicial flexibility." It was argued that due to the "mutual" nature of the principle it could provide a "solution to an especially hard case or emergent difficulty."⁹⁸

Butcher contends that where the content of the obligations of disclosure and pre-contractual misrepresentations are clearly defined in legislation, utmost good faith serves no clear useful purpose and that arguments for its retention in order to cater for the unexpected are weak.⁹⁹

2.56 During the last 30 years Irish case law from *Aro Road* to *Manor Park Homebuilders*, has focussed more upon possible questionable behaviour of insurers seeking to avoid payment than upon consumers' pre-contractual obligations and this increased judicial attention to the role of the insurer may be seen as adding content to the insurers' existing duty of utmost good faith.

The Commission, while supportive of judicial activity in this area, believes that clear legislative reform balancing the obligations of consumer and insurer, is preferable to uncertain, albeit developing, judicial rules. If the obligations of disclosure and pre-contractual misrepresentations are clearly defined in legislation, there is no practical argument for the retention of the principle of "utmost good faith", either as an implied term as in Australia, or as an aid to interpretation as in the United Kingdom.

The Commission, therefore, no longer sees a place for the principle at the pre-contractual stage of an insurance contract and has concluded that its continued retention at the pre-contractual stage will serve no useful purpose. Abolition of the principle coupled with legislative provisions defining the duties of the insurer and policyholder will be of greater value to consumer policyholders in contemporary Ireland.

(2) The duty of disclosure

2.57 In the Consultation Paper the Commission provisionally recommended that the duty of disclosure should, in accordance with case law in Ireland such as *Aro Road*, be restricted to facts or circumstances of which a consumer has actual knowledge. It also provisionally recommended that the duty of disclosure should not extend to every fact or circumstance which ought to be known by the consumer, under a test of constructive knowledge.¹⁰⁰

⁹⁶ Lord Justice Longmore.

⁹⁷ As noted above, another reason was that it would assist with interpreting the duty of fair presentation of the risk, now set out in the *Insurance Act 2015*. However, this role is irrelevant, as the Commission does not recommend the adoption of this duty.

⁹⁸ Law Commission of England and Wales and Scottish Law Commission *Report on Insurance Contract Law: Business Disclosure; Warranties; Insurers' Remedies For Fraudulent Claims; and Late Payment* (Law Com No.353/Scot Law Com No.238, 2014) paragraph 30.23(3).

⁹⁹ Butcher "Good Faith in Insurance Law: A Redundant Concept?" (2008) JBL 375, 382.

¹⁰⁰ Law Reform Commission *Consultation Paper on Insurance Contracts* (LRC CP 65-2011) paragraph 3.22.

The Commission provisionally recommended a duty of disclosure based on actual knowledge but qualified with a degree of objectivity so that insurers would not be permitted to repudiate liability on the basis of non-disclosure of material facts of which the policyholder could not reasonably be expected to have actual knowledge at the time of applying for cover.¹⁰¹

2.58 The historical duty of disclosure has created a number of difficulties for consumers, namely: understanding that it involves a duty to volunteer information; identifying facts that might be material to a prudent insurer; and the “all-or-nothing” nature of the sanction of repudiation of cover available to the insurer regardless of whether the failure to disclose was innocent or intentional.¹⁰²

Long-established case law has accepted that there are a number of exceptions or modifications to the duty of disclosure, and many of those have been codified in section 18(3) of the *Marine Insurance Act 1906*. More recent case law, such as *Aro Road* and *Manor Park Homebuilders*, has identified other instances, such as: the nature of the questions posed; the wording of the proposal form; the method of selling insurance products; and the failure of some insurers to inform themselves adequately of material facts or deal fairly with and consider the interests of consumers.

2.59 In *Carter v Boehm*,¹⁰³ Lord Mansfield accepted that the proposer often has exclusive access to specific information which should be disclosed, although in the case itself the insurer was actually in possession of better information in terms of the risk undertaken. Moreover, in the intervening two and a half centuries since that decision the respective capacities, resources and characters of insurers and consumer policyholders have also changed radically. In addition, when Lord Mansfield delivered his judgment in 1766 there were no mass-market insurance policies, and the modern concept of a consumer¹⁰⁴ was unknown.

Most 21st century insurers are now large multi-national conglomerates with vast financial and other resources including technical expertise, communications and other technology resulting in vastly increased bargaining power, some of which results from statutory regulation of prudential and risk management and consequent improved risk assessment methods.¹⁰⁵

Since consumers do not normally enjoy such resources, the balance of bargaining power in relation to consumer insurance contracts now lies with insurers. In consequence, there is a move internationally away from the common law duty of disclosure. Both Australia (in the 1984 Act) and the United Kingdom (in the 2012 and 2015 Acts) have chosen to reform the duty, and although they have implemented separate obligations for individual consumers, as distinct from businesses, they have not retained the current law in either case.

2.60 These movements towards statutory regimes that reflect the reality of the respective bargaining powers of modern insurance undertakings and consumers are also consistent with the approach taken in modern general consumer protection legislation, which already applies to contracts for the supply of services, including insurance contracts.¹⁰⁶

The Commission does not consider it appropriate to retain a duty that requires a consumer to understand and identify particular facts that may be “material” to the decision of a prudent insurer to accept or reject a risk. Equally the Commission does not consider it appropriate to retain a duty that facilitates avoidance of

¹⁰¹ *Ibid* at paragraph 3.28.

¹⁰² See also Law Commission of England and Wales and Scottish Law Commission *Report on Consumer Insurance Law: Pre-contract Disclosure and Misrepresentation* (Law Com No.319/Scot Law Com No.219, 2009) at paragraphs 2.10-2.15.

¹⁰³ (1766) 3 Burr 1905, at 1909.

¹⁰⁴ Tyldesley “Consumer Insurance and the Duty of Disclosure” (2011) 123 BILA 38, at 43.

¹⁰⁵ *Ibid* at 44-45. See also the discussion of the relevant statutory and regulatory requirements in Chapter 9, below

¹⁰⁶ See the discussion in Chapter 9, below.

an insurance contract where the consumer has failed to understand and identify particular facts that may be “material” to the decision of a prudent insurer to accept or reject the risk.

2.61 The Commission recommends the abolition of the pre-contractual principle of utmost good faith (whether statutory or at common law) as it applies to consumer insurance contracts.

2.62 The Commission recommends the abolition of the pre-contractual duty of disclosure (whether statutory or at common law) as it applies to consumer insurance contracts and its replacement with specified statutory duties and obligations.

CHAPTER 3 PRE-CONTRACTUAL DISCLOSURE: SPECIFIC RECOMMENDATIONS AND PROPORTIONATE REMEDIES

A Reformulated duty of disclosure: the consumer's duties

(1) No general requirement to volunteer information

3.01 The manner in which insurance products are sold has altered the nature of the duty of disclosure. For example, the limited time for disclosure instanced in cases such as *Aro Road and Land Vehicles Ltd v Insurance Corporation of Ireland Ltd*¹ prevents the discharge of the current duty of disclosure in many instances. Similarly, over-the-counter insurance, such as that available at airports, where no proposal form is required, operates to limit its application.

3.02 It appears to be generally accepted as good practice in the insurance industry for insurers to ask specific questions about "material facts." This is recognised by Insurance Ireland's Life and Non-life Codes of Practice which encourage insurers to ask "clear" questions about such "material facts."² The codes also provide that insurers "should avoid asking questions which would require knowledge beyond that which the signatory could reasonably be expected to possess".³

3.03 The courts have expressed the view that insurers should not be content to play a passive role during the disclosure process but should instead be prepared to make necessary enquiries about the risk to be underwritten.⁴ In particular, the Supreme Court in *Aro Road* identified the need for insurers to ask questions in order to guide policyholders in determining what is material to their applications.⁵

"If the determination of what is material were to lie with the insurer alone, I do not know how the average citizen is to know what goes on in the insurer's mind, unless the insurer asks him by way of the questions in a proposal form or otherwise. I do not accept that he must seek out the proposed insurer and question him as to his reasonableness, his prudence and what he considers material."

3.04 While in Irish law there is no express requirement on an insurer to pose questions it would now appear to be in the interests of insurers to ask questions in a clear and direct way in order to identify what they consider to be "material" to the risk to be insured.

3.05 There appears to be international consensus that obtaining relevant information from consumer proposers via precise questions is preferable to the common law duty to volunteer and disclose information. Both Australia (in its *Insurance Contracts Act 1984*) and the United Kingdom (in its *Consumer*

¹ [1986] IR 403, discussed in Chapter 2, above.

² Insurance Ireland *Code of Practice on Life Assurance—Duty of Disclosure*, paragraph 1(c); Insurance Ireland *Code of Practice on Non-Life Insurance*, paragraph 1(c).

³ Insurance Ireland *Code of Practice on Life Assurance—Duty of Disclosure*, paragraph 1(d); Insurance Ireland *Code of Practice on Non-Life Insurance*, paragraph 1(d).

⁴ *Manor Park Homebuilders Ltd v AIG Europe (Ireland) Ltd* [2008] IEHC 174; [2009] 1 ILRM 190, discussed in Chapter 2, above.

⁵ *Aro Road and Land Vehicles Ltd v Insurance Corporation of Ireland Ltd* [1986] IR 403 at 414, discussed in Chapter 2, above.

*Insurance (Disclosure and Representations) Act 2012 and Insurance Act 2015*⁶) have adopted reform measures for consumers that limit the duty of disclosure to information requested by the insurer.

3.06 The Commission confirms and adopts the view that the duty of disclosure imposed upon consumer proposers should be confined to the provision of responses to precise questions posed by insurers for the purpose of identifying relevant material facts .

3.07 The Commission recommends that the statutory pre-contractual duty of disclosure of a consumer should be confined to providing responses to questions asked by the insurer, and that consumers should not be under a duty to volunteer any information over and above that required by such questions.

(2) Duty to answer questions honestly and with reasonable care

(a) Representations

3.08 During the application process policyholders may provide information to insurers in a variety of ways: statements may be made voluntarily by a proposer without prompting by an insurer; they may be in response to a verbal question (for example an over the telephone question in which the proposer may be given little or no time to reflect on the answer), or they may be the subject of a specific written question on a proposal form or in a “tick box” internet user interface.

These statements are termed representations and are considered to be made as to a matter of fact, or as to a matter of expectation or belief. At common law, codified in section 20(1) of the *Marine Insurance Act 1906*, every material representation made by a proposer to an insurer during negotiations of a contract and before the contract is concluded must be true, and should a misrepresentation be made the insurer may rescind or avoid the contract (unless the insurer waives the breach).

In addition, at common law and codified in section 20(2) of the 1906 Act, a representation is deemed material if it would influence the judgement of a “prudent insurer” in fixing the premium, or taking the risk.

The common law, codified in section 20(4) of the 1906 Act, provides that a representation is true if it is substantially correct (in other words if the difference between what is represented and what is actually correct would not be considered material by a prudent insurer).

3.09 Misrepresentations relating to “facts”, even if made in good faith, enable insurers to avoid liability because a representation as to a “fact” must be true and will be objectively assessed.⁷ For an answer to be true it does not depend on the proposer answering the question honestly, negligently or fraudulently; and even when the proposer has a reasonable belief in the veracity of a statement, it will be deemed a misrepresentation if it is proved untrue.⁸

Misrepresentations relating to “expectation or belief” are deemed true if made in good faith.⁹ They can only be deemed false if the policyholder did not hold that opinion or intention.¹⁰ The test is not whether the belief was reasonably held but whether the proposer had some basis for the belief, the requirement being solely one of honesty and good faith.¹¹

⁶ As discussed in Chapter 2, above, non-consumer business proposers remain subject to a modified duty of fair presentation under the UK *Insurance Act 2015*.

⁷ Buckley *Insurance Law* 3rd ed (Thomson Round Hall 2012) at paragraph 3-55 describes the following distinction: “a proposer is not obliged to disclose information of which he is unaware, e.g. early stages of cancer, but an untrue declaration of health is actionable even if innocent.”

⁸ *HIH Casualty and General Insurance Ltd v Chase Manhattan Bank Casualty and General Insurance Ltd v Chase Manhattan Bank* [2003] UKHL 6; [2003] 1 All ER Comm 349, at para 88 (Lord Hobhouse).

⁹ See *Coleman v New Ireland Assurance plc* [2009] IEHC 273.

¹⁰ Buckley *Insurance Law* 3rd ed (Thomson Round Hall 2012) at paragraph 3-46.

¹¹ *Ibid* at paragraph 3-55.

Buckley notes that a policyholder would appear to be in difficulty if, in the absence of an opinion, he or she “makes a blind guess or alternatively, is aware of factors that could render the opinion doubtful and turns a blind eye to them.”¹²

3.10 The position in insurance contract law appears to be more limited than the position in general contract law, where it has been remarked that liability regarding a statement of opinion depends on whether the reliance on the statement was “reasonable and therefore to be expected.”¹³ *Chitty on Contracts* comment that the distinction between fact and opinion is not easy to make in practice:¹⁴

“no simple distinction between statements of fact and statements of opinion or intention will sufficiently take account of the different varieties of possible statements which may be made in pre-contractual negotiations.”

The Commission endorses that view. The courts have been reluctant to find that a proposer’s statement about his or her medical history is a statement of fact rather than of opinion and in practice insurers generally insist on obtaining a medical report before accepting a proposal.¹⁵

3.11 The courts have also sought to limit the law relating to actionable misrepresentation in a number of ways, namely:

- interpreting representations in favour of the policyholder, for example, those that are laudatory, imprecise or bombastic may be non-actionable “puffs”;
- attributing liability to the agent;¹⁶
- interpreting ambiguous questions against the party who prepared them, usually the insurer (the *contra proferentem* rule).¹⁷
- determining that an honest but incorrectly held belief can form the satisfactory basis for an opinion.¹⁸

3.12 In the Consultation Paper the Commission considered the circumstances of a consumer seeking standard form, mass market insurance cover and provisionally recommended replacing the duty to furnish “true” answers with a duty to answer specific questions honestly and carefully.¹⁹

(b) United Kingdom

3.13 The Law Commission of England and Wales and Scottish Law Commission considered that a consumer policyholder’s duty is to be honest and careful in answering an insurer’s questions. They recommended that an insurer should not be able to rely on a misrepresentation in order to repudiate liability under the contract if the consumer was acting honestly and reasonably in the circumstances when the misrepresentation was made.²⁰

¹² *Ibid* at paragraph 3-114.

¹³ McDermott *Contract Law* (Butterworths 2001) at paragraphs 13.16-13.25.

¹⁴ Beale (ed) *Chitty on Contracts Volume I: General Principles*, 29th ed (Sweet & Maxwell 2004) paragraph 6-010.

¹⁵ Buckley *Insurance Law* 3rd ed (Thomson Round Hall 2012) paragraph 3-55.

¹⁶ See *Chariot Inns Ltd v Assicurazioni Generali Spa and Coyle Hamilton Hamilton Phillips Ltd* [1981] IR 199, discussed in Chapter 2, above; and section 51 of the *Insurance Act 1989*, discussed in Appendix C, below. As noted in Chapter 1, the liability of insurance brokers and intermediaries is outside the scope of this Report.

¹⁷ This is discussed in detail in Chapter 9, below, in the context of unfair terms.

¹⁸ *Economides v Commercial Union Insurance Co* [1997] EWCA Civ 1754; [1998] QB 587.

¹⁹ *Consultation Paper on Insurance Contracts* (LRC CP 65 – 2011) paragraph 4.34.

²⁰ Law Commission of England and Wales and Scottish Law Commission *Consumer Insurance Law: Pre-contract Disclosure and Misrepresentation* (Law Com No.319/Scot Law Com No.219, 2009).

3.14 The Commissions considered whether this test should be subjective, and take into account the consumer's individual circumstances, or whether it should be objective, looking at what one would expect from a reasonable consumer in the market, in particular whether account should be taken of the consumer's age, education or knowledge of English.²¹ Recognising that a strict objective or subjective test posed difficulties the Commissions observed that:²²

"The insurer cannot be expected to know about every idiosyncrasy of every insured. It cannot know that the person completing the form has suffered bereavement, or understands very little about house maintenance or medical terms. On the other hand, it seems harsh to penalise a policyholder for falling below some objective standard, when this was quite reasonable given their particular circumstances."

3.15 Reflecting this analysis section 2(2) of the UK *Consumer Insurance (Disclosure and Representations) Act 2012* provides:

"It is the duty of the consumer to take reasonable care not to make a misrepresentation to the insurer".

3.16 Section 3(1) of the 2012 Act provides:

"Whether or not a consumer has taken reasonable care not to make a misrepresentation is to be determined in the light of all the relevant circumstances."

3.17 Section 3(2) of the 2012 Act provides the following non-exhaustive list of factors that may be taken into account when determining whether the duty has been discharged:

- (a) the type of consumer insurance contract in question, and its target market,
- (b) any relevant explanatory material or publicity produced or authorised by the insurer,
- (c) how clear, and how specific, the insurer's questions were,
- (d) in the case of a failure to respond to the insurer's questions in connection with the renewal or variation of a consumer insurance contract, how clearly the insurer communicated the importance of answering those questions (or the possible consequences of failing to do so),
- (e) whether or not an agent was acting for the consumer."

3.18 The standard to be applied to the consumer is that of "reasonable care." Any particular subjective characteristics are discounted unless "the insurer was, or ought to have been, aware of any particular characteristics or circumstances of the actual consumer,"²³ in which case subjective characteristics are to be considered.

3.19 Additionally "a misrepresentation made dishonestly is always to be taken as showing an absence of reasonable care".²⁴ Lowry and Rawlings explain that this was included in the 2012 Act because the exclusion of the subjective characteristics might mean there would be no breach of the duty if a consumer possessed more than unusual knowledge and dishonestly withheld it²⁵ and was intended to combat what is commonly termed "wilful ignorance."

²¹ Law Commission of England and Wales and Scottish Law Commission *A summary of Responses to Consultation Paper on Insurance Contract Law: Misrepresentation, Non-Disclosure and Breach of Warranty by the Insured* (May 2008) paragraph 2.76.

²² Law Commission of England and Wales and Scottish Law Commission *Issues Paper 1 on Misrepresentation and Non-Disclosure* (September 2006) paragraph 6.17.

²³ Section 3(4) of the *Consumer Insurance (Disclosure and Representations) Act 2012*.

²⁴ Section 3(5) of the 2012 Act.

²⁵ Lowry and Rawlings "That Wicked Rule, that Evil Doctrine": Reforming the Law on Disclosure in Insurance Contracts" (2012) 75 MLR 1099, at 1111.

3.20 In the context of remedies, the 2012 Act provides that it is to be presumed, unless the contrary is shown:

“(a) that the consumer had the knowledge of a reasonable consumer, and

(b) that the consumer knew that a matter about which the insurer asked a clear and specific question was relevant to the insurer.”

(c) Australia

3.21 In the context of the general duty of disclosure the Australian Law Reform Commission (ALRC) in its 1982 *Report on Insurance Contracts* had taken the view that fairness to the policyholder, in relation to non-disclosure, would best be achieved by taking account of the differing circumstances between individual policyholders, such as their position in life, mental condition and ability, education, literacy, knowledge, experience and cultural background. These were described as “the circumstances of the insured.” However, the *Insurance Contracts Act 1984* contains something less than the 1982 recommendation.

3.22 Section 21 of the 1984 Act imposed a requirement on a policyholder, before a contract is entered into, to disclose particular information. What had to be disclosed was determined by a test that contains both subjective elements (what the policyholder knows to be relevant to the insurer’s decision) and objective elements (what a reasonable person in the circumstances could be expected to know would be relevant to the insurer’s decision).

3.23 Section 21 of the 1984 Act, as amended by the *Insurance Contracts Amendment Act 2013*, expanded the objective element of the test to include two additional non-exclusive factors to which the court may have regard when determining what “a reasonable person in the circumstances could be expected to know to be a matter so relevant” to the decision of the insurer whether to enter the contract of insurance. The two factors to which the court may have regard are:

“(i) the nature and extent of the insurance cover to be provided under the relevant contract of insurance; and

(ii) the class of persons who would ordinarily be expected to apply for insurance cover of that kind.”

3.24 Section 21, as amended in 2013, moves closer to considering the relevant individual characteristics of the policyholder. However it does not include a broader third factor of “circumstances in which the contract of insurance is entered into including the nature and extent of any questions asked by the insurer.”²⁶

3.25 In “eligible contracts” (that concern consumers) section 21A(5) of the 1984 Act, as amended in 2013, provides that policyholders must disclose what is known to them and what “a reasonable person in the circumstances could be expected to have disclosed in answer to that question.”

(d) Principles of European Insurance Contract Law (PEICL)

3.26 Article 2:101 of PEICL provides that in general a proposer “shall inform the insurer of circumstances of which he is or ought to be aware, and which are the subject of clear and precise questions put to him by the insurer”. This is further qualified by stating that these circumstances “include those which the person to be insured was or should have been aware”. This is an objective rule in that it presumes that proposers have certain kinds of knowledge.

Underlying this is an expectation that statements to insurers will be made honestly. The authors of the PEICL commented that it had been suggested that proposers should not be allowed to “turn a blind eye”

²⁶ Commenting in 2010 on the draft Bill that was enacted as the 2013 Act, Mr Justice Michael Kirby (Chair of the ALRC when the 1982 Report was published) lamented this approach, commenting that he “would have preferred to see the reform go further: enabling a court to take into account the policyholder’s literacy, knowledge, experience and cultural background, where relevant.” See Kirby “Australian Insurance Contract Law: Out of the Chaos – A Modern, Just and Proportionate Reforming Statute,” (Hugh Rowell Memorial Lecture 2010), at 35, available at michaelkirby.com.au.

to the possibility of information which is adverse to their application but which can be readily unearthed and they are expected to make reasonable enquiries.²⁷

In applying Article 2:101, courts would be required to recognise that certain proposers can be expected to be in possession of more information than others (the example of a doctor applying for health insurance is used).²⁸ Accordingly both objective and subjective elements appear to be present within this rule.

(e) Conclusion and Recommendations

3.27 The Consultation Paper, which centred on “actual knowledge” of facts or circumstances (qualified by a degree of objectivity), provisionally recommended that an insurer should not be permitted to repudiate liability because of non-disclosure of material facts of which the consumer could not “reasonably” be expected to have actual knowledge at the time of applying for cover.²⁹

3.28 The Commission recommends objectivity tempered by subjectivity. A number of relevant factors must be taken into account including those adopted in the United Kingdom and Australia, and identified by the authors of PEICL. These include: that certain applicants can be expected to be in possession of more information than others (such as a doctor applying for health insurance); and the characteristics of “over the counter” insurance products that largely rely on speedy purchase and implementation.

A response provided by a proposer (to a question asked by an insurer) which is merely a guess or which has no foundation in fact would not be made with honest belief and would not be answered “honestly and carefully”. It might, in some circumstances, comprise a fraudulent misrepresentation.

3.29 The Commission concludes that a consumer should be under a duty to take reasonable care to avoid misrepresentation when responding to the questions of insurers. What is considered to be reasonable should be informed by all of the relevant circumstances, and where an insurer was, or ought to have been, aware of the characteristics or circumstances of a consumer, that knowledge should be taken into account. A misrepresentation made dishonestly should always be taken as showing lack of reasonable care.

3.30 The Commission recommends that it should be the duty of consumers to answer the questions posed by insurers honestly and with reasonable care (the test of reasonable care being by reference to that of an “average consumer”³⁰).

3.31 The Commission recommends that in determining whether the consumer has complied with this duty, regard should be had to the following matters: (a) the type of consumer insurance contract in question and its target market, (b) any relevant explanatory material or publicity produced or authorised by the insurer, (c) how clear, and how specific, the insurer’s questions have been, (d) whether the consumer is represented by an agent, and (e) certain consumers can be expected to be in possession of more information than others.

(3) Exceptions to the duty of disclosure

3.32 In *Carter v Boehm*³¹ Lord Mansfield set out a number of exceptions to the duty of disclosure so that it did not operate beyond its intended effect, which is “to prevent fraud and encourage good faith.” In the Consultation Paper the Commission suggested that the codified exceptions in section 18(3) of the *Marine Insurance Act 1906* had been widely applied in case law in an attempt by the courts to curtail the otherwise harsh nature of the duty.³²

²⁷ Basedow et al (eds), *Principles of European Insurance Contract Law* (Sellier, 2009) at 79 paragraph C7.

²⁸ *Ibid* at 78 paragraph C4.

²⁹ Law Reform Commission *Consultation Paper on Insurance Contracts* (LRC CP 65-2011) paragraph 3.28.

³⁰ On the definition of “average consumer”, see paragraph 9.51, below.

³¹ (1766) Burr 1905.

³² See Law Reform Commission *Consultation Paper on Insurance Contracts* (LRC CP 65 – 2011) paragraph 3.42.

3.33 Section 18(3)(a) of the 1906 Act provides that a proposer is not required to disclose facts or circumstances which diminish the risk to be undertaken. Section 18(3)(b) of the 1906 Act provides that a proposer is not required to disclose circumstances which are known or presumed to be known by an insurer. Section 18(3)(c) of the 1906 Act provides that a proposer is not required to disclose particular circumstances and information when an insurer has waived its right to receive such information. Section 18(3)(d) of the 1906 Act provides that a proposer is not required to disclose “any circumstance which it is superfluous to disclose by reason of any express or implied warranty.”

3.34 The Commission concludes that in light of the reformulated duty of disclosure recommended above these exceptions are no longer necessary, and the Commission does not propose to recommend their incorporation into the draft *Consumer Insurance Contracts Bill* appended to this Report.

3.35 The Commission recommends that, in light of the reformulated duty of disclosure recommended in this Report, it is not necessary to include in the draft *Consumer Insurance Contracts Bill* appended to this Report the exceptions to the common law pre-contractual duty of disclosure.

B Reformulated duty of disclosure: the insurer

3.36 Since the Commission has recommended that the statutory pre-contractual duty of disclosure to be imposed on consumers should be confined to providing responses to questions asked by insurers, and because consumers should not be under any duty to volunteer any information over and above that required by such questions, the effects of this recommendation on insurers should be considered and in particular whether insurers should be entitled to include general “catch all” questions.

(1) Types of Questions

(a) The limits of general “catch-all” questions

3.37 Limiting insurers to obtaining information from questions raises the possibility that they will include general “catch all” questions in the application forms. Such an ability might undermine the reform recommendations by reintroducing a duty to volunteer information.

(i) United Kingdom

3.38 The Law Commission of England and Wales and Scottish Law Commission illustrated this with the following example.³³ A question such as “are there any other hazards that we should be made aware of?,” asked in the context of a buildings policy proposal, leads to the following observations:

“would a reasonable consumer mention that they manufactured fireworks at home? We think the answer would be: “yes”. Although the question was general, this particular hazard was so obvious and extreme that it is the sort of thing that ought to be mentioned by a reasonable consumer. However, it may not be reasonable to expect the consumer to mention that they are near a river in response to such a question.”

3.39 The Law Commissions queried whether it would be fair and reasonable to penalise those that failed to mention the river. They proposed that insurers should be allowed to ask general questions, but should undertake the risk of receiving vague answers. In assessing the merits of this recommendation, the House of Lords Special Public Bill Committee in its review of what became the *Consumer Insurance (Disclosure and Representations) Act 2012* made the following comments.³⁴

- The Association of British Insurers *Guidance for Non-Disclosure on Claims for Long-Term Protection Insurance Products* recommends that “very little weight” should be given to general questions.

³³ Law Commission of England and Wales and Scottish Law Commission *Issues Paper 1 on Misrepresentation and Non-Disclosure* (September 2006) paragraph 6.20.

³⁴ House of Lords Special Public Bill Committee: *Consumer Insurance (Disclosure and Representations) Bill* [HL] (10 November 2011) at 37.

- Insurers have “well developed practices” and a “good understanding” of the types of questions required to capture relevant information as they are “best placed to know which information is material”.
- Such questions may prove disadvantageous to the insurer as they may be unable to rely on the answers provided. Insurers will only be entitled to access the remedies after establishing that the information provided by the consumer had ‘induced’ them into the contract. This could prove difficult in circumstances where catch all questions were posed.
- In deciding whether or not the consumer has taken reasonable care not to make a misrepresentation when answering a question, all relevant circumstances will be taken into account, including how clear and specific the insurer’s questions were.
- Given the Financial Services Authority³⁵ guidance and Financial Ombudsman Service decision-making, “the majority of insurers would not substantially change their existing practices and rely on catch-all questions where they had not previously done so.”³⁶ If they did, “they run the risk that consumers may act reasonably but still fail to give the relevant information”.³⁷

3.40 Despite the objections and concerns thus raised the *Consumer Insurance (Disclosure and Representations) Act 2012* does not explicitly ban general questions.

(ii) Australia

3.41 Section 21A of the *Insurance Contracts Act 1984*³⁸ provides that, in connection with eligible (consumer³⁹) insurance contracts, the insurer will be taken to have waived the duty of disclosure unless it asks specific questions.⁴⁰

As originally enacted section 21A allowed an insurer who had asked specific questions also to expressly request the policyholder to disclose any exceptional circumstances known to them (or which a reasonable person could be expected to know) which was not a matter that the insurer could reasonably have been expected to make the subject of a question.⁴¹

3.42 Section 21A as originally conceived did not deal with or prohibit catch-all questions. Arising from the 2004 review of the 1984 Act, section 21A was amended by the Australian *Insurance Contracts Amendment Act 2013* to expressly prohibit such questions. The Explanatory Memorandum to the 2013 Act published by the Australian House of Representatives notes the difficulty attached to catch-all questions because they tend to.⁴²

³⁵ The Financial Services Authority (FSA) has since become two separate regulatory authorities, the Financial Conduct Authority (FCA) and the Prudential Regulation Authority (PRA). The FCA now regulates the financial services industry in the UK.

³⁶ House of Lords Special Public Bill Committee: *Consumer Insurance (Disclosure and Representations) Bill* [HL] (10 November 2011) at 14.

³⁷ *Ibid.*

³⁸ Inserted into the 1984 Act by the *Insurance Laws Amendment Act 1998*.

³⁹ The “eligible” contracts to which section 21A applies are motor vehicle, home buildings, home contents, accident and sickness, consumer credit and travel insurance. Section 21A(9) of the 1984 Act defines an eligible contract of insurance as one specified in Regulations made under the 1984 Act. At the time of writing (June 2015) the relevant Regulations are the *Insurance Contracts Regulations 1985* (Australian Statutory Rules 1985, No.162), as amended.

⁴⁰ See Merkin *Reforming Insurance Law: Is there a Case for Reverse Transportation? A Report for the English and Scottish Law Commissions on the Australian Experience of Insurance Law Reform* (Law Commission of England and Wales and Scottish Law Commission, 2007) at paragraph 4.18.

⁴¹ Section 21A(4) of the 1984 Act.

⁴² Australian House of Representatives *Explanatory Memorandum Insurance Contracts Amendment Act 2013* (2013) at 20.

“undermine the benefits for insureds of the framework for eligible contracts of insurance. Insurers should be in a position to decide what matters are material to their decision to provide eligible contracts of insurance and formulate specific questions accordingly. In the event that an insurer is unable to foresee a matter that is relevant to their decision whether to accept the risk of a particular contract, then it is difficult to justify expecting an unsophisticated insured to realise its relevance.”

Insurers may ask one or more specific questions that are relevant to the decision whether to accept risk and, if so, on what terms. Where insurers do not ask such questions, they are taken to have waived compliance with the duty of disclosure.

Further, and significantly, if an insurer makes a request in relation to “any other matter” outside the specific questions that would be covered by the duty of disclosure, they are taken to have waived compliance with the duty of disclosure.

If an insurer asks one or more specific questions and the policyholder in response to those questions discloses each matter that is known to the policyholder (that a reasonable person in the circumstances should be expected to have disclosed in answer to that question) the policyholder is taken to have complied with the duty of disclosure in relation to the contract.

(b) Lengthy and complex questionnaires

3.43 Limiting insurers to specific questions and prohibiting general questions may give rise to the objection that these measures could lead to lengthy and complex questionnaires.

This was considered by the Law Commission of England and Wales and Scottish Law Commission⁴³ when it was suggested that such reforms might encourage some insurers to make the task of completing proposal forms burdensome and unduly inquisitive, bringing about situations that privacy law and the data protection principles are intended to prevent.

The British Institute of Insurance Brokers argued that:

“We do not believe that it is practically possible for an insurer to ask every possible material question relating to a risk at the time of proposal. An attempt to do so would create proposal forms of enormous size and complexity – which would add substantial costs to the business process.”⁴⁴

The Law Commission of England and Wales and Scottish Law Commission discounted these concerns, noting that the UK’s Financial Ombudsman Service already operated on the “principle that policyholders are only required to answer questions asked – and they still respond to market pressures to keep forms short;” and Lloyd’s conceded in its submission that the “practice of the FOS may have taken expectations past the point of no return.”⁴⁵

3.44 During the Parliamentary debates on the *Consumer Insurance (Disclosure and Representations) Act 2012*, the House of Commons Public Bill Committee identified the following reasons why lengthy forms would not result:⁴⁶

⁴³ Law Commission of England and Wales and Scottish Law Commission *A summary of Responses to Consultation Paper on Insurance Contract Law: Misrepresentation, Non-Disclosure and Breach of Warranty by the Insured* (2008), paragraph 2.28.

⁴⁴ *Ibid.* As an alternative to the proposal the Institute suggested, *ibid* at paragraph 2.29, that “private policyholders should be under a duty to disclose anything that a right-minded lay person would consider material, whether specifically asked for or not”, an example being “where keys had been taken in a previous break-in and the locks had not been changed.”

⁴⁵ Law Commission of England and Wales and Scottish Law Commission *A summary of Responses to Consultation Paper on Insurance Contract Law: Misrepresentation, Non-Disclosure and Breach of Warranty by the Insured* (2008), paragraph 2.30.

⁴⁶ House of Commons Public Bill Committee: *Consumer Insurance (Disclosure and Representations) Bill* [Lords] Debates Session 2010-12 First Sitting (22 February 2012).

- The internal cost pressures placed on insurers should prevent them from creating burdensome forms. Cost benefit analysis, therefore, will probably result in insurers asking as few questions as possible in order to assess the relevant risks;
- The onus will rest upon insurers to prove that particular answer(s) induced them to enter into particular contract(s); they are unlikely to ask numerous irrelevant questions. The expectation would be that insurers would only pose questions to elicit relevant information. This would ensure that the questions asked will be proportionate to the benefit that insurers derive from them.
- Lengthy questionnaires are likely to facilitate inadvertent, innocent misrepresentation while a short more compact questionnaire would focus a consumer's mind. This was expected to incentivise the insurer to consider carefully the questions posed; and
- A competitive marketplace will provide a strong incentive for insurers not to overload consumers with too much paperwork as consumers will simply seek cover elsewhere.

3.45 The Commission agrees with those conclusions and anticipates that lengthy pre-contractual questionnaires are unlikely to result from the recommendation to replace the duty of disclosure with a duty to ask specific questions.

Where disputes arise the onus should rest on insurers to provide evidence that they have discharged their duty to ask clear and specific questions. The evidence could involve a recorded exchange between the proposer and the insurer's representative or, in telephone or internet sales, evidence of the questions asked during the process;⁴⁷ or be documentary, such as a copy of the information that the insurer has sent the consumer.⁴⁸

(c) Conclusion and Recommendation

3.46 Lowry and Rawlings observed that general questions are not a reliable way of eliciting information relevant to assessing the risk, and, if the question is broad or vague, it may be legitimately answered in kind. In addition, it would be difficult for the insurer to show it was influenced by the misrepresentation in entering into the contract.⁴⁹

The Commission agrees with that analysis and also places weight on the detailed analysis by the House of Lords during the debates on the *Consumer Insurance (Disclosure and Representations) Act 2012*, discussed above, and concludes that insurers should not be permitted to rely upon the answers to general questions in order to avoid insurance contracts.

This view is reinforced by the Australian experience and the Commission considers that sections 21 and 21A of the Australian *Insurance Contracts Act 1984*, as amended in 2013, provide a useful model for reform. The Commission recommends that in consumer insurance contracts, insurers should be under a duty to ask specific questions and should not be permitted to rely on general ("catch-all") questions.

3.47 The Commission recommends that where insurers request consumers at the pre-contractual stage to provide information to the insurer, the insurer should be under a duty to ask specific questions, in writing, and should not ask general questions.

(2) Materiality

(a) A presumption of materiality attaches to the questions

3.48 The Law Commission of England and Wales and Scottish Law Commission recommended that, to complement the requirement to ask specific questions, there should be a rebuttable presumption (in

⁴⁷ House of Commons: *Consumer Insurance (Disclosure and Representations) Bill* [HL] Research Paper 12/06 20 January 2012 at 5.

⁴⁸ See the statutory documentary requirements discussed in Chapter 10, below.

⁴⁹ Lowry and Rawlings "That Wicked Rule, that Evil Doctrine": Reforming the Law on Disclosure in Insurance Contracts" (2012) 75 MLR 1099, at 1112.

respect of alleged deliberate, reckless or careless misrepresentation) that the consumer knew that a matter about which the insurer asked a clear and specific question was relevant to the insurer.

That recommendation was implemented in section 5(5)(b) of the *Consumer Insurance (Disclosure and Representations) Act 2012* which provides that:

“it is to be presumed, unless the contrary is shown... that the consumer knew that a matter about which the insurer asked a clear and specific question was relevant to the insurer.”

3.49 The Commission has already recommended that insurers should be required to obtain information from consumers by asking specific questions because insurers are best placed to identify the “material facts” relevant to the insurance contract. A presumption of materiality should, accordingly, attach to the questions.

(b) The hypothetical prudent insurer or the particular insurer

3.50 The law currently provides that a misrepresentation is only actionable if it is “material” in that it would influence the judgement of a hypothetical prudent insurer. The Law Commission of England and Wales and Scottish Law Commission identified the difficulty attached to the “prudent insurer” test as follows:

“[S]ome insurers may wish to develop niche markets, by asking questions that seem irrelevant to the generality of insurers. For example, an insurer may assess risk on the basis that all their policyholders are members of a particular profession or union. This means that a question about occupation may be material to them, even if it is irrelevant to most prudent underwriters..”⁵⁰

Therefore following an incorrect answer (and in the absence of fraud) the “niche” insurer, having stepped outside the realm of the prudent insurer market, may find that there has been no actionable misrepresentation.

3.51 The authors of PEICL, while limiting the proposer’s duty to answering an insurer’s questions truthfully, suggest that the questions identify facts which the particular insurer regards as material. However it favours attaching the presumption that the relevant insurance market would agree.⁵¹ Therefore PEICL appears to favour the hypothetical insurer, in other words the “prudent insurer”.

3.52 The Commission remains unconvinced that it is appropriate to retain the “prudent insurer” test in circumstances where the insurer is already affected by the abolition of the duty to volunteer information.

The Commission agrees with the conclusions of the Law Commission of England and Wales and Scottish Law Commission that such an objective approach would serve to prevent insurers from developing niche markets, by undertaking risks notwithstanding facts which might deter other insurers.

The Commission therefore recommends a statutory presumption that the questions asked are relevant and material to the assessment of the risk and that insurers should no longer have to prove that the question asked is material to a “prudent insurer.”

3.53 The Commission recommends that it should be presumed, unless the contrary is shown, that a consumer will know that a matter about which an insurer asks a specific question is material to the risk undertaken by that insurer or the calculation of the premium by that insurer, or both.

(c) Ambiguous questions

3.54 How ambiguous or misleading questions are to be treated by the proposer has been examined by the Irish courts on a number of occasions. The weight of Irish authority is in favour of viewing and

⁵⁰ Law Commission of England and Wales and Scottish Law Commission *Issues Paper 1 on Misrepresentation and Non-Disclosure* (September 2006) paragraph 6.26.

⁵¹ Basedow et al (eds), *Principles of European Insurance Contract Law* (Sellier, 2009) at 87 paragraph C3.

interpreting these ambiguous provisions against the party who prepared the question or contract term, the *contra proferentem* rule.⁵²

A similar rule also forms part of the *European Communities (Unfair Terms in Consumer Contracts) Regulations 1995*.⁵³ The 1995 Regulations require that terms in a consumer contract (limited to a natural person acting for purposes which are outside their business) must be drafted in plain, intelligible language and that where there is a doubt about the meaning of a term the interpretation most favourable to the consumer shall prevail.⁵⁴

3.55 In the Consultation Paper the Commission provisionally recommended that where there is doubt about the meaning of a question, it should be interpreted in accordance with a standard of what is fair and reasonable.⁵⁵ This recommendation formed a response to the main objection to the *contra proferentem* rule: that reading a clause against a party who prepared it need not necessarily lead to an interpretation that a reasonable person would deduce from the words themselves. It reflected the approach in section 23 of the Australian *Insurance Contracts Act 1984*, which provides:

“Where a statement is made in answer to a question asked in relation to a proposed contract of insurance... and a reasonable person in the circumstances would have understood the question to have the meaning that the person answering the question apparently understood it to have, that meaning shall, in relation to the person who made the statement, be deemed to be the meaning of the question.”

3.56 In Chapter 10 below, the Commission recommends that all documents provided by the insurer must be drafted in plain and intelligible language and where there is doubt about the meaning of the wording of any document or information so provided, the interpretation most favourable to the consumer, as appropriate, will prevail.

3.57 As questions provided by the insurer form part of the documents provided by the insurer they too should be drafted in plain and intelligible language and where there is doubt about the meaning of the wording of the question so provided, the interpretation most favourable to the consumer, as appropriate, will prevail.

Insurers are already at an advantage because consumer insurance contracts are generally drafted in standard form which means that they are not open to negotiation. Proposers will not have the opportunity to object to the questions asked. In such circumstances it does not seem unreasonable that such questions should then be interpreted against the insurer who drafted them.

3.58 The Commission recommends that all questions provided by an insurer should be drafted in plain and intelligible language and where there is doubt or ambiguity about the meaning of the wording of any question so provided, the interpretation most favourable to the consumer should prevail, and the onus of proving that the questions are plain and intelligible should rest with the insurer.

(d) Unanswered Questions

3.59 For cost and other reasons insurers usually provide consumers with standard contracts and forms. Such forms inevitably contain more questions than the average proposer would strictly need to answer. Unsurprisingly forms can be returned with questions remaining unanswered because the proposer did not, for example, consider the question relevant to the application, even though the question may later prove relevant.

⁵² This rule is analysed as it applies to insurance contracts in Chapter 9, below.

⁵³ SI No.27 of 1995, as amended. The 1995 Regulations, which implemented Directive 93/13/EEC, the Directive on Unfair Terms in Consumer Contracts, are discussed in Chapter 9, below.

⁵⁴ Regulation 5 of the 1995 Regulations.

⁵⁵ Law Reform Commission *Consultation Paper on Insurance Contracts* (LRC CP 65 – 2011) at paragraph 4.14.

Some questions can be returned unanswered because the proposer chooses not to answer them in the hope that the insurer will incorrectly presume that the question was not relevant.

Therefore failure to answer questions in an insurance proposal form may be the result of innocence, carelessness or fraud.

3.60 In Australia, the ALRC concluded in its 1982 Report that provisions or conditions inserted in insurance contracts by insurers which deemed a proposer's failure to reply to a question to be a negative answer had led to uncertainty and confusion, particularly in relation to questions which were not obviously susceptible of a negative answer.⁵⁶

As a result of this analysis, section 21(3) of the Australian *Insurance Contracts Act 1984* provides that "where a person: (a) failed to answer; or (b) gave an obviously incomplete or irrelevant answer to; a question included in a proposal form about a matter, the insurer shall be deemed to have waived compliance with the duty of disclosure in relation to the matter."

Section 27 of the 1984 Act provides that an omission is not a misrepresentation "by reason only" of the fact that the proposer failed to answer or gave an incomplete or irrelevant answer to a question. This suggests that other factors may justify a conclusion of fraud, for example, if the proposer was aware of the incomplete nature of the answer and had abstained from giving a complete answer in order to conceal material facts.

3.61 In the UK, section 2(2) of the *Consumer Insurance (Disclosure and Representations) Act 2012* imposes a duty on the consumer to take reasonable care not to make a misrepresentation to the insurer, implying that if a consumer acted reasonably in providing an incomplete answer, the insurer would still be obliged to honour the contract.

Section 2(3) of the 2012 Act provides that the failure by a proposer to comply with an insurer's request to confirm or amend previously submitted particulars may amount to a misrepresentation. This suggests that an incomplete form will not be deemed to include misrepresentations if no follow-up requests are made by the insurer. The Commission concurs with that view.

3.62 The authors of the PEICL note that where an insurer concludes a contract based on an application form with incomplete or blank answers "the inference is that the answer was not material to the decision or that it was so marginal to the decision that the insurer was willing to assume that, if supplied, the information would not have been material."⁵⁷

3.63 In summary, it is the responsibility of a proposer to answer relevant questions in a proposal form honestly and with reasonable care, and it is the responsibility of the insurer to follow up on any matters that they consider relevant; this would include an answer left blank in relation to a question.

3.64 The Commission recommends that an insurer's failure to investigate an absent or obviously incomplete answer to a relevant material question should be deemed a waiver by the insurer of any further duty of disclosure by the consumer (other than the duty not to engage in fraudulent, intentional or reckless conduct).

(e) Data protection

3.65 When assessing the risk associated with the application for insurance insurers should, in accordance with the recommendations of this Report, make clear by way of specific questions what information they require.

When these questions probe sensitive issues concerning for example personal data principles, the scope of questions should be governed by the 2013 *Code of Practice on Data Protection for the Insurance Industry*, which was approved by the Data Protection Commissioner in accordance with section 13 of the *Data Protection Act 1988*, as amended.⁵⁸

⁵⁶ Australian Law Reform Commission *Report on Insurance Contracts* (Report No. 20, 1982) at paragraph 184.

⁵⁷ Basedow et al (eds), *Principles of European Insurance Contract Law* (Sellier, 2009) at 86 paragraph C1.

⁵⁸ On the status of Codes of Practice, see Chapter 1, above and Appendix C, below.

The Commission considers that this statutory code, which is subject to external oversight by the Data Protection Commissioner, deals adequately with the issue of the scope of questions that arise in this context, including the scope of questions concerning genetic information.

(f) Moral hazard and previous criminal convictions

3.66 The assessment of risk is more difficult when questions deal with matters relating to “moral hazard,” which arise in particular in relation to previous criminal convictions.⁵⁹ The Commission accepts that previous criminal convictions may be of relevance to the risk undertaken by the insurer. However their disclosure creates significant difficulties for proposers who, often justifiably, may not appreciate the necessity to disclose prior criminal convictions, which appear to have little or no connection with the insurance contract. This was the precise question that arose in *Aro Road*.⁶⁰

3.67 Similarly, the facts of the English Court of Appeal case *Lambert v Co-Operative Insurance*⁶¹ illustrate the difficulty. Mrs Lambert took out an insurance policy to cover her own and her husband’s jewellery. The insurer did not ask about previous convictions and Mrs Lambert provided no such information although, to her knowledge, her husband had been convicted of a crime of dishonesty some years earlier. The policy was renewed each year, the last application being in March 1972. In December 1971 Mrs Lambert’s husband was imprisoned for an offence of dishonesty, a fact which was also not disclosed to the insurer when the policy was renewed.

3.68 When Mrs Lambert claimed £311 for lost jewellery the insurer avoided the policy. The English Court of Appeal held that the insurers were entitled to do so as the conviction was a material circumstance which would have influenced a prudent insurer. MacKenna J expressed dissatisfaction with requiring Mrs Lambert to disclose the fact of her husband’s conviction, on the basis that she was unlikely to have thought that it was necessary to disclose it when she was renewing the policy on her jewellery. He added: “She is not an underwriter and has presumably no experience on these matters.”⁶²

3.69 A more extreme example arose in the High Court decision of Hanna J in *Flynn v Financial Services Ombudsman and Allianz Plc*,⁶³ where the respondent insurer had declined to indemnify the appellant under a household policy on the basis that he had failed to disclose, at the renewal of the policy, that he was facing pending criminal charges in relation to alleged possession of cocaine. Although the charges were subsequently dismissed, the Financial Services Ombudsman (FSO) held that the pending charge was a material fact that should have been disclosed to the insurer. In the High Court, Hanna J dismissed the appellant’s appeal on the basis that the correct test of materiality had been applied by the FSO and that the insurance contract in question had converted the non-disclosure into a “basis of contact” warranty.⁶⁴ Hanna J added that it was “regrettable” that the appellant “who stands wholly innocent of the drugs charges which were levelled against him, must find himself in a position where he cannot recoup insurance on a premises seriously damaged in wholly innocent circumstances.”⁶⁵

3.70 The *Criminal Justice (Spent Convictions) Bill 2012*⁶⁶ proposes a statutory framework in which some criminal convictions may be deemed “spent” for certain purposes such as when applying for a job

⁵⁹ Buckley *Insurance Law* 3rd ed (Thomson Round Hall 2012) paragraph 3-121.

⁶⁰ [1986] IR 403; see the discussion in Chapter 2, above.

⁶¹ [1975] EWCA Civ J0122-2; [1975] 2 Lloyd’s Rep 485.

⁶² [1975] EWCA Civ J0122-2; [1975] 2 Lloyd’s Rep 485, at 491.

⁶³ High Court, 28 July 2010.

⁶⁴ See the discussion of warranties and the Commission’s proposals for reform in Chapter 4, below.

⁶⁵ *Ibid* at paragraph 27. See also Buckley *Insurance Law* 3rd ed (Thomson Round Hall 2012) paragraph 3-121.

⁶⁶ At the time of writing (June 2015), while the 2012 Bill has passed most stages in both Houses of the Oireachtas, it has been decided it will not proceed to final stage until further consideration is given to whether it is fully compatible with the European Convention on Human Rights (ECHR). This is to take account in particular of the decision in *R (on the application of T) v Secretary of State for the Home Department* [2013] EWCA Civ 25; [2014] UKSC 35, in which it was held that some aspects of the comparable British legislation,

and, consequently, need not be disclosed in those circumstances. The 2012 Bill also deals, in part, with the question of disclosure of criminal convictions in the insurance setting.

The 2012 Bill provides that certain categories of offences, including sexual offences and offences which are tried at the Central Criminal Court (such as murder and certain competition law offences) are excluded from ever being regarded as spent. The 2012 Bill also proposes that where a sentence of over 12 months is imposed this will also be excluded from being regarded as spent.

Subject to these exceptions the 2012 Bill provides that, in general, convictions will become “spent” over various time periods by reference to a number of factors such as whether a custodial or non-custodial sentence was imposed.

Accordingly, under the 2012 Bill,⁶⁷ where a person is sentenced to imprisonment for a term of 12 months or less but more than 6 months, the conviction will become spent 5 years after the date of conviction. The 2012 Bill also follows a sliding scale approach to non-custodial sentences, including the following:⁶⁸

- term of imprisonment of 12 months or less which is suspended: becomes spent after 3 years, or the period specified by the court, whichever is the longer;
- fine not exceeding the maximum amount that can be imposed as a Class A fine (currently, under the *Fines Act 2010*, €5,000 or less): becomes spent after 2 years;
- community service order imposed on a person as an alternative to a sentence of imprisonment for a term of 12 months or less: becomes spent after 2 years.

Section 7(2) of the 2012 Bill also proposes that a person who is convicted of fraud, deceit or dishonesty in respect of a claim under a life or non-life insurance contract will not be excused under the Bill from disclosing any such conviction on an insurance proposal form.

The 2012 Bill also proposes that where a sentence of over 12 months is imposed this will also be excluded from being regarded as spent. In *Aro Road*,⁶⁹ the plaintiff company had not disclosed that its managing director had a criminal conviction for which he was sentenced to 21 months in prison some 19 years prior to completing the proposal form. The Supreme Court held that this could not be regarded as a material non-disclosure, even applying the current prudent insurer test, because it would not be reasonable to regard this as material to the risk undertaken.

3.71 The principle behind the 2012 Bill that certain convictions need not be disclosed after a certain period of time is, in general, consistent with a test of materiality in insurance contract law. Yet it is also notable that the specific conviction in *Aro Road* would not be regarded as spent if the 2012 Bill had been in place when the circumstances in that case arose.

This does not necessarily give rise to a conflict. A key purpose of the 2012 Bill is to encourage offender rehabilitation by providing that a person’s old and relatively minor criminal conviction does not present a high barrier to his or her employment prospects.⁷⁰

While the 2012 Bill discusses an aspect of insurance fraud and is in that respect relevant to this Report, the test of materiality in insurance addresses a somewhat different matter, namely, whether the insurer is in a position to assess the risk being undertaken. The Commission therefore concludes that the recommendations made in this Report on disclosure and materiality can be regarded as being without prejudice to the specific provisions in the 2012 Bill, which are directed primarily at the rehabilitation of offenders.

the *Rehabilitation of Offenders Act 1974*, were not compatible with the right to protection of private life under Article 8 of the ECHR.

⁶⁷ See *Criminal Justice (Spent Convictions) Bill 2012*, as amended in Seanad Éireann, schedule 2, part 1.

⁶⁸ *Ibid* at schedule 2, part 2.

⁶⁹ [1986] IR 403: see the discussion in Chapter 2, above.

⁷⁰ See the Commission’s 2007 *Report on Spent Convictions* (LRC 84–2007), which formed the general basis of the 2012 Bill.

3.72 The Commission recommends that the test of what is material, and consequently the scope of questions that the insurer may ask the consumer, are without prejudice to the requirements of the *Data Protection Acts 1988 and 2003* and to the provisions of the *Criminal Justice (Spent Convictions) Bill 2012*, if enacted.

(3) Whether the answers “induce” the insurer to enter into the contract

3.73 In *Chariot Inns Ltd v Assicurazioni Generali Spa*⁷¹ the Supreme Court relied on English case law at that time to conclude that the insurer is entitled to repudiate liability under the policy regardless of whether the non-disclosure or misrepresentation “induced” the insurer to enter into the contract. The Supreme Court held that an insurer need not prove inducement in that sense, because an insurer was only required to show that the non-disclosure or misrepresentation might have affected its judgement (the objective prudent insurer test), not that it actually did affect its judgement (a subjective test).⁷²

3.74 The recommendation made above that a presumption of materiality should attach to the questions asked of the proposer raises the question whether this approach remains valid. In addition, since *Chariot Inns* was decided English case law has taken a radically different approach to this question.

3.75 The UK House of Lords in *Pan Atlantic Insurance Co Ltd v Pine Top Insurance Co Ltd*⁷³ held that there is to be implied into the common law duty of disclosure, as codified in section 18 of the *Marine Insurance Act 1906*, a qualification that a material misrepresentation will not entitle the underwriter to avoid the policy unless the misrepresentation induced the making of the contract. Significantly, it was decided in *Pine Top Insurance* that, contrary to the common law “prudent insurer” test (codified in section 20 of the 1906 Act) the inducement test “looks at the actual insurer in question, not a hypothetical insurer in the market.”⁷⁴

3.76 In *Assicurazioni Generali SpA v Arab Insurance Group (BSC)*⁷⁵ the English Court of Appeal summarised inducement as follows:

“(i) In order to be entitled to avoid a contract of insurance or reinsurance, an insurer or reinsurer must prove on the balance of probabilities that he was induced to enter into the contract by a material non-disclosure or by a material misrepresentation.

(ii) There is no presumption of law that an insurer or reinsurer is induced to enter in the contract by a material non-disclosure or misrepresentation.

(iii) The facts may, however, be such that it is to be inferred that the particular insurer or reinsurer was so induced even in the absence of evidence from him.

(iv) In order to prove inducement the insurer or reinsurer must show that the non-disclosure or misrepresentation was an effective cause of his entering into the contract on the terms on which he did. He must therefore show at least that, but for the relevant non-disclosure or misrepresentation, he would not have entered into the contract on those terms. On the other hand, he does not have to show that it was the sole effective cause of his doing so.”

3.77 In *Drake Insurance Plc v Provident Insurance Plc*⁷⁶ the English Court of Appeal placed what Buckley terms “significant limitations”⁷⁷ on an insurer’s right to rely on inducement.

⁷¹ [1981] IR 199, which is discussed in detail in Chapter 2, above.

⁷² *Ibid* at 226 and 231, discussing the judgment of MacKinnon LJ in *Zurich General Accident and Liability Insurance Co Ltd v Morrison* [1942] 2 KB 53.

⁷³ [1995] 1 AC 501.

⁷⁴ *Ibid* at 551 (Lord Mustill, delivering the leading Opinion in the case).

⁷⁵ [2002] EWCA Civ 1642, [2003] Lloyd’s Rep IR 131 (judgment of Clarke LJ for the Court).

⁷⁶ [2003] EWCA Civ 1834; [2004] Q.B. 601.

⁷⁷ Buckley *Insurance Law* 3rd ed (Thomson Round Hall 2012) paragraph 3-15.

The Court held that it was not enough for the insurers to show that they would have rejected the proposal or accepted it on different terms. Faced with such evidence, the policyholder has a right of reply and is to be allowed to show that, with full disclosure at the onset, he or she might have been able to persuade the insurer to insure on the usual terms.

The case concerned an insurer who sought to avoid a motor insurance policy when a proposer failed to disclose a speeding conviction. When applying for indemnity under an earlier motor policy with the same insurer the proposer had disclosed a “fault accident.” When applying for cover under the policy before the Court, the proposer had failed to disclose that this earlier accident had been reclassified as a “no-fault accident.”

The question was whether, if the conviction had been mentioned, would the status of the accident have been discussed? The Court held that it was very likely that it would have been. The Court held that even if the speeding conviction had been disclosed, information would have come to light that the earlier accident had not been the policyholder’s fault and the proposal would have been accepted at a normal rate of premium.

3.78 In the Consultation Paper the Commission provisionally recommended that an inducement test be introduced into Irish law and that an insurer should be required to show that non-disclosure of a material fact played a part in the insurer’s decision to enter the contract.⁷⁸ Submissions received by the Commission suggested that it is necessary to clarify the law in relation to disclosure and inducement.

3.79 The UK *Consumer Insurance (Disclosure and Representations) Act 2012* places the inducement test on a statutory footing. Section 4(1)(b) of the 2012 Act provides that an insurer has a remedy against a consumer for a misrepresentation made by the consumer before a consumer insurance contract was entered into or varied only if:

“the insurer shows that without the misrepresentation, that insurer would not have entered into the contract (or agreed to the variation) at all, or would have done so only on different terms.”

During the Parliamentary debates on the 2012 Act the consequences of failing to establish inducement were highlighted as follows:⁷⁹

“If the insurer cannot prove inducement then the policy will remain valid, even if the non-disclosure was deliberate. The burden of proving inducement will not be high in clear-cut cases. For example, if a customer fails to disclose that their house has serious cracks, we are likely to believe the insurer would not have offered them full buildings insurance. However, it is rare for cases to be this clear-cut and we will usually require evidence that inducement took place. This may be in the form of a statement from the underwriters and/or a copy of the underwriting manual.”

3.80 The authors of PEICL (in the explanatory notes) identify as an exception to the duty of disclosure what is termed “immaterial information.” Article 2:103(b) provides that, for information to be material, it must be “sufficiently significant to be causative, in the sense that, if it had been disclosed, it would have had a certain effect on the conduct of the insurer: that the insurer would have refused to conclude the contract at all or would have done so only on different terms.”⁸⁰

3.81 The Commission endorses the approach in the UK 2012 Act which provides that, in order to rely upon inducement to avoid a contract of insurance, the onus rests upon an insurer to prove, on the balance of probabilities, that a material non-disclosure had a significant influence on and was the effective cause of the decision of the insurer to enter into the contract.

⁷⁸ Law Reform Commission *Consultation Paper Insurance Contracts* (LRC CP 65 – 2011) paragraph 3.33.

⁷⁹ House of Commons: *Consumer Insurance (Disclosure and Representations) Bill* [HL] Research Paper 12/06 20 January 2012 at 5.

⁸⁰ Basedow et al (eds) *Principles of European Insurance Contract Law* (Sellier, 2009) at 86 paragraph C2.

The Commission does not favour a test that would require the insurer to prove that the relevant non-disclosure was the sole cause of the insurer entering into the contract or that it was the sole decisive influence on the insurer's decision to enter into the contract.

Insurers who seek to avoid liability do not have to show that particular misrepresentations or non-disclosures would have influenced other underwriters in the market, they merely have to prove that they influenced them.

3.82 The Commission recommends that an insurer should be entitled to repudiate liability and to refuse to indemnify only if it can prove on the balance of probabilities that non-disclosure of material information was an effective cause of the insurer entering into the relevant contract of insurance on the terms on which it did.

(4) Duty to explain the consequences of non-disclosure

3.83 In the Consultation Paper the Commission provisionally recommended that the insurer should have a duty to explain to a proposer both the nature of the duty of disclosure and the consequences of non-disclosure.⁸¹ This recommendation derived from section 22 of the Australian *Insurance Contracts Act 1984*.

Submissions received by the Commission suggested that the recommendation was unnecessary as it was covered by the *Consumer Protection Code 2012*. However the Code was drafted against the background of the duty of disclosure as it currently operates, and does not reflect the reformulated duty recommended in this Report.

In light of the reformulation of the duty the Commission considers that it is preferable to include a general provision requiring the insurer to notify the proposer of the new duty, and the consequences of breaching it.

The Commission concludes that this requirement should be a prerequisite to the conclusion of the contract, and should the insurer fail to comply with this, it should not be entitled to rely on any of the remedies available for the breach of the new duty.

The exception to this would be fraud, as fraud should not be tolerated under any circumstances.

3.84 The Commission recommends that insurers should be under a statutory duty to inform consumers in writing, before a contract of insurance is entered into, or renewed, of the general nature and effect of the reformulated duty of disclosure.

C Proportionate Remedies: Avoidance, Rescission and Damages

(1) The penalty for misrepresentations

3.85 Historically, the law of contract did not have any controlling influence on the consequences that follow from the provision of false or misleading information prior to the conclusion of a contract. The law of tort and principles of equitable relief filled the ensuing void.

Equity provided a person to whom a misrepresentation was made with the (often draconian) remedy of rescission of the contract, that is, the right to withdraw from the transaction in certain circumstances.⁸² This right was available in equity even if the misrepresentation was made carelessly or innocently, that is, without fraud.

Some flexibility was introduced into English law by the enactment of section 2(1) of the *Misrepresentation Act 1967*, which provides the person to whom the misrepresentation was made with a statutory cause of action in damages following an innocent (that is, non-fraudulent) misrepresentation, while section 2(2) of the 1967 Act gives courts discretion to award damages in place of rescission.⁸³

⁸¹ Law Reform Commission *Consultation Paper on Insurance Contracts* (LRC CP 65-2011) at paragraph 3.103.

⁸² See *Bank of Ireland v Bell* [1966] IR 646; *Carey v Independent Newspapers (Ireland) Ltd* [2003] IEHC 67.

⁸³ For Northern Ireland see the *Misrepresentation Act (Northern Ireland) 1967*.

The provisions of the 1967 Act were largely replicated in Ireland in section 45(1) and (2) of the *Sale of Goods and Supply of Services Act 1980*,⁸⁴ which provide:

“(1) Where a person has entered into a contract after a misrepresentation has been made to him by another party thereto and as a result thereof has suffered loss, then, if the person making the misrepresentation would be liable to damages in respect thereof had the misrepresentation been made fraudulently, that person shall be so liable notwithstanding that the misrepresentation was not made fraudulently, unless he proves that he had reasonable ground to believe and did believe up to the time the contract was made that the facts represented were true.

(2) Where a person has entered into a contract after a misrepresentation has been made to him otherwise than fraudulently and he would be entitled, by reason of the misrepresentation, to rescind the contract, then, if it is claimed in any proceedings arising out of the contract that the contract ought to be or has been rescinded, the court may declare the contract subsisting and award damages in lieu of rescission, if of opinion that it would be equitable to do so, having regard to the nature of the misrepresentation and the loss that would be caused by it if the contract were upheld, as well as to the loss that rescission would cause to the other party.”

3.86 In insurance contract law, the result that flows from a misrepresentation is that if a material representation proves untrue, an insurer may avoid the contract; this was codified in section 20(1) of the *Marine Insurance Act 1906*. This is a strict duty that remains unaffected by varying degrees of fault.⁸⁵

The common law rule, as codified in section 84(3)(a) of the 1906 Act, provides:

“Where the policy is void, or is avoided by the insurer as from the commencement of the risk, the premium is returnable, provided that there has been no fraud or illegality on the part of the assured; but if the risk is not apportionable, and has once attached, the premium is not returnable.”

Thus, where an insurer elects to rescind an insurance contract, the proposer is entitled to the return of premiums, except where fraud or illegality by the policyholder is present, in which case the premiums are forfeit.

(2) From the “all-or-nothing” approach of repudiation towards proportionality

3.87 The Commission in the Consultation Paper highlighted dissatisfaction with the present availability and use of remedies in insurance contract law. The Irish courts have sought to provide relief to policyholders regarding certain non-disclosures or misrepresentations. Ireland is not alone in expressing dissatisfaction with this “all-or-nothing” remedy of repudiation: Australia, the United Kingdom and the authors of PEICL, have expressed similar views.⁸⁶

3.88 In its 1982 Report the ALRC discussed the use of avoidance as a remedy for non-disclosure and misrepresentation at common law,⁸⁷ comparing the consequences of avoidance in insurance law with the consequences of avoidance outside of insurance law. It concluded that an insurer’s remedy was often out of proportion to the harm caused by a policyholder’s breach of duty and declared that:⁸⁸

⁸⁴ On the Reports which led to the enactment of the 1980 Act, see Chapter 9, below.

⁸⁵ See *HIH Casualty and General Insurance Ltd v Chase Manhattan Bank Casualty and General Insurance Ltd v Chase Manhattan Bank* [2003] UKHL 6; [2003] 1 All ER Comm 349.

⁸⁶ Basedow, Hopt & Zimmermann (eds) *Max Planck Encyclopaedia of European Private Law* (Oxford University Press, 2012), at 4.

⁸⁷ Australian Law Reform Commission *Report on Insurance Contracts* (Report No. 20,1982) at paragraph 186-199.

⁸⁸ *Ibid* at paragraph 187. Section 28 of the *Insurance Contracts Act 1984* provides that the insurer’s right to avoid the contract for non-disclosure and/or misrepresentation is confined to cases of fraudulent non-disclosure or fraudulent misrepresentation.

“The remedy of avoidance or rescission of a contract is not unique to insurance. But there is a vital difference between the operation of that remedy in insurance and its operation in relation to other contracts. Avoidance of a contract for, say, the sale of land does not usually result in great hardship to either party. The vendor regains his interest in the land; the purchaser recovers his money. But avoidance of an insurance contract normally takes place after a loss has occurred and a claim has been made. In such a case, it inevitably results in a loss which may well be overwhelming. The principle of *restitutio in integrum* is satisfied only in the most technical sense. The insured gets back his premium and the insurer is freed from its obligations. But that does not put the parties back into the substantial position they were in at the time of the contract; at that time, the insured had not suffered an uninsured loss.”

3.89 In the Consultation Paper the Commission provisionally recommended that: (1) avoidance of an insurance policy should no longer be the sole or principal remedy available to the parties in cases of non-disclosure and misrepresentation; (2) in such cases the principal remedy should be one of damages; and (3) where damages are awarded they should be proportionate to the nature, extent and consequences of the non-disclosure or misrepresentation.⁸⁹

The Commission invited submissions regarding damages and asked whether the provisions on misrepresentation in section 45 of the *Sale of Goods and Supply of Services Act 1980* should be tailored for insurance contracts to provide a remedy in damages in place of rescission in respect of pre-contractual misrepresentations made by the proposer.

3.90 The Commission discussed whether it would be possible to build on section 45(2) of the 1980 Act by providing a court (and, where relevant, the Financial Services Ombudsman) with a number of indicative factors that could be reference points when the section 45(2) discretion arises in the context of insurance contracts disputes. The suggested factors were as follows:

- the factual context in which the misrepresentation was made;
- the practicality of providing the insurer with an alternative remedy in damages;
- the availability of a remedy to the proposer against a third party such as an insurance broker;
- the relevant insurance sector and the reaction within it had no misrepresentation been made (that is would the proposal have been declined or the premium loaded);
- the commercial experience of the proposer and his/her familiarity with the relevant insurance sector; and
- the need to ensure that the remedy given takes account of and is consistent with any proposed reliefs that may be available in relation to any breach by the proposer of the duty of disclosure.

3.91 Submissions received by the Commission argued that the 1980 Act could not be applied to insurance contracts because policyholders are often impecunious and language such as “damages” can lead to confusion.

3.92 The Commission accepts that terminology such as “damages” is confusing. The Commission envisages a compensatory remedy rather than confining the remedy to a right to sue for damages. What should be assessed is whether the policyholder would lose all their entitlements under the policy due to the misrepresentation or should their entitlements be reduced in proportion to their degree of fault. Compensation should be awarded in proportion to the misrepresentation.

3.93 A proportionality approach has been adopted as a method of compensation in insurance through the decisions of the statutory FSO and the earlier decisions of the non-statutory Insurance Ombudsman. The FSO has introduced a level of proportionality to its decision-making and has permitted a percentage recovery of the benefit under the policy (calculated as a percentage of the amount claimed)

⁸⁹ Law Reform Commission *Consultation Paper on Insurance Contracts* (LRC CP 65 – 2011) paragraph 10.21.

notwithstanding a possible basis in law for avoiding the policy,⁹⁰ while the non-statutory Insurance Ombudsman had also applied principles of proportionality.⁹¹

3.94 In 1980, the Joint Oireachtas Committee on Secondary Legislation of the European Communities reviewed a similar recommendation in the draft EU Directive on Insurance Contracts published in 1979 (which was ultimately withdrawn), which proposed using three categories of misrepresentation: innocent, improper and with intention to deceive.

3.95 The Joint Committee acknowledged that “[t]he provision of varying remedies depending on the degrees of fault of the policyholder would introduce a new element into our law” but declared that it had “no serious objection to it.”⁹² The Commission agrees that the principle of proportionality, suitably adapted, should be applied to consumer insurance contracts.

3.96 **The Commission recommends that the consequences of non-compliance with the reformulated duty of disclosure applicable to insurance contracts should be related to the presence or absence of fault by consumers in making the misrepresentation and be proportionate to the effects of the misrepresentation upon the interests of insurers and consumers.**

(3) Categories of misrepresentations: innocent, negligent and fraudulent

3.97 Since proportionate remedies will not suffice in every circumstance, the Commission has considered three categories of misrepresentation: innocent, negligent and fraudulent. The United Kingdom, Australia and PEICL have considered similar categories. These categories also reflect similar ones in the *Sale of Goods and Supply of Services Act 1980*, discussed above, and which were adopted by the (lapsed) 1979 draft Directive.

(a) Innocent misrepresentation

3.98 The fact that a misrepresentation is innocent is not a defence to an allegation of misrepresentation. Although *Coleman v New Ireland Assurance plc*⁹³ comes close to holding that when an expectation or belief is made in good faith, rescission for an innocent misrepresentation is no longer available to an insurer under Irish law. In *Coleman* the High Court (Clarke J) held that:⁹⁴

“insofar as the answers to questions raised in a proposal form is concerned, a party will only be exposed to the risk of the contract of insurance being voided where the party fails to answer such questions to the best of the party’s ability and truthfully. This would be so even where an answer is inaccurate as a result of ignorance or even, in the words of McCarthy J [in *Keating*], the ‘obtuseness which may be sometimes due to a mental block on matters affecting one’s health.’”

3.99 Insurance Ireland’s non-statutory *Code of Practice on Life Assurance: Duty of Disclosure*⁹⁵ and *Code of Practice: Non Life Insurance*⁹⁶ recommend that only fraudulent or negligent (and not innocent)

⁹⁰ See for example the case studies of the *Financial Services Ombudsman 2008 Annual Report* at 68: “While accepting that the Company had justifiable grounds for refusing the claim on the grounds of non-disclosure nevertheless the Ombudsman taking into account all the circumstances of the case and bearing in mind what was fair and reasonable, found the Complainant was entitled to 50% of the benefit payable under the policy in respect of the cancellation of the holiday.”

⁹¹ See *Digest Decisions of the Insurance Ombudsman 1992-1998*.

⁹² Joint Oireachtas Committee on the Secondary Legislation of the European Communities *Insurance Contracts*, Report No.68 (1980), at paragraph 13. The Report confined its criticisms to the prescribed time periods in the draft Directive.

⁹³ [2009] IEHC 273.

⁹⁴ *Ibid* at paragraph 3.5.

⁹⁵ Paragraph 3(a) of the Code.

⁹⁶ Paragraph 3(a)(ii) of the Code.

non-disclosure or misrepresentations should lead to repudiation of the contract. It appears that insurers have largely followed this recommendation, so that for example in *McAleenan v AIG (Europe) Ltd*⁹⁷ the terms of the policy at issue provided:⁹⁸

“The approved indemnity terms shall not be subject to repudiation or rescission by the qualified insurer, or the level of cover shall not be subject to reduction below the minimum level of cover, on the grounds of innocent misrepresentation or innocent non-disclosure on the part of the insured, and the onus of providing [sic] that a misrepresentation or a non-disclosure was not innocent shall be on the qualified insurer.”

This reflects developments in other jurisdictions.

(i) United Kingdom

3.100 The Law Commission of England and Wales and Scottish Law Commission recommended that the insurer should not be entitled to refuse to pay the claim, or to avoid the policy, on the ground that there was an innocent misrepresentation, and that the burden of showing that the consumer acted unreasonably in making the misrepresentation is on the insurer.⁹⁹

3.101 Section 5 of the UK *Consumer Insurance (Disclosure and Representations) Act 2012* implemented this analysis and provides that the proportionate remedies available to the insurer under the 2012 Act apply only to deliberate, reckless or careless misrepresentations, described in the 2012 Act as “qualifying misrepresentations.” It also provides that it is for the insurer to prove that a “qualifying misrepresentation” was deliberate or reckless.

(ii) Australia

3.102 Section 28 of the *Insurance Contracts Act 1984* provides that an insurer cannot avoid a contract of insurance for an innocent non-disclosure or an innocent misrepresentation. Instead, an insurer can reduce its liability by the amount of the loss caused as a result of the non-disclosure or misrepresentation.¹⁰⁰ The desired effect is to place the insurer in the position it would have been in had the non-disclosure or misrepresentation not occurred. As the ALRC commented:¹⁰¹

“For example, if the insurer would have charged a higher premium had the misrepresentation not been made, it would be entitled to reduce the claim by the amount of the additional premium. If the insurer would not have entered into the contract at all, it would be entitled to pay nothing in respect of the claim except the premium paid by the insured. If the insurer would have inserted a different term in the contract, then the insurer would only be liable for the amount for which it would have been liable if that term had been a term of the contract. The principle is the one generally applied in assessing damages for misrepresentation.”

It is possible that under section 28 of the 1984 Act the liability of the insurer could be reduced to nil.¹⁰² However where the insurer would have entered into the contract for the same premium and on the same terms and conditions even with the non-disclosure or misrepresentation, it follows that the insurer has no remedy.¹⁰³

⁹⁷ [2010] IEHC 128.

⁹⁸ *Ibid* at paragraph 46.

⁹⁹ Law Commission of England and Wales and Scottish Law Commission Report *Consumer insurance law: Pre-contract Disclosure and Misrepresentation* (Law Com No.319/Scot Law Com No.219, 2009) paragraph 6.13.

¹⁰⁰ Australian Law Reform Commission *Report on Insurance Contracts* (Report No. 20) (1982), *Notes to the Draft Insurance Contracts Bill 1982* at 284 clause 29 paragraph 5.

¹⁰¹ *Ibid*.

¹⁰² Review Panel *Report on the Review of the Insurance Contracts Act 1984 Final Report on second stage: Provisions other than section 54* (Australian Treasury 2004) paragraph 10.107.

¹⁰³ Section 28(1) of the 1984 Act.

(iii) PEICL

3.103 Article 2:102(3) of the PEICL proposes that an insurer should be entitled to terminate a contract of insurance where the proposer has made an innocent misrepresentation, if the insurer can show that the contract would not have been concluded if the true facts had been known. Article 2:102(5) of the PEICL provides that “when the error or non-disclosure is innocent, policyholders should not be unduly prejudiced.” Thus, in such an eventuality the insurance money shall remain payable to a policyholder in full and in such circumstances the effect is prospective rather than retrospective.

(iv) Conclusion and Recommendation

3.104 The Commission concludes that where consumers discharge their duty to answer questions honestly and with reasonable care and where a misrepresentation is innocent, insurers should not be entitled to refuse to pay the claim, or to avoid the policy on the ground that there was a misrepresentation.

3.105 The Commission recommends that where consumers discharge their duty to answer questions honestly and with reasonable care and where a misrepresentation is innocent, insurers should pay the claim and should not be entitled to avoid the policy on the ground that there was a misrepresentation.

(b) Negligent misrepresentation

3.106 Under general contract law, section 45 of the *Sale of Goods and Supply of Services Act 1980* provides for damages in lieu of rescission following a negligent misrepresentation. As already noted, in insurance contract law an insurer is entitled to avoid the insurance contract for negligent misrepresentation.

(i) United Kingdom

3.107 The Law Commission of England and Wales and Scottish Law Commission summarised negligent (careless) misrepresentation as a concept that covers “a broad swathe of conduct” where the consumer “failed to take sufficient care to understand what the insurer wanted to know or to check their facts”.¹⁰⁴ They concluded that there was no need to define the concept because “a misrepresentation is careless if the consumer has not taken reasonable care but has not acted deliberately or recklessly.”¹⁰⁵ They also recommended that insurers should have available to them proportionate remedies to replace the “all or nothing” common law remedy of repudiation.

The *Consumer Insurance (Disclosure and Representations) Act 2012* implemented this recommendation and provides for the following remedies for negligent misrepresentation, which reflect what an insurer would have done had the consumer complied with their duty to take reasonable care not to make a misrepresentation:¹⁰⁶

- where an insurer would not have entered into the contract on any terms, it may avoid the contract, refuse all claims but must return the premiums paid;¹⁰⁷
- where an insurer would have entered the contract but on different terms (excluding terms relating to the premium), the contract is to be treated as if it had been formed based on the insurer’s revised terms, if the insurer so requires.¹⁰⁸
- where an insurer would have entered the contract (whether the terms relating to matters other than the premium would have been the same or different) but would have charged a higher

¹⁰⁴ Law Commission of England and Wales and Scottish Law Commission *Consumer insurance law: Pre-contract Disclosure and Misrepresentation* (Law Com No.319/Scot Law Com No.219, 2009) at paragraph 6.57.

¹⁰⁵ *Ibid.*

¹⁰⁶ Schedule 1 Part 1 paragraph 4 of the 2012 Act.

¹⁰⁷ Schedule 1 Part 1 paragraph 5 of the 2012 Act.

¹⁰⁸ Schedule 1 Part 1 paragraph 6 of the 2012 Act.

premium, it may reduce proportionately the amount to be paid on a claim;¹⁰⁹ and reducing the payment proportionately means that the insurer is only required to pay the percentage of the claim that it would otherwise have been obliged to pay under the terms of the contract.¹¹⁰

(ii) Australia

3.108 The application of section 28 of the *Insurance Contracts Act 1984* is discussed above.

(iii) Principles of European Insurance Contract Law (PEICL)

3.109 Article 2:102 of the PEICL provides that where there has been a misrepresentation or breach of a duty of disclosure an insurer should be entitled to propose a reasonable variation of the contract within a prescribed period of time.

It provides for termination of the contract if either: (a) the insurer can prove that the misrepresentation (or undisclosed information) has been so significant (namely so material to the risk) that if it had been fully and accurately informed the insurer would not have concluded the contract of insurance at all; or (b) if the parties to the insurance contract are unable to agree a reasonable variation after the prescribed period of time (variations, like terminations, do not have retrospective effect).

The PEICL also provides that insurers should not be required to indemnify if the insured event is caused by the element of the risk which is the subject of negligent non-disclosure or misrepresentation but that “if the insurer would have concluded the contract at a higher premium or on different terms, the insurance money shall be payable proportionately or in accordance with such terms.”¹¹¹

This suggests no entitlement to terminate if the inaccuracy was not significantly material to the risk and that an insurer must indemnify where the negligent behaviour is not causally connected to the insured event.

(iv) Conclusion and Recommendations

3.110 In making their proportionate compensatory recommendation, the Law Commission of England and Wales and Scottish Law Commission departed from an earlier 1980 Report from the Law Commission of England and Wales which saw proportionality as an imprecise and often arbitrary mechanism. Even if this is so, they argued:

“In any event, in our view it is preferable to allow judges to aim imprecisely at the correct figure than to apply one that is clearly wrong (as where a policy is avoided altogether when there would have been only a small increase in the premium). There are many occasions in which the courts are forced to place arbitrary figures on the level of damages, particularly in personal injury cases. The level of imprecision involved here would appear to fall within acceptable limits.”¹¹²

This recommendation permits the court (or, where relevant, the FSO) to decide on a case by case basis that, even though the proposer may not have been fraudulent, the degree of negligence demonstrated in the particular case is one whereby the “policing” function¹¹³ and the link between misrepresentation and breach of the duty of disclosure, makes avoidance or rescission an appropriate remedy.

3.111 The Commission does not anticipate that this measure will continue to afford the insurer the right to rescind for a purely negligent misrepresentation readily or frequently. It may be that the alternative

¹⁰⁹ Schedule 1 Part 1 paragraph 7 of the 2012 Act.

¹¹⁰ Schedule 1 Part 1 paragraph 8 of the 2012 Act contains a formula to calculate this.

¹¹¹ Article 2:102(5) of the PEICL.

¹¹² Law Commission of England and Wales and Scottish Law Commission *Consumer insurance law: Pre-contract disclosure and misrepresentation* (Law Com No.319/Scot Law Com No.219, 2009) paragraph 6.66.

¹¹³ See *Highlands Insurance v Continental Insurance* [1987] 1 Lloyd’s Rep 109. In the Consultation Paper the Commission questioned whether the “policing function” of avoidance, identified by Steyn J in the *Highlands* case as being inherent in the law of misrepresentation, would be undermined if it was tempered to tackle its sometimes disproportionate effect as a remedy.

financial remedy will be difficult to calculate with any ease, but the court or FSO should be empowered to resort to what amounts to rescission, by allowing for reduction of a claim to zero, as an appropriate remedy in exceptional circumstances.

Where there is a negligent misrepresentation, which arises where the consumer has not taken reasonable care but has not acted fraudulently (the Commission discusses and defines fraud below), there is an element of fault. The consequence should, therefore, take account of what the insurer would have done had it been presented with all the material facts. Where there is doubt in such circumstances the balance should weigh in favour of the insurer and in such circumstances it will be possible for a claim to be reduced to zero.

A compensatory and proportionate approach in line with the provisions of the UK's *Consumer Insurance (Disclosure and Representations) Act 2012*, as described above, would meet these requirements.

3.112 The Commission recommends that where it has been established that a consumer has made a negligent misrepresentation, that is, where the consumer has not taken reasonable care but has not acted fraudulently, the remedy available to an insurer should reflect what the insurer would have done had it been aware of the full facts, and should be based on a compensatory and proportionate test as follows:

(a) if the insurer would not have entered into the insurance contract on any terms, the insurer should be entitled to avoid the contract and refuse all claims, but should return the premiums paid,

(b) if the insurer would have entered into the insurance contract, but on different terms (excluding terms relating to the premium), the contract should be treated as if it had been entered into on those different terms if the insurer so requires,

(c) if the insurer would have entered into the insurance contract (whether the terms relating to matters other than the premium would have been the same or different), but would have charged a higher premium, the insurer should be entitled to reduce proportionately the amount to be paid on a claim.

However where there is not any outstanding claim under the insurance contract, the insurer should be entitled to either:

(i) give notice to the consumer that in the event of a claim it will exercise the remedies in paragraphs (a) to (c), or

(ii) in the case of a non-life insurance contract only, terminate the contract by giving reasonable notice to the consumer.

(c) *Fraudulent misrepresentation*

3.113 In the Supreme Court decision *Banco Ambrosiano Spa v Ansbacher & Co Ltd*¹¹⁴ Henchy J commented that:

“If the court is satisfied, on balancing the possible inferences open on the facts, that fraud is the rational and cogent conclusion to be drawn, it should so find.”

In the UK House of Lords decision in *Manifest Shipping Co Ltd v Uni-Polaris Insurance Co Ltd (The Star Sea)* Lord Hobhouse took the same view, observing that:

“The logic is simple. The fraudulent insured must not be allowed to think: if the fraud is successful, then I will gain; if it is unsuccessful, I will lose nothing.”¹¹⁵

The Commission believes that in general terms fraud must be strongly discouraged and, in particular, that fraudulent insurance claims must be denied.

¹¹⁴ [1987] ILRM 669.

¹¹⁵ [2001] UKHL 1, [2003] 1 AC 469, 499 paragraph 62.

3.114 In *McAleenan v AIG (Europe) Ltd*¹¹⁶ the High Court (Finlay Geoghegan J) discussed and applied the test for fraudulent misrepresentation in insurance contracts. In that case, the defendant insurer had entered into a contract to provide professional indemnity cover for a firm of solicitors, Michael Lynn & Co, which was in effect a sole trading firm.

The firm's principal Mr Lynn and his office manager had completed the proposal form for the insurance contract and the plaintiff, Ms McAleenan, a solicitor in the firm, was wrongly described in it as a partner in the firm. The plaintiff was not, and never had been, a partner in the firm.

When the insurance contract was due to be completed Mr Lynn was absent and the firm's office manager requested the plaintiff to sign the proposal form as a matter of urgency. The plaintiff asked the office manager a number of questions regarding the proposal form, but she did not notice that she had been described in it as a partner in the firm, and she signed the proposal on the firm's behalf with this untrue statement included. Subsequently, the defendant insurer sought to avoid the contract on the ground that the plaintiff had made a fraudulent misrepresentation.

3.115 In the High Court Finlay Geoghegan J held that it was clear that the plaintiff, in signing the proposal form, had misrepresented her status to the defendant insurer and the key question therefore was whether this amounted to a fraudulent misrepresentation. In this respect she quoted and relied on the following well-settled definition of fraud by Lord Herschell in the UK House of Lords decision *Derry v Peek*:¹¹⁷

"First, in order to sustain an action of deceit, there must be proof of fraud, and nothing short of that will suffice. Secondly, fraud is proved when it is shown that a false representation has been made (1) knowingly, or (2) without belief in its truth, or (3) recklessly, careless whether it be true or false. Although I have treated the second and third as distinct cases, I think the third is but an instance of the second, for one who makes a statement under such circumstances can have no real belief in the truth of what he states. To prevent a false statement being fraudulent, there must, I think, always be an honest belief in its truth. And this probably covers the whole ground, for one who knowingly alleges that which is false, has obviously no such honest belief. Thirdly, if fraud be proved, the motive of the person guilty of it is immaterial. It matters not that there was no intention to cheat or injure the person to whom the statement was made."¹¹⁸

This definition of fraud has been applied in a number of Irish cases.¹¹⁹ In *McAleenan* Finlay Geoghegan J also relied on the following summary in *MacGillivray on Insurance Law*:¹²⁰

"In order to constitute an actionable fraudulent misrepresentation the statement of which complaint is made must be:

- (1) false,
- (2) made dishonestly, and
- (3) acted upon by the recipient in the sense that it induced him to make the proposed contract.

Requirement (2) is the hallmark of fraudulent misrepresentation. It means that the false statement is made without an honest belief on the part of its maker that it is true but with the

¹¹⁶ [2010] IEHC 128.

¹¹⁷ (1889) 14 App Cas 337.

¹¹⁸ (1889) 14 App Cas 337, at 374, quoted in *McAleenan v AIG (Europe) Ltd* [2010] IEHC 128 at paragraph 112.

¹¹⁹ For example, by the Supreme Court in *Superwood Holdings Plc v Sun Alliance & London Insurance Plc* [1995] 3 IR 303 and in *Fagan v General Accident Fire and Life Assurance Corp Plc* [1998] IESC 27; and by the High Court in *Michovsky v Allianz Ireland Plc* [2010] IEHC 43 and in *McAleenan v AIG (Europe) Ltd* [2010] IEHC 128, discussed below.

¹²⁰ Legh-Jones Birds Owen (eds) *MacGillivray on Insurance Law* 11th ed (Sweet & Maxwell, 2008) at 405 and paragraph 16-001, quoted in *McAleenan v AIG (Europe) Ltd* [2010] IEHC 128 at paragraph 113.

intention nonetheless that the recipient shall act on it. Either the maker knows that what he says is false or he makes the statement recklessly without caring whether it be true or false.”

3.116 In *McAleenan*, Finlay Geoghegan J held that while the plaintiff made an untrue statement that she was a partner in the firm “I find as fact that she did not do so knowingly.” This was because the Court accepted both that the plaintiff had not read the answer given in the proposal form that she was a partner (the Court noting that, if she had read it before signing, she would have corrected the clear misspelling of her surname as “McAneelan”) and also that she had not noticed that she had signed the proposal from under a description of her as partner. Nonetheless, as Finlay Geoghegan J correctly pointed out:¹²¹

“in accordance with the principles set out above, neither of the above findings precludes a finding of fraud in the making of the false statement if the untrue statement was made “recklessly”, in the sense that the term was used in *Derry v Peek*, i.e. careless as to whether the statement be true or false. It is clear that “careless” for this purpose is not the same as when used in relation to the tort of negligence. The carelessness must be something greater to constitute recklessness for the purposes of fraud. As pointed out by Lord Herschell in the extract from his speech referred to above, a statement may be considered as made recklessly where the circumstances are such that the Court considers the maker can have no real belief in the truth of what he states.”

3.117 In *McAleenan* the Court held that the plaintiff’s own evidence led to a finding that the statements in the proposal form that she was a partner “were made recklessly, in the sense that they were made carelessly as to whether they were true or false” because “she did not read the answers given in relation to her status in the practice and was unaware of the type of person by whom the form was required to be completed and signed.”¹²² Since an honest belief was, as set out by Lord Herschell in *Derry v Peek*, a requirement to prevent a false statement being regarded as fraudulent, the plaintiff’s lack of knowledge of how she was described in the proposal form meant that it was not possible for the Court to conclude that she had any belief in the truth of the statements made. On that basis the Court held that the misrepresentation constituted a fraudulent misrepresentation and the defendant insurer was therefore entitled to avoid the policy.

(i) United Kingdom

3.118 The UK *Consumer Insurance (Disclosure and Representations) Act 2012* has, in effect, consolidated in statutory form the existing common law test of fraudulent misrepresentation, as defined in *Derry v Peek*, thereby implementing the view of the Law Commission of England and Wales and Scottish Law Commission that the existing law should be retained. Section 5(2) of the 2012 Act provides that a misrepresentation is “deliberate or reckless” where a consumer:¹²³

“(a) knew that it was untrue or misleading, or did not care whether or not it was untrue or misleading, and

(b) knew that the matter to which the misrepresentation related was relevant to the insurer, or did not care whether or not it was relevant to the insurer.”

In accordance with the Law Commissions’ analysis, this follows the common law approach since *Derry v Peek* which describes acting recklessly as “not caring” whether a statement is untrue or misleading, or “not caring” whether the matter was relevant to the insurer. It denotes a lack of interest in the truth of

¹²¹ [2010] IEHC 128 at paragraph 123.

¹²² [2010] IEHC 128 at paragraph 124.

¹²³ Section 1 of the 2012 Act defines a consumer as an individual who enters into the contract wholly or mainly for purposes unrelated to the individual’s trade, business or profession.

what one is saying, rather than acting carelessly by not checking the facts.¹²⁴ This is therefore consistent with the “honest belief” test in *Derry v Peek* and other case law.¹²⁵

3.119 The 2012 Act provides that where a misrepresentation is deliberate or reckless the insurer “(a) may avoid the contract and refuse all claims, and (b) need not return any of the premiums paid, except to the extent (if any) that it would be unfair to the consumer to retain them”.¹²⁶

Section 4(5) of the 2012 Act provides that to prove fraud an insurer must show that a misrepresentation was deliberate or reckless and in doing so the insurer will have the benefit of two presumptions, which apply unless the contrary is shown:

“(a) that the consumer had the knowledge of a reasonable consumer, and

(b) that the consumer knew that a matter about which the insurer asked a clear and specific question was relevant to the insurer.”

The Law Commissions explained that consumers can rebut these presumptions with evidence of their state of mind. They gave as an example circumstances where a consumer, in response to a clear and specific question, might fail to mention having sustained a heart attack.

3.120 The Commissions observed that, as most reasonable people would know that they had suffered a heart attack, the insurer would not need to prove that the consumer had acted deliberately or recklessly in such a case. Instead, it would be for the consumer to show lack of knowledge of the heart attack or lack of understanding of the question, (for example, that the doctor failed to tell them about a minor heart attack), or provide other evidence of lack of understanding.

The Commissions recommended that if the court (or the Financial Services Ombudsman) believes this evidence then insurers should be provided with remedies that are solely compensatory and should be entitled to avoid contracts only by proving that if provided with the relevant information they would have refused the risk. They should not be entitled to avoid contracts on grounds that they would have charged a higher premium or imposed different terms.¹²⁷

(ii) Australia

3.121 Section 28(2) of the *Insurance Contracts Act 1984* provides that an insurer is entitled to avoid a contract of general insurance only where there has been a fraudulent misrepresentation or non-disclosure. The 1984 Act does not define what constitutes a fraudulent non-disclosure, but the Australian courts continue to apply the test in *Derry v Peek* so that a statement is deemed to have been made fraudulently “if it is made with knowledge of its falsity or without belief in its truth or recklessly, not caring whether it is true or false”¹²⁸ and therefore there does “not necessarily need to be an intention to deceive.”¹²⁹

While section 28 of the 1984 Act and the relevant case law in general follows the *Derry v Peek* principle, section 31 of the 1984 Act confers a discretion on the courts to hold that the insurance contract should not be avoided by the insurer where it would be “harsh and unfair” to do so, and permits the policyholder

¹²⁴ Law Commission and Scottish Law Commission *Consumer insurance law: Pre-Contract Disclosure and Misrepresentation* (Law Com No.319/Scot Law Com No.219, 2009) paragraph 6.32.

¹²⁵ This was also the approach in the 2009 Association of British Insurers Code of Practice, which in turn had been applied in decisions of the UK Financial Ombudsman Services: see Law Commission of England and Wales and Scottish Law Commission *Consumer insurance law: Pre-contract disclosure and Misrepresentation* (Law Com No.319/Scot Law Com No.219, 2009) paragraph 6.29.

¹²⁶ Schedule 1 Part 1 paragraph 2 of the 2012 Act.

¹²⁷ Law Commission of England and Wales and Scottish Law Commission *Consumer insurance law: Pre-Contract Disclosure and Misrepresentation* (Law Com No.319/Scot Law Com No.219, 2009) paragraph 6.37.

¹²⁸ See Mann and Lewis *Mann’s Annotated Insurance Contracts Act* 6th ed (Lawbook Co, 2014) at paragraph 28.20.2.

¹²⁹ *Ibid.*

to “recover the whole, or such part as the court thinks just and equitable in the circumstances, of the amount that would have been payable if the contract had not been avoided.”

3.122 The court is only permitted to exercise this discretion “if the insurer has not been prejudiced by the failure or misrepresentation or, if the insurer has been so prejudiced, the prejudice is minimal or insignificant”.

In exercising this power the court must have regard to the need to deter fraudulent conduct and must “weigh the extent of the culpability” of the policyholder in the “fraudulent conduct against the magnitude of the loss that would be suffered” by the policyholder “if the avoidance were not disregarded.” The court may, however, “also have regard to any other relevant matter.”

(iii) Discussion and Recommendation

3.123 The Commission endorses the view that insurers should continue to be able to avoid contracts of insurance where there is fraudulent misrepresentation, but considers that the wide definition of fraudulent misrepresentation, derived from *Derry v Peek* and applied in *McAleenan v AIG (Europe) Ltd*,¹³⁰ does not adequately define the concept of fraud for the purposes of insurance contracts and gives rise to consequent difficulty, sometimes enabling insurers to unfairly avoid insurance contracts and repudiate liability.

The Commission considers that the first type of fraud referred to in *Derry v Peek* (where a statement involves an intentional or knowing misrepresentation or, in other words, is made deliberately with an intention to deceive) clearly corresponds with the ordinary meaning of fraud.

The Commission also believes that the second type of fraud referred to in *Derry v Peek* (a statement made “recklessly”) also corresponds with the ordinary meaning of fraud.

3.124 However, “recklessness” in the context of an insurance contract should, in the Commission’s view, be limited to circumstances in which the maker of the statement consciously disregards whether or not the statement is true.

Similarly, “recklessness” in *Derry v Peek* includes being “careless whether it be true or false” which is linked to whether the maker has an “honest belief” in its truth. This, in the Commission’s view, adds another unhelpful level of complexity to the test.

While Finlay Geoghegan J noted in the *McAleenan* case that “careless” in this context is not to be equated with negligence in tort law, the Commission considers that the reference in *Derry v Peek* to the term “careless” immediately after “reckless” suggests that the two are synonymous and is likely to bring within its scope inadvertent behaviour, such as that identified in the *McAleenan* case.

That behaviour could, perhaps, be described as containing a high degree of negligence or even “gross negligence” (that is, behaviour falling far below the standard of care ordinarily expected in the circumstances) but it should be distinguished from fraud.

3.125 Moreover, whereas a predominantly subjective test of knowledge ordinarily applies when determining whether a person intends to deceive or was reckless,¹³¹ the reckless/careless element of *Derry v Peek* is judged, as in the *McAleenan* case, by an objective test, which is a hallmark of determining liability for negligence in tort law.

Given that the definition of fraud set out in *Derry v Peek* includes not only intentional deception and conscious recklessness but also inadvertent carelessness that approximates to gross negligence, it is not surprising that various jurisdictions have sought to modify in some respects its wide scope.

¹³⁰ [2010] IEHC 128.

¹³¹ In the context of the criminal law, the Supreme Court confirmed in *The People (DPP) v Cagney and McGrath* [2007] IESC 46, [2008] 2 IR 111 that the test of recklessness is subjective. The Court also approved the adoption by Henchy J in *The People (DPP) v Murray* [1977] IR 360 of the “conscious disregard” test of recklessness in the American Law Institute’s Model Penal Code.

3.126 The Australian 1984 Act gives a limited discretion to the courts to decline to allow an insurer to repudiate a contract where a fraudulent misrepresentation (as currently defined under *Derry v Peek*), would be “harsh and unfair.” This is an approach which has some support in the context of general contract law.

The Commission agrees with the view of the Law Commission of England and Wales and Scottish Law Commission that the power conferred by section 31 of the Australian 1984 Act can be “excessively lenient towards dishonest behaviour”¹³² and concludes that a discretionary power to prevent avoidance should be confined to circumstances where the relevant misrepresentation was definitively innocent, careless or negligent in nature.

3.127 In *Northern Bank Finance Co Ltd v Charlton*¹³³ the bank had financed a take-over bid by entering into a loan agreement with the defendant investors, but in so doing the bank had fraudulently misrepresented to them that other investors had lodged large sums related to the takeover with the bank. The defendant investors subsequently refused to repay the loan and sought rescission of the loan agreement on the ground that there had been fraud by the bank. The Supreme Court held that, notwithstanding the fraudulent misrepresentation, the defendants were not entitled to rescind the contract and were therefore required to repay the money that they had received under the loan agreement because full restitution of the defendants to their position prior to the fraudulent misrepresentation (*restitutio in integrum*) was not possible. This was because, in the circumstances, the take-over bid could not now proceed and so the defendants were confined to a remedy in damages.

This is of significance for insurance contracts because, as the ALRC pointed out,¹³⁴ in such contracts the *restitutio* principle is satisfied “only in the most technical sense.”

The UK 2012 Act differs from the Australian approach by including a rebuttable presumption concerning the level of knowledge of the consumer, (e.g. this could apply where a consumer is given specific information as to their health status during a visit to a doctor). The Commission notes that this rebuttable presumption could be appropriate where actual knowledge is at issue but it may be less applicable where inadvertence arises, as in the *McAleenan* case.

The fundamental difficulty with the existing definition of fraud, as derived from *Derry v Peek*, is that it can include behaviour that is simply inadvertent.

3.128 The Commission has concluded that, in an insurance contract, a fraudulent misrepresentation should be defined as a representation made either (a) intentionally or knowingly that is, deliberately with an intention to deceive or (b) recklessly, that is, with conscious disregard as to whether it is true.

This will mean that all forms of inadvertent behaviour (such as negligence) will be treated similarly in terms of remedies available and, furthermore, that if the Commission’s recommendations on the reform of the law on warranties (described in Chapter 4 below) were to be applied to the facts in the *McAleenan* case, the result would be consistent with this analysis.

3.129 If the Commission’s proposal to limit the definition of fraud were applied to the facts in the *McAleenan* case, it would result in a proportionate remedy for negligent misrepresentation of the kind discussed above in this Chapter.

Two features of the case are worth noting. First, although there was no specific finding by the High Court on this point, the Commission infers from the judgment that, while the misstatement was found to be material, it was not necessarily of a kind that *would* have been critical to the insurer’s acceptance of the risk, but rather was of a kind that *could* have affected the level of the premium.

¹³² Law Commission of England and Wales and Scottish Law Commission *Consultation Paper on Insurance Contract Law: Misrepresentation, Non-Disclosure and Breach of Warranty by the Insured* (Law Com. No. 182/Scottish Law Com. No. 134, July 2007) paragraph 4.182.

¹³³ [1979] IR 149.

¹³⁴ See ALRC *Report on Insurance Contracts* (Report No.20, 1982), at para 3.153.

Second, the High Court, while holding that the plaintiff had no honest belief in the truth of her statement that she was a partner also exonerated her from having any intention to deceive. And while her negligence in signing a document which stated that she was a partner was, perhaps, exacerbated by the fact that she was a solicitor, her wrongdoing was at the lower end of the spectrum of the definition of fraud in *Derry v Peek*.

These remedies, if available, would have enabled the court in *McAleenan* to order that a reduced sum be paid under the policy that accurately reflected the difference between the premiums actually paid and those that would have been payable had there been no misstatement, and would also have enabled the court to have regard to the plaintiff's actual degree of negligence.

3.130 The definition of fraud limited to an intention to deceive and advertent recklessness (as proposed above) has a precedent in a related area of civil liability.

Section 26 of the *Civil Liability and Courts Act 2004*,¹³⁵ which is headed "fraudulent actions",¹³⁶ provides that where a plaintiff in a personal injuries action gives or adduces, or dishonestly causes to be given or adduced, evidence that: "(a) is false or misleading, in any material respect, and (b) he or she knows to be false or misleading" the court must dismiss the claim "unless for reasons which the Court shall state in its decision, the dismissal of the action would result in injustice being done."¹³⁷

It is notable that section 26 of the 2004 Act defines such fraudulent activity as being confined to where the plaintiff "knows" that the evidence is false or misleading, and that the evidence must be material, a term that is well-known in the context of misrepresentation in insurance contract law.

In *Salako v O'Carroll*¹³⁸ the High Court (Peart J) noted that section 26 is not intended to deprive a person of damages where the evidence has established that the plaintiff "in some unintended way has given evidence which is wrong, or even where it establishes that the plaintiff deliberately gave false or misleading evidence but only in relation to some immaterial matter." The Court held that, while it would not allow the plaintiff to benefit by reference to the false or misleading evidence, it would be unjust to dismiss the entirety of the claim where it involved an immaterial matter.¹³⁹

The Commission considers that section 26 of the 2004 Act is a good statutory example of dealing clearly with intentional and knowing fraudulent behaviour, which is also focused on material fraud, and is consistent with the proposals on fraudulent misrepresentation.

3.131 The Commission recommends that an insurer should continue to be entitled to avoid the contract of insurance where an answer by a consumer comprises a fraudulent misrepresentation, which should be defined as one which is false or misleading in any material respect and which the consumer either (a) knows to be false or misleading or (b) consciously disregards whether it is false or misleading; and also recommends that "fraud" and "fraudulent" should be interpreted in the same manner where they are used elsewhere in this Report.

¹³⁵ Section 26 of the 2004 Act is also discussed in Chapter 8, below on post-contractual fraudulent claims.

¹³⁶ The 2004 Act forms part of the legislative response to the recommendations in the 2002 *Report of the Motor Insurance Advisory Board* whose main focus was on general reform of the non-life insurance sector, notably motor insurance, including proposals to prevent and reduce fraudulent and exaggerated claims (related to what is often described as the "compensation culture"), and therefore reduce insurance costs. As noted in Appendix C to this Report, the 2002 Report also recommended reform of insurance contract law including the duty of disclosure and misrepresentation.

¹³⁷ Section 26(1) of the 2004 Act. Section 26(2) provides that the same applies where a plaintiff has sworn a false verifying affidavit under section 24 of the 2004 Act.

¹³⁸ [2013] IEHC 172.

¹³⁹ [2013] IEHC 172 at paragraph 2.

D Renewal of Insurance Contracts

3.132 Under current Irish law the renewal of an existing insurance policy is deemed the entry by the parties into a new contract thereby triggering the duty of disclosure. The policyholder must “disclose any material changes in circumstances occurring since the original application or the date of last renewal.”¹⁴⁰ Buckley observes that “[m]ost laymen are not aware that such a duty exists.”¹⁴¹

(a) United Kingdom

3.133 During the Parliamentary debates on the *Consumer Insurance (Disclosure and Representations) Act 2012* it was commented that as most consumers do not know that renewing an insurance contract creates a new insurance contract, they would be equally unaware that the posing and answering of questions, whether at an initial proposal or at a renewal, have equivalent status.¹⁴²

3.134 In their 2006 Issues Paper the Law Commission of England and Wales and Scottish Law Commission termed this an “additional potential pitfall,” pointing out that, on renewal, most insurers will simply ask if there has been any material change in circumstances thereby compelling policyholders to review all previously disclosed information. This may prove difficult as policyholders may not have been given (or retained) a copy of the original proposal form, and may not have taken copies of information submitted at the various renewals.¹⁴³

The Commissions provisionally recommended that general questions should be accompanied by copies of all the information previously provided to the insurer and that insurers should lose their rights to rely on non-fraudulent misrepresentations made in response to such questions unless such copies have been provided either as paper or electronic duplicates of the original documents, or as paper or electronic output of data stored on an insurer’s computer systems, having been extracted from the original documents.¹⁴⁴

3.135 In their 2009 Report, they recommended that if an insurer writes to a consumer asking if anything has changed, and the consumer fails to reply, leading the insurer to believe that nothing has changed, this may amount to a misrepresentation. Depending on the clarity of the question and the other circumstances discussed below, the misrepresentation might be made without reasonable care.¹⁴⁵

As a result, section 2(3) of the *Consumer Insurance (Disclosure and Representations) Act 2012* provides:

“A failure by the consumer to comply with the insurer’s request to confirm or amend particulars previously given is capable of being a misrepresentation for the purposes of this Act.”

¹⁴⁰ Buckley *Insurance Law* 3rd ed (Thomson Round Hall 2012) paragraph 3-44. See also *Latham v Hibernian Insurance Co Ltd*, High Court, 22 March 1991 (Blayney J). The Court held that the fact that a policyholder had committed an offence prior to renewal was a material fact that should have been disclosed.

¹⁴¹ Buckley *Insurance Law* 3rd ed (Thomson Round Hall 2012) paragraph 3-67.

¹⁴² House of Lords Special Public Bill Committee: *Consumer Insurance (Disclosure and Representations) Bill* [HL] (10 November 2011) at 44.

¹⁴³ Law Commission of England and Wales and Scottish Law Commission *Issues Paper 1 on Misrepresentation and Non-Disclosure* (September 2006) paragraph 2.49.

¹⁴⁴ *Ibid* at paragraph 6.100.

¹⁴⁵ Law Commission of England and Wales and Scottish Law Commission *Consumer insurance law: Pre-contract Disclosure and Misrepresentation* (Law Com No.319/Scot Law Com No.219, 2009) paragraph 5.48.

(b) Australia

3.136 Section 21B of the Australian *Insurance Contracts Act 1984* contains detailed obligations of both the insurer and the policyholder at the renewal of “eligible” (consumer) contracts. For an insurer to ensure that the information is updated on renewal they must either:¹⁴⁶

- ask one or more specific questions that are relevant to the decision of the insurer whether to accept the risk and, if so, on what terms¹⁴⁷ or
- provide the policyholder with a copy of any matter previously disclosed by the policyholder in relation to the contract and request the policyholder (i) to disclose to the insurer any change to that matter; or (ii) to inform the insurer that there is no change to that matter.¹⁴⁸

A “change to a matter previously disclosed” means a change that: (a) is known to the policyholder; and - (b) a reasonable person in the circumstances could be expected to disclose in relation to that matter.¹⁴⁹

If the insurer does not comply with these requirements it is taken to have waived compliance with the duty of disclosure in relation to the renewed contract.¹⁵⁰

Additionally and in general, if an insurer makes a request that the policyholder disclose to the insurer any other matter that would be covered by the duty of disclosure in relation to the renewed contract, then the insurer is also taken to have waived compliance with the duty of disclosure in relation to that other matter.¹⁵¹

This is intended to ensure that “catch all” questions covering other matters (in addition to asking specific questions and/or seeking updates to information previously disclosed) will result in waiver of compliance with the duty of disclosure with respect to the other matters.

Where a policyholder does not respond to a request from an insurer to update matters previously provided, but nevertheless pays the renewal premium, the policyholder is taken to have informed the insurer that there is no change to the matter.¹⁵²

3.137 Where an insurer has complied with the renewal requirements and the policyholder has responded, or is taken to have advised that there is no change to the matter, the waiver provisions in sections 21(3) and 27 of the 1984 Act will not apply.¹⁵³

Section 21(3) of the 1984 Act provides that where a person has either failed to answer or has given an obviously incomplete or irrelevant answer to a question included in a proposal form about a matter, the insurer will be deemed to have waived compliance with the duty of disclosure in relation to the matter. Section 27 of the 1984 Act provides that a person shall not be taken to have made a misrepresentation by reason only that the person failed to answer a question included in a proposal form or gave an obviously incomplete or irrelevant answer to such a question.

However section 21B(12) of the 1984 Act, as inserted in 2013, provides that where a policyholder “failed to comply with the duty of disclosure in relation to the contract as originally entered into or any renewal of

¹⁴⁶ Section 21B(3) to (6) of the 1984 Act outline the position of the insurer and detail the requirements for an insurer wishing to rely on a policyholder’s duty of disclosure in relation to the renewal of an eligible contract of insurance.

¹⁴⁷ Section 21B(3)(a) of the 1984 Act.

¹⁴⁸ Section 21B(3)(b) of the 1984 Act.

¹⁴⁹ Section 21B(13) of the 1984 Act.

¹⁵⁰ Section 21B(4) of the 1984 Act.

¹⁵¹ Section 21B(5) and (6) of the 1984 Act.

¹⁵² Section 21B(10) of the 1984 Act.

¹⁵³ Section 21B(11) of the 1984 Act.

that contract”, the insurer is not taken to have waived compliance, nor the policyholder taken to have complied, with the duty of disclosure in relation to the earlier failure.

The Explanatory Memorandum accompanying the 2013 Act that inserted this section into the 1984 Act provides the following example:¹⁵⁴

“suppose when originally applying for a home buildings policy, an insured breaches the duty of disclosure in relation to providing information on the main construction materials used in the home. At a subsequent renewal, the insurer seeks updates to various matters but does not ask the insured to update the information previously provided on main construction materials, because they are unlikely to change between inception and renewal. In such a case, even though the insured may be taken to comply with the duty of disclosure in respect of the renewed contract by providing all updates as requested, the effect of section 21B(12) is that compliance with the duty under the renewed contract does not operate to negate the earlier failure.”

3.138 The Explanatory Memorandum also noted that this was designed to permit insurers to continue to rely on the accuracy, as at the time of inception or the previous renewal, of matters disclosed on inception and previous renewals.¹⁵⁵

It was decided that without such a provision insurers seeking to rely on any information previously provided by a policyholder (such as, for example, what materials a home is constructed of) would need to seek updates to every such matter at every renewal, which would be onerous and time consuming for both insurers and insureds.¹⁵⁶

(c) Conclusion and Recommendations

3.139 The Commission does not suggest that insurers should request policyholders to fill out full application forms upon every renewal of an insurance contract, or to simply ask consumers general “catch all” questions on renewal.

3.140 The provisions enacted in section 21B of the Australian *Insurance Contracts Act 1984*, as inserted by the *Insurance Contracts Amendment Act 2013* provides a suitable basis on which a consumer’s duty of disclosure at renewal should be discharged.

3.141 Therefore insurers who wish to ensure that information is updated at renewal, should either ask policyholders specific questions, or ask them to update the information previously provided by providing consumers with copies of previously disclosed material. Insurers should not be able to ask general catch-all questions in the hope of covering areas unrelated to the specific questions asked or previously asked.

3.142 The Commission also favours the following three caveats provided for in the Australian 1984 Act.

First, where a policyholder does not respond to a request from an insurer to update information previously provided, but nevertheless pays the renewal premium; then the policyholder should be taken to have informed the insurer that there has been no change affecting the insured risk..

Second, therefore, unlike at the initial pre-contractual stage of the first contract of insurance, insurers should not be penalised for failing to investigate an absent or obviously incomplete answer to a relevant material question and should not be deemed to have waived compliance with the duty of disclosure.

The Commission considers it necessary to exclude the application of this recommendation at the renewal stage where a policyholder responds to the insurer’s specific questions or request to update any change to the matter, or is deemed to have so responded, because although the renewal is a new contract, it is not exactly identical to the initial contract of insurance.

¹⁵⁴ Parliament of the Commonwealth of Australia House of Representatives *Insurance Contracts Amendment Bill Explanatory Memorandum* paragraph 1.73.

¹⁵⁵ *Ibid* paragraph 1.74.

¹⁵⁶ *Ibid*.

Policyholders presume that they have already informed the insurer of the relevant material at the onset of the first contract, and therefore this should be a simple matter of accepting the renewal rather than an elaborate form filling exercise. They are required to inform the insurer of change and should they choose not to then the insurer should not be penalised for continuing the contract. Otherwise, unfavourable circumstances might emerge.

For example, where a policyholder does not respond to a request from an insurer to update matters previously provided because they mistakenly believe that this is just a formality, the insurer has to decide whether to (a) continue insuring them and hope that nothing material has changed, or (b) stop accepting the insurance premiums, and reject the renewal. An innocent policyholder could be left without insurance.

The third caveat in the 1984 Act is that renewal by the insurer of the contract of insurance should not, in itself, be taken to cure any previous breach of any duty of disclosure arising under the contract of insurance.

The Commission has also concluded that an insurer should, within a reasonable time before renewal of a contract of insurance (and in any event no later than 15 working days prior to the renewal¹⁵⁷) notify the consumer in writing of any alteration to the terms and conditions of the policy, and should also use plain and intelligible language in doing so.

3.143 The Commission recommends that the duty of disclosure should not be taken to imply that a consumer who has on a previous occasion discharged that duty of disclosure is under an obligation at renewal of the contract of insurance to provide the insurer with any additional information, whether concerning matters that have changed or otherwise, unless the insurer has expressly required the consumer to do so.

3.144 The Commission recommends that where an insurer intends that the consumer is to provide additional information at renewal concerning a particular matter, it should either: (a) ask the consumer a specific question in writing regarding that matter, or (b) request the consumer in writing to update information previously provided concerning that matter, which the insurer should specifically describe and should provide to the consumer a written copy of the details of the matter previously disclosed.

3.145 The Commission recommends that where an insurer requests the consumer at renewal to provide information to the insurer, the insurer should be under a duty to ask specific questions, in writing, and should not use general questions.

3.146 The Commission recommends that the consumer should be under a duty to respond honestly and with reasonable care to any requests by the insurer at the renewal of the contract of insurance and, if the consumer does not provide any new information in response to the insurer's request and where the consumer continues to pay the renewal premium, it should be presumed that the information previously provided has not altered.

3.147 The Commission recommends that the renewal by the insurer of the contract of insurance should not, in itself, be taken to cure any previous breach of any duty of disclosure arising under the contract of insurance.

3.148 The Commission recommends that an insurer should, within a reasonable time before renewal of a contract of insurance, (and in any event no later than 15 working days prior to the renewal) notify the consumer in writing of any alteration to the terms and conditions of the policy, using plain intelligible language in doing so.

¹⁵⁷ The basis for this 15 working day notice period is discussed in Chapter 10, below.

CHAPTER 4 WARRANTIES AND TERMS THAT DESCRIBE THE RISK

A Defining Warranties

4.01 In general contract law, breach of a warranty gives rise to a claim for damages only. A condition, on the other hand, is a contract term of such importance that its breach entitles the injured party to terminate the contract (in addition to claiming damages).¹

In insurance contract law, however, a warranty is broadly the equivalent of a condition in general contract law, so that breach of an insurance warranty allows the injured party – usually the insurer – to repudiate the contract.²

4.02 Looked at neutrally, insurance contract warranties appear unobjectionable, as they serve to identify or define the risk being underwritten. However, their use has been the subject of controversy for over 200 years³ and while they have been criticised on a number of grounds the main concern stems from the fact that once breached a warranty releases an insurer from liability from the date of the breach, “even if the content of the warranty is not material to the risk or the breach material to the loss.”⁴

4.03 In the classic 18th century case *De Hahn v Hartley*⁵ Lord Mansfield defined a warranty in an insurance contract as “a condition or a contingency and unless that be performed, there is no contract. It is perfectly immaterial for what purpose a warranty is introduced; but, being inserted, the contract does not exist unless it be literally complied with.”

The strictness of the rule that a warranty must be “literally” complied with is illustrated by the facts of that case. The plaintiff had warranted that a ship would have a complement of at least 50 crewmen. Although on departure from port only 46 were on board a further six crewmen boarded at a subsequent port. The ship capsized in a storm and all 52 crew on board died.

The insurer repudiated liability under the insurance contract on the grounds that the plaintiff was in breach of the warranty from the time the ship first departed port with a crew of less than 50. Although this had been remedied before the loss occurred, and could not be regarded as directly related to the risk undertaken, the Court held that the defendant was entitled to repudiate liability.

A minor breach of warranty is treated in the same way as a major breach, so that arguments that the breach was technical or trivial will fail.⁶

¹ Buckley *Insurance Law* 3rd ed (Thomson Round Hall 2012) paragraphs 5-01-5-02; Legh-Jones, Birds, Owen (eds) *MacGillivray on Insurance Law* 11th ed (Sweet & Maxwell 2008) paragraph 10-003; and Clark *Contract Law in Ireland* 6th ed (Thomson Round Hall 2008), pp.347-350.

² Legh-Jones, Birds, Owen (eds) *MacGillivray on Insurance Law* 11th ed (Sweet & Maxwell 2008) paragraph 10-022.

³ See Law Reform Commission *Consultation Paper on Insurance Contracts* (LRC CP 65 – 2011) at paragraph 5.01, citing Hasson “The Basis of the Contract Clause in Insurance Law” (1971) 34 MLR 29; Clarke “Insurance Warranties: the absolute end?” [2007] LMCLQ 474; and Soyer “Reforming Insurance Warranties—Are we finally moving Forward?” in *Soyer Reforming Marine and Commercial Insurance Law* (Informa Law 2008).

⁴ Buckley *Insurance Law* 3rd ed (Thomson Round Hall 2012) paragraph 5-04.

⁵ (1786) 1 Term Reports 343.

⁶ Buckley *Insurance Law* 3rd ed (Thomson Round Hall 2012) paragraph 5-06.

(1) Types of insurance warranties⁷

(a) Warranties of past or present fact

4.04 A warranty of past or present fact (“warranties of fact”) relates to a state of affairs existing in the past or in the present (for example “I warrant that my car is roadworthy”). In general, breach of such a warranty allows the insurer to treat the insurance contract as being void *ab initio* since the breach of warranty occurs at the time of entering into the contract.

(b) “Basis of contract” clauses, or clauses of similar effect

4.05 “Basis of contract” clauses operate to convert pre-contractual representations made by the proposer into warranties. They occur where a consumer signs a proposal form that contains a statement to the effect that all answers “are true and complete in every respect” and form “the basis of the contract”.⁸ In general breach of such a warranty allows the insurer to treat the insurance contract as being void *ab initio* since the breach of warranty occurs at the time of entering into the contract.

(c) Warranties of opinion

4.06 A warranty of opinion is created when the policyholder warrants that facts are or will be true “to the best of my knowledge and belief.” Breach of a warranty of opinion occurs, and an insurer will be entitled to repudiate the contract, only if the insurer can prove that the statement was not made by the policyholder in good faith.⁹

For example, an honest belief that a property is in good repair may not allow an insurer to avoid the contract *ab initio* even if investigation of the facts, on an objective basis, reveals that it was not in good repair at the commencement of cover.

(d) Warranties as to the future (“continuing or promissory” warranties)

4.07 A warranty as to the future (also known as a “continuing or promissory” warranty) is essentially a promise by a consumer that a particular thing will or will not be done or maintained throughout the term of the insurance contract. For example, a houseowner may promise to install and maintain a particular type of burglar alarm.

As the obligations imposed by these type of warranties continue throughout the length of the contract, their breach can occur anytime during the course of the contract. The insurer must honour any claim prior to the occurrence of the breach but not subsequent to it.

⁷ Birds *Birds’ Modern Insurance Law* 8th ed (Sweet & Maxwell 2010) section 9.3. See also Law Commission of England and Wales *Insurance Law Non Disclosure and Breach of Warranty* (Law Com. No. 104, 1980), paragraph 6.4.

⁸ In *Keating v New Ireland Insurance Co Ltd* [1990] 2 IR 383, at 393, McCarthy J, commenting on a “basis of contract” clause, stated: “The contention is that their effect in law is that all answers in the proposal form are incorporated into the contract as warranties and that, if any one of them is inaccurate, the insurer may repudiate the contract for breach of warranty without regard to the materiality of the particular answer to the risk: *Thomson v Weems* (1884) 9 App Cas 671 at p.689. The corollary is that the fact that the insured may have answered the questions in good faith and to the best of his knowledge and belief is irrelevant if the answers are in fact inaccurate. It is not difficult to think of instances where a serious symptomless condition exists affecting the life expectancy of a proposer for insurance and is unknown and unknowable; yet if he were to die and it be discovered that such condition had existed at the time of the creation of the contract of insurance, the contract, it is said, is vitiated.” (emphasis removed). This passage was quoted with approval by McMahon J in the High Court decision *Manor Park Homebuilders Ltd v AIG (Europe) Ireland Ltd* [2008] IEHC 174, [2009] 1 ILRM 190, discussed further below.

⁹ See *Quin v National Assurance Co* (1839) Jo & Car 316.

(2) No specific form of words required for warranty (general rules for interpretation of contracts apply)

4.08 While a warranty must be a term of the contract it can be incorporated into the policy by reference. Thus in the High Court decision in *Manor Park Homebuilders Ltd v AIG (Europe) Ireland Ltd*,¹⁰ McMahon J noted that a proposal form may expressly state that the statements or representations by the insured are to be regarded as warranties and the proposal form may be stated to be the basis of the contract of insurance. The Court also noted that a warranty cannot arise from representations made prior to the contract (whether in a proposal or otherwise) unless the insurer makes entirely clear that they are to form the basis of the contract.¹¹

4.09 A warranty can arise without reference to formal or technical language. In that respect, the courts apply the general rules of contractual interpretation in determining whether a term in an insurance contract amounts to a warranty, including where a term may be ambiguous.

In *Keating v New Ireland Assurance Co Ltd*,¹² the Supreme Court held that if insurers wish to base an insurance contract on a particular warranty “it must be expressed in clear terms without any ambiguity” and any ambiguity must be read against the persons who prepared it¹³ (that is, applying the *contra proferentem* rule).¹⁴ The Court in this case therefore held that like any commercial contract an insurance policy must be given a reasonable interpretation.

The plaintiff and her late husband had taken out life insurance policies with the defendant insurer. The proposal form had contained a “basis of contract” clause. Prior to entering into the insurance contract, the plaintiff’s husband had been referred by his GP to a consultant for stomach pain. The relevant tests disclosed angina, but he was not told this. In response to a question as to whether he had ever suffered from a heart condition he had answered “no.”

He later died and the plaintiff claimed under the policy but the defendant repudiated on the basis of breach of warranty. The High Court and, on appeal, the Supreme Court, held that the defendant insurer was not entitled to repudiate because it would be irrational to interpret the contract as requiring the plaintiff’s husband to have disclosed facts of which he was completely unaware.

Although the application of general principles of contractual interpretation in the *Keating* case softened the impact of the legal effect of insurance contract warranties in the specific circumstances of that case, such judicial intervention does not provide a clear indication of the status of particular contractual terms; and an insurer remains perfectly entitled (as the Supreme Court noted in *Keating*) to rely on a warranty that is “expressed in clear terms without any ambiguity.”

4.10 However, McMahon J in *Manor Park* acknowledged that “[t]here is a reluctance to construe warranties as applying to circumstances arising during the currency of the contract of insurance or to construe them as continuing or promissory warranties”.¹⁵ In support of this statement the Court referred to

¹⁰ [2008] IEHC 174; [2009] 1 ILRM 190.

¹¹ [2008] IEHC 174; [2009] 1 ILRM 190. These statements were in reference to a basis of contract clause.

¹² [1990] 2 IR 383.

¹³ [1990] 2 IR 383, at 394-5. Similarly, in *Brady v Irish National Insurance Co Ltd* [1986] ILRM 669, which involved an insurance policy for a pleasure boat, the Supreme Court considered a warranty which stated that, while the boat was laid-up, it would not be used for any purpose other than, among other matters “customary overhauling.” The majority of the Court held that as this phrase was not further defined in the policy it was to be interpreted against the insurer.

¹⁴ See Chapter 9, below, where the Commission discusses the *contra proferentem* rule and the related common law and statutory rules on unfair and onerous terms.

¹⁵ [2008] IEHC 174; [2009] 1 ILRM 190. See also the discussion of this point in Buckley *Insurance Law* 3rd ed (Thomson Round Hall 2012) paragraph 5-08 to 5-12.

*Re Sweeney and Kennedy's Arbitration*¹⁶ and *Hussain v Brown*¹⁷ in holding that statements made relating to the installation of alarm and shutters on the insured premises were not warranties. The Court held:¹⁸

"In order for there to be a continuing warranty in relation to the maintenance of an alarm, an alarm warranty would need to have been required by the insurers and it is accepted by the underwriter that this did not happen. In addition, in the representations made, the broker states that if the alarm went off it *would* be heard by the security people. The wording is important: the broker did not say that the alarm *will* be heard. Furthermore, applying the *ratio* in *Hussain*¹⁹... it is submitted that if in a case where there was a proposal form with specific questions posed by the insurance company, the answers to which were warranted to be true and were to be the basis of the contract, does not amount to a continuing warranty, how much stronger must the case be in respect of a simple representation which does not use the word "warranty" and which is not incorporated into the contract of insurance and which was not made the basis of the contract?"

(3) Non-compliance with warranty may be excused (a) where circumstances change, (b) where compliance would be unlawful or (c) through waiver

4.11 Non-compliance with a warranty can be excused (a) when, because of a change of circumstances, the warranty ceases to be applicable to the circumstances of the contract; (b) if the warranty is rendered unlawful by a subsequent law; and (c) if the insurer waives the breach of warranty.

While the concept of waiver is clear and well-known its application in insurance contracts has given rise to some difficulty.²⁰ This is because, on breach of a warranty, avoidance of the contract of insurance is automatic, and therefore logic would imply that the insurer is not in a position to waive anything as the contract no longer exists.²¹

However Clarke argues that while the contract no longer exists the insurer can waive it back to life.²² An alternative view adopted by the English courts is to apply waiver by estoppel.²³ This occurs where a person having legal rights against another unequivocally represents by words or conduct that he or she does not intend to enforce those legal rights,²⁴ for example, the acceptance of a premium by the insurer after acquiring knowledge of the breach.²⁵ However as this is an equitable remedy, it is discretionary and

¹⁶ [1950] IR 85.

¹⁷ [1996] 1 Lloyd's Rep 627.

¹⁸ [2008] IEHC 174; [2009] 1 ILRM 190.

¹⁹ [1996] 1 Lloyd's Rep. 627, at 629, in which Saville LJ stated: "there is no special principle of insurance law requiring answers in proposal forms to be read, prima facie or otherwise, as importing promises as to the future. Whether or not they do depends upon ordinary rules of construction, namely, consideration of the words the parties have used in the light of the context in which they have used them and (where the words admit of more than one meaning) selection of that meaning which seems most closely to correspond with the presumed intention of the parties."

²⁰ Buckley *Insurance Law* 3rd ed (Thomson Round Hall 2012) at paragraph 5-162.

²¹ For a discussion of this matter see the UK House of Lords decision in *Bank of Nova Scotia v Hellenic Mutual War Risks Association (Bermuda) Ltd (The Good Luck)* [1992] 1 AC 233. See the discussion in the Law Commission of England and Wales and Scottish Law Commission' *Issues Paper 2 on Warranties* (November 2006) paragraphs 7.154-7.160.

²² Clarke "Insurance warranties: the absolute end?" 2007 LMCLQ 474, 481. Clarke was referring to section 33(3) of the *Marine Insurance Act 1906*, which is discussed below.

²³ *HIH Casualty and General Insurance Ltd v AXA Corporate Solutions* [2002] EWCA Civ 1253, [2002] 2 All ER Comm 1053.

²⁴ Buckley *Insurance Law* 3rd ed (Thomson Round Hall 2012) at paragraph 5-162.

subject to the usual equitable defences (for example, that the person has come to equity with “clean hands”).

Nonetheless, insurers cannot lose their right to repudiate simply by failing to respond to a policyholder’s claim and, as Buckley notes, their rights can only be lost if the insurers act positively and indicate that they intend to reinstate the risk, so that they are estopped from relying on the termination of the risk.²⁶

4.12 A particular insurance policy may limit the full extent of the right to repudiate in order to comply with relevant statutory requirements. For example, in *McAleenan v AIG (Europe) Ltd*²⁷ the plaintiff, a solicitor in a firm of solicitors, held a professional indemnity insurance policy with the defendant insurer. The policy contained a basis of contract warranty (“whereas the insured has made to insurers a proposal which shall be the basis of this contract that proposal is deemed to be incorporated herein”) but it also contained a clause which stated:

“Insurers will not exercise their right to avoid this Policy, or to modify it in any way whatsoever where it is alleged that there has been non-disclosure or misrepresentation of facts or untrue statements in the proposal form(s), if such alleged non-disclosure, misrepresentation or untrue statement was innocent and free of any fraudulent intent. The onus of proving otherwise shall be upon the Insurers.”

In the High Court, Finlay Geoghegan J noted that this placed a clear contractual limit on the insurer’s right to repudiate and that it was, moreover, necessary in order to meet the plaintiff’s minimum statutory cover for professional indemnity insurance which she required at that time in order to have a solicitor’s practising certificate under the relevant Regulations made under the *Solicitors Acts 1954 to 1994*.²⁸

The Court held that, despite the presence of the “basis of contract” clause, the limitation on its right to repudiate as required by the Regulations made under the *Solicitors Acts 1954 to 1994* had the effect of requiring the insurer to indemnify the plaintiff to the extent undertaken (although as discussed above,²⁹ the Court held that the defendant was entitled to repudiate liability because it held that, under current law, the plaintiff had engaged in a fraudulent misrepresentation).

(4) Codification of general rules on warranties in Marine Insurance Act 1906

4.13 Sections 33 to 35 of the *Marine Insurance Act 1906* codified the general characteristics of insurance warranties developed at common law.³⁰

²⁵ See Insurance Ombudsman of Ireland *Digest of Cases 1992-1998*, Case 85. Waiver was recognised by the Insurance Ombudsman where the complainant, who was self employed, took out a policy to cover loss of income during periods of illness. Three claims were made under the policy. The third claim was rejected under a clause which provided that a claim must be notified within 50 days of the commencement of the illness. In this instance the notification was some 120 days later. Notice had also been late for the previous two claims, which had been paid by the company without comment. The complainant had no reason to believe that course of dealing had changed. The company had therefore waived its right to rely on the time clause.

²⁶ Buckley *Insurance Law in Ireland* 3rd ed (Thomson Round Hall 2012) paragraph 5-06.

²⁷ [2010] IEHC 128.

²⁸ The relevant Regulations at that time were the *Solicitors Acts 1954-1994 (Professional Indemnity Insurance) Regulations 1995* (SI No.312 of 1995). The 1995 Regulations provided that an insurer providing professional indemnity insurance to a solicitor was entitled (at its option) to exclude all and any liability to indemnify in any way the insured in respect of any dishonest, fraudulent, criminal or malicious act or omission by the insured, but that the indemnity provided “shall not be subject to repudiation... on the grounds of innocent misrepresentation or innocent non-disclosure on the part of the insured, and the onus of proving that a misrepresentation or a non-disclosure was not innocent shall be on the qualified insurer.”

²⁹ See the discussion of the *McAleenan* case at paragraph 3.114ff, above.

³⁰ While sections 36-41 of the 1906 Act are principally concerned with warranties in marine insurance, they are regarded as codifying the common law and were, for example, quoted on that basis by the High Court

Section 33 of the 1906 Act provides:

“(1) A warranty, in the following sections relating to warranties, means a promissory warranty, that is to say, a warranty by which the assured undertakes that some particular thing shall or shall not be done, or that some condition shall be fulfilled, or whereby he affirms or negatives the existence of a particular state of facts.

(2) A warranty may be express or implied.

(3) A warranty, as above defined, is a condition which must be exactly complied with, whether it be material to the risk or not. If it be not so complied with, then, subject to any express provision in the policy, the insurer is discharged from liability as from the date of the breach of warranty, but without prejudice to any liability incurred by him before that date.”

Section 34 of the 1906 Act provides:

“(1) Non-compliance with a warranty is excused when, by reason of a change of circumstances, the warranty ceases to be applicable to the circumstances of the contract, or when compliance with the warranty is rendered unlawful by any subsequent law.

(2) Where a warranty is broken, the assured cannot avail himself of the defence that the breach has been remedied, and the warranty complied with, before loss.

(3) A breach of warranty may be waived by the insurer.”

Section 35 of the 1906 Act provides:

“(1) An express warranty may be in any form of words from which the intention to warrant is to be inferred.

(2) An express warranty must be included in, or written upon, the policy, or must be contained in some document incorporated by reference into the policy.

(3) An express warranty does not exclude an implied warranty, unless it be inconsistent therewith.”

(5) Insurance Ireland Codes on warranties

4.14 The Insurance Ireland Code of Practice on Non-life Insurance recommends that the general right to repudiate for breach of warranty or condition is not to be used where the circumstances of the loss are unconnected with the breach, unless fraud is involved.³¹

The Code of Practice on Life Insurance contains a more detailed provision to the effect that a breach of warranty is not to invalidate a claim unless the circumstances of the claim are connected with the breach and a specific warranty has been created that is material to the risk and has been drawn to the proposer’s attention before or at time of contracting.³²

The status and value of these Codes has been undermined because some insurers have repudiated liability where the Codes indicate they should not. For example, in *Justice (decd) v St Paul Ireland*³³ the Circuit Court upheld the decision of an insurer to refuse indemnity despite the fact that the non-fraudulent breach of warranty had no link with the loss and the refusal contravened the relevant provisions of the Insurance Ireland Code. This reinforces the Commission’s view that the Insurance Ireland Codes are no substitute for legislative reform.

(McMahon J) in *Manor Park Homebuilders Ltd v AIG (Europe) Ireland Ltd* [2008] IEHC 174; [2009] 1 ILRM 190.

³¹ Insurance Ireland *Code of Practice on Non-Life Insurance*, paragraph 3(a)(iii).

³² Insurance Ireland *Code of Practice on Life Assurance – Duty of Disclosure*, paragraph 3(b).

³³ Circuit Court (Record No.008024/2003), 25 November 2004, discussed in Buckley “Insurers’ Self-Regulation Does Not Work” (2005) 1 CLP 10 and Buckley *Insurance Law* 3rd ed (Thomson Round Hall, 2012) at paragraphs 3-75 to 3-77

(6) Consumer Protection Code 2012 and warranties

4.15 The Central Bank's statutory *Consumer Protection Code 2012* provides that all regulated entities, including insurance undertakings, must act honestly, fairly and professionally in the best interests of its customers³⁴ and that any warranties or endorsements that apply to the policy must also be clearly set out in the quotation provided.³⁵

The 2012 Code does not, however, contain any provision that expressly provides for circumstances where it is not permissible to rely on a warranty, such as where the customer has acted innocently or negligently, as opposed to fraudulently.

(7) The Unfair Terms Regulations 1995 and warranties

4.16 The *European Communities (Unfair Terms in Consumer Contracts) Regulations 1995*³⁶ empower the courts generally to assess whether terms that have not been individually negotiated are enforceable by reference to whether they are unfair within the meaning of the Regulations.

Regulation 4 of the 1995 Regulations contains an important exception to this general test by providing that the test is not applicable to certain core terms that define the subject-matter of the contract. These core terms may include warranties because under the current law, warranties define the subject-matter of an insurance contract.

While the Commission recommends elsewhere in this Report that Regulation 4 of the 1995 Regulations should be amended in some respects to clarify its scope,³⁷ it nonetheless remains the case that the current law concerning insurance warranties requires further consideration concerning its reform.

(8) Conclusions and recommendation on general reform of insurance warranties

4.17 The Commission considers that the current law on insurance warranties is in need of reform. Since the decision in *De Hahn v Hartley*³⁸ an insurer has the right to repudiate an insurance contract for breach of warranty even when the breach is not related to the risk assumed. The right to repudiate is on the basis that the contract has been void *ab initio* and it applies to all forms of warranties, including "basis of contract" clauses which often involve general, rather than specific, representations by policyholders.

While the courts have applied general contract law principles and rules to warranties by holding that they should be described in specific terms and that where they are unclear they should be interpreted against the insurer (the *contra proferentem* rule), the extensive litigation as to what is or is not a warranty indicates that it has proven difficult to determine in advance whether a term is, in fact, a warranty or a less onerous contract term.

4.18 In Britain, the Law Commission of England and Wales and Scottish Law Commission have noted that because warranties give insurers wide-ranging grounds for repudiating a policy they may therefore serve to defeat the policyholder's reasonable expectation of cover.³⁹ In particular, "basis of contract" warranties are correctly described as "traps" for the policyholder because the law enables insurers to elevate representations to warranties thereby allowing insurers to avoid a policy for a minor non-material inaccuracy.

³⁴ Central Bank of Ireland *Consumer Protection Code 2012* provision 2.1.

³⁵ Central Bank of Ireland *Consumer Protection Code 2012* provision 4.31.

³⁶ SI No.27 of 1995, which implemented Directive 93/13/EEC, the 1993 EU Directive on Unfair Terms in Consumer Contracts, discussed in Chapter 9, below.

³⁷ See Chapter 9, below.

³⁸ (1786) 1 Term Rep 343.

³⁹ Law Commission of England and Wales and Scottish Law Commission *Issues Paper 2 on Warranties* (2006) paragraph 4.61.

4.19 Insurers contend that the principle of freedom of contract legitimises the current legal effect of warranties, and they argue that this principle provides an insurer with effective protection from fraudulent proposers and assists the insurer in fixing or circumscribing the risk.

In an acknowledgement that insurance contract warranties are capable of operating harshly where the proposer has acted innocently and in good faith, the relevant non-statutory Insurance Ireland Codes provide that an insurer should not invoke a warranty which has no causal link to the loss occasioned.

While this approach is to be commended the Commission considers that it is no substitute for substantive reform, especially as there have been occasions when insurers have defended insurance claims even where the Codes indicated they should not.⁴⁰

4.20 In the Consultation Paper, the Commission provisionally suggested that the general concept of warranties could be preserved while reforming the more severe consequences of a strict application of the law in this regard, but on further consideration the Commission has concluded that a greater level of reform is required.

The Commission considers that the current law applicable to warranties in insurance contracts is inconsistent with the Commission's recommendations that there should be a general duty imposed on insurers to ask consumers specific questions and a corresponding duty on consumers to answer those questions honestly and with reasonable care.

The Commission recommends that in consumer insurance contracts the law on insurance warranties should be abolished and replaced with specific rules consistent with the recommendations already made.

4.21 The Commission recommends the abolition of warranties in consumer insurance contracts, (whether that law arose at common law or under an enactment) and their replacement with specific provisions.

B Specific Reforms to Replace Warranties of Fact and Warranties of Opinion (Including "Basis Of Contract" Clauses)

4.22 Warranties of fact and opinion are pre-contractual representations which have been converted into warranties. Notably, the current law allows this conversion using a blanket "basis of contract" clause.

While an insurer may repudiate for misrepresentation only where such misrepresentation is material to the risk undertaken, a breach of warranty (including breach of a "basis of contract" clause) entitles an insurer to repudiate liability even where this involves a minor inaccuracy that does not affect the risk undertaken. The innocuous wording of such a clause does little to warn the consumer of its far-reaching effects.

4.23 In *Keenan v Shield Insurance Co*⁴¹ the plaintiff had entered into a fire insurance contract for his home with the defendant insurer, having completed a proposal form which included a question as to whether he had ever sustained loss or damage by any of the risks he wished to insure against. He had answered this question "no."

The plaintiff then signed the proposal form just below a declaration that "the above particulars and answers are true and complete in every respect and... no material fact has been suppressed or withheld" and that the declaration and the answers given should be the "basis of the contract" between the parties.

The plaintiff's home was subsequently destroyed in a fire and he claimed under the policy. The defendant repudiated liability on the ground that he had not disclosed that, a year prior to taking out the insurance policy with the defendant, he had made a claim under another insurance policy for fire damage to a pump and had been paid £53 on foot of that claim.

⁴⁰ See *Justice (decd) v St Paul Ireland*, Circuit Court (Record No.008024/2003), 25 November 2004, discussed at paragraph 4.14, above.

⁴¹ [1987] IR 113.

In the High Court, Blayney J accepted that the non-disclosure of this previous claim was not material to the risk being undertaken in the fire policy and would therefore not have entitled the defendant to repudiate liability for non-disclosure under the test of materiality identified in, for example, *Chariot Inns Ltd v Assicurazioni Generali Spa*.⁴²

Nonetheless, because the plaintiff had also declared that his answers were “true and complete in every respect” and were subject to the “basis of contract” warranty, the Court held that the defendant was entitled to repudiate liability.

Blayney J accepted that the plaintiff’s inability to claim under the policy arose from “a relatively unimportant inaccuracy in an answer to a question in the proposal form” but held that, because of the effect of the warranty, he had to dismiss the claim, adding that he did so “with considerable regret.”⁴³

4.24 Although the courts have accepted that insurers are entitled to include warranties in insurance contracts, they have on occasion gone further than expressing regret at their effect. In *Anderson v Fitzgerald*⁴⁴ Lord St Leonards stated that to give effect to a warranty in that case would be to render the policy “not worth the paper upon which it was written” while in *Zurich General Insurance Co Ltd v Morrison* warranties were described as “vicious” devices and “traps” for the unwary.⁴⁵ These comments were cited with approval by the Supreme Court in *Keating v New Ireland Assurance Co Ltd*.⁴⁶

4.25 In the Consultation Paper, the Commission provisionally recommended that “basis of contract” clauses should not be permitted to convert statements of fact or opinion into contractual warranties.⁴⁷

Although submissions received by the Commission argued that insurers should be able to continue to convert “basis of contract” clauses into warranties, the Commission is satisfied that the law of misrepresentation addresses the needs and concerns of insurers. It is notable in this respect that Australia,⁴⁸ New Zealand⁴⁹ and the United Kingdom⁵⁰ have enacted legislation which prohibit representations being converted into warranties.

(a) Australia

4.26 The Australian Law Reform Commission (ALRC) remarked that “warranties of existing fact are more akin to representations than they are to continuing warranties and similar terms in the contract” and determined that it “would be undesirable in principle for the remedies for a breach to depend on the form in which the relevant obligation was phrased. Consequentially, all warranties of existing fact should be treated as representations.”⁵¹

In implementing that analysis, section 24 of the *Insurance Contract Act 1984* treats warranties of existing facts as representations.

⁴² [1981] IR 199, discussed in Chapter 2, above.

⁴³ [1987] IR 113, at 119.

⁴⁴ (1853) 4 HLC 484, at 485.

⁴⁵ [1942] 1 All ER 529, at 537.

⁴⁶ [1990] 2 IR 383, at 394.

⁴⁷ Law Reform Commission *Consultation Paper on Insurance Contracts* (LRC CP 65 – 2011) paragraph 5.29.

⁴⁸ Section 24 of the Australian *Insurance Contracts Act 1984*.

⁴⁹ Sections 4 and 56 of the New Zealand *Insurance Law Reform Act 1977* prevent insurers from using basis of the contract clauses to avoid liability for non-material representations made in proposal forms or other pre-contractual documentation.

⁵⁰ Section 6 of the UK *Consumer Insurance (Disclosure and Representations) Act 2012* (for consumers) and section 9 of the UK *Insurance Act 2015* (for non-consumers) prohibit “basis of contract” clauses. Insurers cannot contract out of the 2012 Act; and while they may contract out of most provisions of the 2015 Act (subject to its transparency requirements), they cannot contract out of section 9.

⁵¹ Australian Law Reform Commission *Report on Insurance Contracts* (Report No.20, 1982) paragraph 195.

“A statement made in or in connection with a contract of insurance, being a statement made by or attributable to the insured, with respect to the existence of a state of affairs does not have effect as a warranty but has effect as though it were a statement made to the insurer by the insured during the negotiations for the contract but before it was entered into.”

Section 24 ensures that a statement made by a policyholder in respect of an existing state of affairs is not to be treated as having been converted into a warranty but must remain a representation (abolishes “basis of contract clauses”).

Section 24 goes one step further and covers all statements of current fact and not just those made in response to a question. Therefore it covers specific statements contained in the contract. This is designed to ensure that “the substantive rights and obligations of insurer and policyholder are the same, irrespective of the form in which those obligations are phrased”.⁵²

(b) United Kingdom

4.27 The Law Commission of England and Wales and Scottish Law Commission recommended that reform in this area be restricted to “basis of contract” clauses only. The Commissions suggested that the wider approach to reform of warranties adopted in Australia could lead to uncertainty in the way in which contract terms were interpreted. They commented that the Australian approach would affect a term such as “warranted: the car is roadworthy,” but would not affect a term that excluded claims which arose when the car was unroadworthy, nor a definition of the risk stating that the policy only covered roadworthy cars.⁵³

4.28 The Commissions concluded⁵⁴ that specific fact warranties did not create a major problem in consumer insurance policies and that potential unfairness could be dealt with by the application of the *Unfair Terms in Consumer Contracts Regulations 1999*, the UK equivalent of the *European Communities (Unfair Terms in Consumer Contracts) Regulations 1995*.⁵⁵ However, as discussed below, this approach has been criticised.

4.29 Implementing the Commissions’ view, section 6 of the UK *Consumer Insurance (Disclosure and Representations) Act 2012* provides that in consumer insurance contracts a representation cannot be converted into a warranty, including by declaring the representation to form the basis of the contract or otherwise. Indeed, even in non-consumer insurance contracts, section 9 of the UK *Insurance Act 2015* also prohibits “basis of contract” clauses and, unlike a number of other provisions in the 2015 Act that apply to non-consumers, contracting out of section 9 is prohibited.

(c) Conclusions and recommendations

4.30 Judicial criticism of “basis of contract” clauses (the ability of insurers to provide that specific representations as to fact or opinion may be converted into warranties) and their prohibition in other common law jurisdictions supports the Commission’s provisional recommendation to abolish “basis of contract” clauses.

However, the Commission, unlike the Law Commission of England and Wales and the Scottish Law Commission, does not consider it sufficient to limit reform to “basis of contract” clauses while preserving specific fact warranties. The Commission agrees with the ALRC that if warranties of fact and opinion are to be left unaffected the proposed reforms to the law of misrepresentation in insurance contracts will be circumvented.⁵⁶ In particular, as highlighted by one consultee in response to the approach in the UK,

⁵² Mann *Annotated Insurance Contracts Act* 4th ed (Thomson Lawbook Co 2003) paragraph 24.10.

⁵³ Law Commission of England and Wales and Scottish Law Commission Report *Consumer Insurance Law: Pre-contract Disclosure and Misrepresentation* (Law Com No. 318/Scottish Law Com. No. 219, 2009) paragraph 6.109-6.110.

⁵⁴ *Ibid.*

⁵⁵ The 1995 Regulations are discussed in Chapter 9, below.

⁵⁶ Australian Law Reform Commission *Report on Insurance Contracts* (Report No.20, 1982) paragraphs 184 and 195.

retaining such warranties may make it possible to convert more than one representation into a warranty by means of a “a joint characterisation clause”.⁵⁷

4.31 Originally, the Law Commissions, in their 2006 *Issues Paper on Warranties*, favoured the approach recommended by the ALRC, concluding that “specific warranties” would offer insufficient protection to consumers, for two reasons:⁵⁸

“First, it would still provide the insurer with the right to refuse a claim even though the consumer had not been fraudulent or even negligent. Secondly, we doubt that consumers would derive much protection from the formal requirements. Merely requiring that the warranty is put into a written document which is given to the consumer within a reasonable time will only protect the consumer who reads the document. Even if the statements have to be in a separate document from the body of the policy, we doubt that many consumers will read them. Normally they will only receive the document after they have, in their view, completed arranging their insurance.”⁵⁹

The Law Commissions accepted that this approach might be easy to circumvent as it would be open to insurers to define the cover. However, they argued that the *Unfair Terms in Consumer Contract Regulations 1999* would deal with any unfairness in that regard. They gave an example of a restriction that stated that the policy only covered a brick house (so that a wooden house would be excluded):

“if the restriction to brick houses was explained upfront and in a clear and transparent way, the term would be classified as a core term and would not be open to review. If the exclusion was only mentioned in the small print, it would be subject to a fairness test. We think that is a just result. A consumer who is told that the insurance offered applies only to certain types of risk and not others, or who is given documents that make this quite clear without the consumer having to read the small print, does not have legitimate grounds for complaint. With warranties of fact the situation is different. The reason for limiting the use of warranties as to existing facts is precisely because consumers are very unlikely to understand the effect of the warranty.”⁶⁰

4.32 Another difficulty recognised by the Law Commissions was that while specific fact warranties are not a significant problem for consumers as individuals, they do affect small businesses (and the recommendations in this Report apply to small businesses). This is exemplified in case law concerning “waste clauses”⁶¹ such as the English case *Bennett v Axa Insurance Plc*.⁶²

That case concerned an all risks policy for a pizza restaurant which had been destroyed by fire. The policy contained a “waste clause” which comprised a warranty that trade waste would be removed from the premises at the end of each day’s trading. The policy also contained a separate clause requiring the claimant to take “reasonable precautions” (including the removal of waste materials from the premises), to avoid the loss underwritten.

Although the Court accepted that the policyholder (the claimant) had in place reasonable systems for the daily removal of waste, the insurer successfully repudiated liability for a breach of this warranty, as the

⁵⁷ Law Commission of England and Wales and Scottish Law Commission *A Summary of Responses to Third Consultation Paper The Business Insured’s Duty of Disclosure and the Law of Warranties* (2013) paragraph 3.10 (quoting submission of Professor Bennett).

⁵⁸ Law Commission of England and Wales and Scottish Law Commission *Issues Paper 2 on Warranties* (2006) paragraphs 7.39-7.43.

⁵⁹ A similar sentiment, albeit in the context of exemption clauses, was expressed by Lord Reid in the UK House of Lords in *Suisse Atlantique Société d’Armement Maritime SA v NV Rotterdamsche Kolen Centrale* [1967] 1 AC 361, at 406.

⁶⁰ Law Commission of England and Wales and Scottish Law Commission *Issues Paper 2 on Warranties* (2006) paragraphs 7.39-7.43.

⁶¹ See also Buckley *Insurance Law* 3rd ed (Thomson Round Hall 2012) paragraph 5-23.

⁶² [2003] EWHC 86 (Comm).

Court found that there had been some trade waste on the premises at the time of the fire in breach of the warranty.

The Court reached that conclusion notwithstanding the fact that the policyholder was unaware of the existence of the warranty and where he had taken reasonable precautions to prevent the loss. The Court expressed sympathy for the policyholder.⁶³

4.33 The Commission considers that there is no real distinction between a contract containing a warranty to the effect “I warrant that my car is in road worthy condition” and a policyholder stating a similar fact such as “my car is in roadworthy condition” in response to a specific question. The Commission takes the view that both should be treated as representations.

This should not prevent an insurer from defining the scope of cover to be provided, and it would still allow an insurer to include a term under which the consumer makes an ongoing commitment, in the form of a future representation, to maintain a car in a roadworthy condition.

The Commission considers that the law concerning these matters requires reform and therefore recommends adoption of the approach taken in section 24 of the Australian *Insurance Contracts Act 1984*.

4.34 The Commission recommends that any statement made by a consumer in or in connection with a contract of insurance, being a statement made by or attributable to a consumer with respect to the existence of a state of affairs or a statement of opinion, should have effect solely as a representation made by the consumer to the insurer prior to entering into the contract.

4.35 The Commission recommends that any provision which purports to convert any such statement into a contractual warranty, including by means of a declared “basis of contract” clause or by any comparable clause (including one described as a warranty, a future warranty, a promissory or a continuing warranty), should be invalid.

C Specific Reforms to Replace Warranties as to the Future (Continuing or Promissory Warranties)

4.36 Warranties as to the future (also known as “continuing or promissory” warranties) are promises by the policyholder that particular things will or will not be done or maintained throughout the term of an insurance contract, such as the installation and maintenance of a particular type of burglar or fire alarm. They differ from other warranties because of their continuing nature during the course of the contract.

However, and as discussed above, the courts have displayed a reluctance to construe warranties as continuing or promissory in nature, in other words, as applying to circumstances arising during the currency of the contract of insurance. The reasoning behind this reluctance is demonstrated by *Bennett v Axa Insurance Plc*.⁶⁴

(1) Distinction between “warranties as to the future” and other contract terms

4.37 Whether a term is treated as a warranty or a term having a less drastic effect often depends upon the application of rules of contractual interpretation rather than the use of specific words. In addition, it can be difficult to distinguish warranties as to the future from other terms with the same stated objective, that is, to reduce the risk undertaken.

Decisions such as *De Hahn v Hartley*⁶⁵ and *Keenan v Shield Insurance Co*⁶⁶ confirm that a statement in a motor policy that the “insured warrants that all drivers will be 25 years or over” is a warranty and must be strictly complied with regardless of whether it is material to the risk undertaken.

⁶³ *Ibid* at paragraph 22.

⁶⁴ [2003] EWHC 86 (Comm): see paragraph 4.32, above.

⁶⁵ (1786) 1 Term Reports 343: see paragraph 4.23, above.

⁶⁶ [1987] IR 113: see paragraph 4.XX, above.

If it is not complied with then (subject to any limiting provision in the policy) the insurer may repudiate liability from the date of the breach but without prejudice to any liability incurred before that date.

A statement in a motor policy that “cover only applies whilst being driven by drivers 25 years or over” may be treated not as a warranty but as a suspensory condition whereby cover is suspended when drivers are under 25 years of age but continues when drivers are 25 years of age or over.

The distinction between suspensory conditions and warranties is crucial because, while both describe the scope of cover and the risk undertaken, when a suspensory condition is not complied with, cover is merely suspended (and the insurer is not liable for any loss incurred in that period), whereas a breach of warranty permits an insurer to repudiate and avoid cover entirely under the policy even where the breach has been remedied.

4.38 The courts sometimes apply general principles of contractual interpretation to avoid categorising contract terms as continuing or promissory warranties. In *Manor Park Homebuilders Ltd v AIG Europe (Ireland) Ltd*⁶⁷ the defendant insurer agreed to provide the plaintiff with property insurance for a period house which formed part of land on which the plaintiff proposed to build new houses.

The period house was not occupied and various steps were taken to protect it from burglary. In the course of the pre-contractual discussions a representation was made on the plaintiff’s behalf to the defendant that an alarm system was installed, which was correct, but the defendant was also separately informed that it was proposed to cut off the electricity supply to the house and this was done.

The High Court (McMahon J), following the principles of contractual interpretation identified by the Supreme Court in *Keating v New Ireland Assurance Co Ltd*,⁶⁸ held that the representation concerning the burglar alarm did not involve a continuing or promissory warranty. Although judicial interventions may ameliorate the effect of warranties, the current law appears to facilitate a disproportionate consequence and requires reform.

(2) Substance over form

4.39 Insurers often draft their policies with warranties and conditions placed under the heading “general terms and conditions.”⁶⁹ Determining whether a term is a warranty has proved difficult with the Law Commission of England and Wales and Scottish Law Commission deeming them an “elusive target.”⁷⁰

The presence or absence of a warranty turns on its interpretation rather than the use of any specific terminology, which leaves room for uncertainty. In the common law jurisdictions that have implemented reform in this area the need to focus on the substance rather than the form of contract terms has dominated.

In New Zealand, section 11 of the *Insurance Law Reform Act 1977* groups warranties and those terms that have a similar objective under the umbrella term “increased risk exclusions.”

In Australia, section 54 of the *Insurance Contracts Act 1984* focuses on whether the “act or omission” could be regarded as capable of “causing or contributing to a loss in respect of which insurance cover is provided.”

The Law Commission of England and Wales and Scottish Law Commission grouped together all terms including warranties relevant to particular descriptions while treating all remaining warranties as suspensive conditions.

⁶⁷ [2009] 1 ILRM 190. See also the discussion of the post-contractual duties involved in this case in Chapter 8, below.

⁶⁸ [1990] 2 IR 383.

⁶⁹ Buckley *Insurance Law in Ireland* 3rd ed (Thomson Round Hall 2012) paragraph 5-02.

⁷⁰ Law Commission of England and Wales and Scottish Law Commission *Consultation Paper on Insurance Contract Law: The Business Insured’s Duty of Disclosure and the Law of Warranties* (Law Com. No. 204/Scottish Law Com. No. 155, 2012) paragraph 11.19.

The authors of the *Principles of European Insurance Contract Law* (PEICL) refer to terms that involve “precautionary measures,” a concept similar but not identical to promissory warranties. Article 4:101 of the PEICL defines them as “a clause in the insurance contract, whether or not described as a condition precedent to the liability of the insurer, requiring the policyholder or the insured, before the insured event occurs, to perform or not to perform certain acts.”⁷¹

The advantage of these approaches is that they avoid technical arguments about whether the relevant term is or is not a warranty and instead focuses on the content of the term.

(3) Causal connection between the contract term and the breach

4.40 One of the main criticisms of warranties has been that a breach triggered an automatic cancellation of cover irrespective of any connection between the breach and the loss. In New Zealand, section 11 of the *Insurance Law Reform Act 1977* provides that policyholders are not bound by a term if they prove on the balance of probabilities that the loss against which they have sought to be indemnified was not caused or contributed to by the happening of an event or the existence of a circumstance referred to in the increased risk exclusion (that is, there is no causal connection between the events).

The 1977 Act was designed to prevent temporal clauses (time of the breach) rather than causative clauses (breach contributed to the loss) defeating the legitimate expectations of the policyholder.

The example given by the New Zealand Contracts and Commercial Law Reform Committee of the wrong to be remedied by the causal approach was that where “a vehicle the driver of which is intoxicated or which is (perhaps unknown to the driver) in an unsafe condition is struck from behind while waiting at traffic lights [and liability to indemnify is avoided] even though the intoxication or the unsafe condition did not contribute to the loss in any way.”⁷²

The difficulty attributed to this type of approach centres on the courts’ inability to distinguish between terms which define the risk and those which limit liability in defined circumstances.⁷³ The wholly causative approach has been interpreted in a manner that forces insurers to honour contracts in circumstances where the policyholder has blatantly breached their terms.

For example, a consumer may insure a car for private purposes but may intend to use it commercially. Had the consumer been honest with the insurer a higher premium would have been applied because statistically, a commercial vehicle is more likely to be involved in an accident than a private vehicle. For example a taxi is more likely to be involved in an accident than the same vehicle confined to private use.

The causal connection approach as it has been interpreted by the courts in New Zealand entitles such a consumer to succeed in a claim by proving that driving the car for commercial purposes had nothing to do with the cause of the accident. This seems unfair in circumstances where it was made clear to the consumer that this type of use was not covered by the contract.⁷⁴

Section 11 of the 1977 Act has also been interpreted in a case where the policyholder paid a reduced premium for motor vehicle cover because it was confined to a named driver. In that case the insurer was required to indemnify for loss caused notwithstanding the fact that the vehicle was being driven by a different driver because the insurer was unable to prove that the unnamed driver caused or contributed to the accident.⁷⁵

⁷¹ Article 4:101 of PEICL largely draws on Finnish law and the civil law equivalent to warranties, precautionary measures. See Basedow et al (eds), *Principles of European Insurance Contract Law* (Sellier, 2009) at 168 to 171.

⁷² Contracts and Commercial Law Reform Committee *Aspects of Insurance Law* (Contracts and Commercial Law Reform Committee, New Zealand) (1975) paragraph 29.

⁷³ See New Zealand Law Commission *Some Insurance Law Problems* (Report 46, 1998), paragraphs 42 to 47.

⁷⁴ *Ibid* at paragraph 43.

⁷⁵ *Ibid*.

The proposed solution (not yet enacted in New Zealand legislation) is to list a number of exceptions to the causal connection test, for example allowing the insurer to include restrictions defining the “ages, identity, and qualifications” of the policyholder.⁷⁶

The Law Commission of England and Wales and Scottish Law Commission criticised the New Zealand solution on grounds that the proposed list was arbitrary.⁷⁷

(4) Causal connection test coupled with the proportionality rule

4.41 The Australian solution in section 54 of the *Insurance Contracts Act 1984* was developed after New Zealand’s section 11, and comprises two elements. The first identifies two types of “acts or omissions”: those that “could reasonably be regarded as being capable of causing or contributing to a loss” and those not capable of achieving such an effect.

The first type entitles an insurer to refuse to pay the claim because these acts or omissions are presumed to have caused the loss. Policyholders can rebut this presumption but only if they can prove that the act or omission did not wholly or even partly cause the relevant loss. Where the second type of act or omission is not capable of causing the loss, the insurer may not refuse to pay the claim.

Accordingly, where a term in a contract prohibits a policyholder from modifying an insured car without the insurer’s consent, but the car is so modified, the insurer is not required to pay the claim provided the modification has caused the accident.

By contrast, in circumstances where the modification did not cause or contribute to the accident, the insurer must pay the claim. This is where the second element of section 54 becomes applicable because, although the insurer is technically prohibited from refusing to pay such a claim, it can reduce the payment to reflect the loss suffered.

In other words, if the insurer had known of the modification, but would still have offered the policy but excluded liability for persons driving under 25 years of age, then only in circumstances where the driver was less than 25 years of age is the insurer entitled to reduce the payment.

Section 54 has given rise to a large body of case law, which has not necessarily clarified its scope.⁷⁸ Thus, the ALRC commented in 2001 that what exactly comes within an “act or omission” is unclear.⁷⁹ Similarly, the 2004 review of the 1984 Act noted that section 54 had given rise to a number of difficulties in respect of particular types of clauses⁸⁰ and while it recommended minor reforms they have yet to be implemented.

Section 54 has also been criticised for being unnecessarily complex because it contains both a causation test and a proportionality rule (which refers to the degree of prejudice suffered).⁸¹

⁷⁶ *Ibid* at paragraphs 47 and 48.

⁷⁷ Law Commission of England and Wales and Scottish Law Commission *Consultation Paper on Insurance Contract Law: Misrepresentation, Non-Disclosure and Breach of Warranty by the Insured* (Law Com. No. 182/Scottish Law Com. No. 134, July 2007) at paragraph 8.37. Australia has encountered similar difficulties regarding scope.

⁷⁸ For a discussion about the difficulties associated with section 54 see Lewins and Lo “Striving for Equilibrium: A Critical Analysis of Section 54 of The Australian Insurance Contracts Act” [2003] *Mur UEJL* 20.

⁷⁹ Australian Law Reform Commission *Report on the Review of the Marine Insurance Act 1909* (Report No 91, 2001).

⁸⁰ Review Panel *Report on the Review of Section 54 of the Insurance Contracts Act 1984* (Australian Treasury, 2003) concluded that a number of litigated difficulties involved ‘claims made’ and ‘claims made and notified’ policies rather than ‘occurrence’ insurance policies.

⁸¹ For a detailed examination of the operation of section 54 of the 1984 Act see Mann *Annotated Insurance Contracts Act* 4th ed (Thomson Lawbook Co 2014), pp.164-202.

(5) Fault based approach

4.42 The authors of the PEICL recommended a fault based approach in which an insurer should be permitted to terminate the contract following a breach of the warranty but only if the policyholder breached their obligation with intent to cause the loss or recklessly and with knowledge that the loss would probably result.⁸²

Alternatively, PEICL suggests that the insurer should be permitted to reduce the amount paid, either totally or partially, if the loss suffered was caused by the breach and in breaching the term the policyholder acted with intent to cause the loss or recklessly and with knowledge that the loss would probably result.⁸³

It also recommends that any clause facilitating the reduction of the insurance money according to the degree of fault of the policyholder should be ineffective in respect of any loss caused by negligent non-compliance.⁸⁴

It is arguable that facilitating a reduction of the insurance money according to the degree of fault would address cases such as *Bennett v Axa Insurance Plc*⁸⁵ and that it might be consistent with the Commission's recommendations made in Chapter 3, above, regarding misrepresentations, which take into account whether the policyholder acted innocently, negligently or fraudulently.

However the Commission has concluded that the similarities between misrepresentations and failure to comply with terms of the policy are not sufficient to lead to the same approach regarding fault. Representations require policyholders to interpret and answer questions about their history (for example, in motor and business insurance) while warranties as to the future set out the scope of the contract.

4.43 The Commission believes that, provided the relevant terms of an insurance contract are brought to the attention of policyholders, and provided the consequences of their breach are fully explained, the scope for misinterpretation is far less than when policyholders are required to answer questions. In addition, policyholders have recourse under the *European Communities (Unfair Terms in Consumer Contracts) Regulations 1995*⁸⁶ where contract terms prove unfair.

(6) Suspensive conditions

4.44 In the United Kingdom section 10 of the *Insurance Act 2015* appears to reduce warranties⁸⁷ to suspensive conditions so that the breach of a term suspends rather than discharges the operation of the whole contract until the term is remedied.⁸⁸ Section 10 of the 2015 Act does not change the definition of an insurance warranty and the explanatory notes accompanying the Act explicitly state that warranties

⁸² Article 4.102 (1) of the PEICL. See in general Basedow et al (eds), *Principles of European Insurance Contract Law* (Sellier, 2009) at 172-175.

⁸³ Article 4.1023(1) of the PEICL.

⁸⁴ Article 4.1023(2) of the PEICL. See Basedow et al (eds), *Principles of European Insurance Contract Law* (Sellier, 2009) at 176-180.

⁸⁵ [2003] EWHC 86 (Comm): see paragraph 4.32, above.

⁸⁶ SI No.25 of 1995: see the discussion of the 1995 Regulations in Chapter 9, below.

⁸⁷ The 2015 Act deals with warranties of past and present fact as well as promissory warranties, but as the Commission has recommended above abolishing warranties of past and present fact, the current discussion applies to warranties as to the future only.

⁸⁸ Section 10 of the 2015 Act essentially replaces the common law remedy for breach of a warranty in an insurance contract, as codified in section 33(3) of the *Marine Insurance Act 1906* and which, as discussed above, allows an insurer to discharge the contract from the date of the breach ensuring that any subsequent remedying of the breach is irrelevant.

must still “be exactly complied with, whether material to the risk or not”.⁸⁹ Under section 10, therefore, insurers remain liable for losses occurring before the breach and for losses occurring after the breach has been remedied. Section 10(2) provides, however, that they are not liable for any “losses occurring, or attributable to something happening, after a warranty (express or implied) in the contract has been breached but before the breach has been remedied.”⁹⁰

The explanatory notes accompanying the 2015 Act clarify that the phrase “attributable to something happening” relates to circumstances where a loss arose during the period of suspension, but was not suffered until after the breach has been “remedied”.⁹¹

Arguably something done (that is, a breach) can never truly be undone, but for the purposes of section 10 of the 2015 Act when a policyholder is no longer in breach the breach must be regarded as remedied. What matters is the risk insured, therefore once the original risk is restored it does not matter that it was altered for a time, provided the claim manifests after the restoration of the breach.

Nonetheless, as not all breaches are capable of being remedied, the 2015 Act provides that an insurer is liable only “if the breach can be remedied”.⁹² Thus, as the Law Commission of England and Wales and Scottish Law Commission explained:

“a warranty in a policy covering fine wines requires the bottles to be stored on their sides. The insured mistakenly stores them upright, with the effect that the corks shrink and the wine becomes oxidised although the insured may ‘remedy’ the breach by laying the bottles on their sides, the permanent loss of quality is ‘attributable to something happening’ during the period of breach so the insurer is not liable”.⁹³

In general a breach of a warranty will be remedied when the policyholder “ceases to be in breach of warranty”.⁹⁴

However some warranties require that by an “ascertainable time something is to be done (or not done), or a condition is to be fulfilled, or something is (or is not) to be the case”.⁹⁵ Technically once the deadline has passed the term cannot be remedied, so the 2015 Act is specifically designed⁹⁶ to ensure that these terms are remedied if they are “ultimately complied with, albeit late”⁹⁷ so that “if the risk to which the

⁸⁹ Explanatory Notes, Insurance Bill [HL] as introduced in the House of Commons on 15 January 2015 [Bill 155] paragraph 87.

⁹⁰ Section 10(3) of the 2015 Act provides that section 10(2) does not apply if “(a) because of a change of circumstances, the warranty ceases to be applicable to the circumstances of the contract, (b) compliance with the warranty is rendered unlawful by any subsequent law, or (c) the insurer waives the breach of warranty.”

⁹¹ Explanatory Notes, Insurance Bill [HL] as introduced in the House of Commons on 15 January 2015 [Bill 155] paragraph 90. No amendments were made to the Bill in the House of Commons, so these Notes reflect the text of the 2015 Act.

⁹² Section 10(4)(b) of the 2015 Act.

⁹³ Law Commission of England and Wales and Scottish Law Commission Report *Insurance Contract Law: Business Disclosure; Warranties; Insurers’ Remedies For Fraudulent Claims; and Late Payment* (Law Com No.353/Scot Law Com No.238, 2014) at paragraph A.76. See also the example at paragraph 17.49 of the Report: “a warranty that a house is constructed from bricks and mortar cannot be remedied if the house is actually made of wood. Similarly, a warranty relating to a duty of confidentiality can never be remedied once confidentiality has been compromised.”

⁹⁴ Section 10(5)(b) of the 2015 Act.

⁹⁵ Section 10(6) of the 2015 Act.

⁹⁶ Law Commission of England and Wales and Scottish Law Commission Report *Insurance Contract Law: Business Disclosure; Warranties; Insurers’ Remedies For Fraudulent Claims; and Late Payment* (Law Com No.353/Scot Law Com No.238, 2014) at paragraphs A.77.

⁹⁷ *Ibid* at paragraphs A.69 and A.70.

warranty relates later becomes essentially the same as that originally contemplated by the parties”⁹⁸ then the term can be considered remedied.

The Law Commission of England and Wales and Scottish Law Commission concluded that what is important is whether “the purpose for which the warranty was inserted in the contract” was “frustrated” or whether, “due to the actions taken to remedy the breach of warranty, the purpose is still in substance fulfilled and the risk profile is restored to that which the insurer accepted.”⁹⁹

(7) Terms descriptive of the risk

4.45 The 2014 Report of the Law Commission of England and Wales and Scottish Law Commission recommended that terms (including certain types of warranties) designed to reduce the risks undertaken (for example installing a particular type of burglar alarm to deter theft) should be treated in such a manner that their breach would only suspend liability in respect of the particular type of loss that they were designed to address.¹⁰⁰

Breach of such a term would only suspend the liability in respect of the particular type of risk that it was designed to address and the rest of the contract would remain in effect. An insurer would be unable to refute liability in circumstances where the breach was unrelated to the particular type of loss in question.

Under the proposed rule, breach of a term “intended” to reduce the risk of a particular type of loss, or the risk of loss at a particular time or in a particular location, would only suspend liability in respect of that type of loss (or a loss at that time or in that place). Consequentially, an insurer would be unable to rely on the breach of such a term in respect of a loss of a different kind, or loss at a different location or time.

If, for instance, the policyholder does not install a burglar alarm as required by the terms of the contract, the insurer’s liability to pay a claim for loss caused by an intruder should be suspended. But the insurer will still be liable if the loss results from a flood or a fire, since the cause of the loss would have been unrelated to the breach alleged.

4.46 However where the term relates more generally to the overall risk that the insurer agreed to undertake and does not target a particular type of risk then in the event of the breach of such a term the insurer will not be liable.¹⁰¹

For example where a car is insured for private use but is instead used for commercial purposes the fact that a policyholder can show that commercial use did not cause an accident is irrelevant because the use to which a vehicle is put “goes more generally to the risk the insurer was prepared to take, rather than targeting particular types of loss which might occur.”¹⁰² This is intended to extend to circumstances where use could be considered to be incidental to the commercial use.¹⁰³

This provision avoids the difficulties encountered in New Zealand by the application of the wholly causative approach while ensuring that a policyholder is not penalised by a breach unrelated to the loss.

⁹⁸ Section 10(5)(a) of the 2015 Act.

⁹⁹ Law Commission of England and Wales and Scottish Law Commission *Insurance Contract Law: Business Disclosure; Warranties; Insurers’ Remedies For Fraudulent Claims; and Late Payment* (Law Com No.353/Scot Law Com No.238, 2014) at paragraph 17.48.

¹⁰⁰ In a consumer insurance contract, these rules are mandatory in the *Consumer Insurance (Disclosure and Representations) Act 2012*, whereas in a business insurance contract the parties are free, under the *Insurance Act 2015*, to contract out.

¹⁰¹ Law Commission of England and Wales and Scottish Law Commission *Insurance Contract Law: Business Disclosure; Warranties; Insurers’ Remedies For Fraudulent Claims; and Late Payment* (Law Com No.353/Scot Law Com No.238, 2014) at paragraphs 18.22 and 18.23.

¹⁰² *Ibid* at paragraphs 18.22 and 18.23.

¹⁰³ The Commissions cited the example (based on *Murray v Scottish Automobile and General Insurance Co* 1929 SC 48) of where the car was parked overnight in the garage between days of hire and suffered damage; the overnight parking was incidental to the commercial use and therefore there could be no liability.

4.47 However, the Commissions' 2014 proposal did not receive universal consensus as a small number of stakeholders believed that it courted uncertainty, and consequentially the clause did not form part of the *Insurance Act 2015*. Instead section 11 of the 2005 Act is entitled "[t]erms not relevant to the actual loss" and is designed to attach to "specific risk mitigation clauses" that is terms which could affect the risk of a specific type of loss taking place at all, or the risk that a particular type of loss would be more extensive.¹⁰⁴ Section 11 of the 2015 Act provides that it does not apply to "terms which reduce the risk profile as a whole"¹⁰⁵ and is therefore intended to exclude terms which describe:

- "(1) the use to which insured property can be put (eg commercial/personal);
- (2) the geographical limits of the policy;
- (3) the class of ship being insured; or
- (4) the minimum age/qualifications/characteristics of a person insured."¹⁰⁶

Section 11 is intended to provide that an insurer should pay a claim in circumstances where a policyholder has shown that the breach was "totally irrelevant" and "could not have affected the actual loss suffered."¹⁰⁷ This will, in particular, be the case where the breach of the term "could not have increased the risk of the loss which actually occurred in the circumstances in which it occurred."¹⁰⁸ This is more prescriptive than the draft clause proposed by the Law Commission of England and Wales and Scottish Law Commission which stated that the "the insurer had to pay for losses of a different kind, or at a different location or at a different time".¹⁰⁹

One of the examples provided to illustrate the practical implementation of the clause is to consider the requirement that a vehicle is roadworthy. In this example the Law Commission of England and Wales and Scottish Law Commission described an insured vehicle with a broken headlight that is involved in an accident after skidding on black ice in darkness. Here the insurer would not be expected to pay the claim as although the breach was not a direct cause of the loss, it "could potentially" have contributed to the accident.

However, if a claim is made after a tree falls onto the car in broad daylight (or the vehicle is involved in a collision), a broken headlight will have no connection to the type of loss that occurred (as it is daytime) and the insurer must pay the claim.¹¹⁰

The Commissions commented that this "keeps the focus looking forward from when the risk was underwritten (the breach could not have increased the risk of the loss) – as opposed to looking backwards from the actual circumstances of the claim (whether it contributed to the loss which occurred - a causation test)."¹¹¹

(8) Conclusions and recommendations

4.48 While some insurance policies make clear that a specific term is a future warranty, the distinction between such a warranty and another contract term that does not have the same drastic effect

¹⁰⁴ Law Commission of England and Wales and Scottish Law Commission *Stakeholder Note: Terms Not Relevant To The Actual Loss Draft Clause* (7 November 2014) paragraph 1.7.

¹⁰⁵ *Ibid* at paragraph 1.8.

¹⁰⁶ *Ibid*.

¹⁰⁷ *Ibid* at paragraph 1.13.

¹⁰⁸ Section 11(3) of the 2015 Act.

¹⁰⁹ Law Commission of England and Wales and Scottish Law Commission *Stakeholder Note: Terms Not Relevant To The Actual Loss Draft Clause* (7 November 2014) at paragraph 1.12.

¹¹⁰ *Ibid* at paragraph 1.18 (2). See additional example at 1.18(1).

¹¹¹ *Ibid* at paragraph 1.16.

is not always clear. This difficulty is compounded by insurers drafting their policies with warranties and conditions placed under the heading “general terms and conditions.”¹¹²

The Commission believes that terms with the same objective should be regulated in the same way. The focus should be placed on the substance of the term, with the added benefit of precluding the development of another type of clause that would attempt to reintroduce a new form of warranty.¹¹³

4.49 Case law from *De Hahn v Hartley* to *Keenan v Shield Insurance Co* has held that breach of a warranty triggers an automatic cancellation of cover even where there is no connection between the breach and the loss underwritten. Consequently, when dealing with breaches of warranty insurers focus on the time that the breach occurred (temporal approach) rather than whether the breach related to the claim (causative approach).

4.50 Insurance Ireland’s Codes of Practice are intended to alleviate the harsh effects of the current law on warranties. They provide that insurers should only repudiate for breach of a warranty where the circumstances of the claim are connected to the breach. The Commission accepts that this is reflected in practice among responsible insurers. However, as already noted, there have been occasions where insurers have not adhered to the provisions of the Codes and have relied on case law such as *Keenan*.

4.51 In recommending reforms regarding how these terms should be treated the Commission has analysed a number of approaches: the wholly causative approach (New Zealand); the mixed causative and proportionality approach (Australia); the degree of fault approach (PEICL); and the double element approach of carving out terms that are designed to reduce risk, while treating all other warranties as suspensive conditions (United Kingdom).

4.52 The Commission takes the view that the specific rules proposed by the Law Commission of England and Wales and Scottish Law Commission protect the legitimate risk assessment made by insurers when developing specific terms, including those which circumscribe or limit the scope of the contract and which can also benefit consumers through a reduced or otherwise favourable premium. These measures also ensure that consumers are not penalised by breach of a term unconnected to the loss.

The two-test approach adopted in the United Kingdom is appropriate in the Irish context because it has the dual benefit of focusing on the substance of risks being undertaken and indirectly on the causative issue that is absent from the current law on future warranties. Bearing in mind that the Commission has already recommended the abolition of warranties, the Commission further recommends that all similar terms, designed to impose continuing restrictive conditions on consumers during the course of the insurance contract, should be treated in the same manner.

The effect of this would be that, on the breach of a term that imposes a continuing restrictive condition on the consumer during the course of an insurance contract (terms including but not limited to warranties), the whole contract is suspended until the breach is remedied. This is unless the term is considered to be a “term descriptive of the risk,” in which case the liability will only be suspended for losses relating to the risk of a particular type of loss, or the risk of loss at a particular time or in a particular location. This is in line with the approach favoured by the Law Commission of England and Wales and the Scottish Law Commission, though not enacted in the UK *Insurance Act 2015*. The Commission does not favour the approach enacted in the 2015 Act as it is far more restrictive in scope than the earlier proposals of the Law Commission of England and Wales and the Scottish Law Commission.

The reforms proposed are not intended to regulate terms limiting or describing the risk or exclusion clauses. The Commission considers that it is sufficient that insurers should draw sufficient and clear attention to any such terms, as recommended separately in this Report.¹¹⁴

¹¹² Buckley *Insurance Law* 3rd ed (Thomson Round Hall 2012) paragraph 5-02.

¹¹³ Law Commission of England and Wales and Scottish Law Commission *A Summary of Responses to Consultation Paper on Insurance Contract Law: Misrepresentation, Non-Disclosure and Breach of Warranty by the Insured* (2008) paragraph 4.13.

¹¹⁴ See the recommendations in Chapter 9, below, on unfair and otherwise onerous terms.

4.53 The Commission recommends that all terms designed to impose continuing restrictive conditions on a consumer during the course of the insurance contract should be treated in the same manner.

4.54 The Commission recommends that any contract term (however such a term is described including being described as a warranty, a future warranty, a promissory or a continuing warranty) that imposes a continuing restrictive condition on a consumer during the course of the insurance contract should be treated as a suspensive condition in that, upon breach of such a condition, an insurer's liability for the whole contract is suspended for the duration of the breach but if the breach has been remedied by the time a loss has occurred, an insurer should be obliged to pay the claim (in the absence of any other defence to the claim).

4.55 The Commission recommends that breach of any contract term that is intended to reduce the risk of a particular type of loss, or the risk of loss at a particular time or in a particular location (however such a term is described, including being described as a warranty, a future warranty, a promissory or a continuing warranty) should only suspend liability in respect of that type of loss, or a loss at that time or in that place and an insurer should be unable to rely on the breach of such a term in respect of a loss of a different kind, or loss at a different location or time.

CHAPTER 5 INSURABLE INTEREST

A Overview of the Law on Insurable Interest

5.01 Insurable interest, a concept that has been part of insurance contract law since the 18th century, can be defined as the policyholder's connection with the subject-matter of the contract of insurance and the event it covers (whether for life cover or non-life cover such as motor insurance).¹

5.02 When insurance began to develop in England in the 16th and 17th centuries, insurable interest was not a legal requirement, but it became so through a combination of case law and legislation.

5.03 While insurable interest is often described as a fundamental concept in insurance contract law, the Law Commission of England and Wales and Scottish Law Commission have criticised it as a "fluid concept" which is "difficult to pin down"² and Professor Merkin has described it as "a confusing and illogical mess."³ It has either been reformed significantly or abolished completely in a number of jurisdictions.⁴

(1) ***Insurable interest is a mandatory requirement for life insurance and non-life indemnity insurance***

5.04 Historically the common law did not require an insurable interest to be present for a contract of insurance to be enforceable.⁵ Insurable interest first became a requirement in English law in the early 18th century because of concern at the time that marine insurance policies were being taken out by policyholders with more interest in making claims for the failure of ships to arrive in port than in trading their cargo. The *Marine Insurance Act 1745* introduced a statutory requirement that the policyholder must have an insurable interest in a marine insurance policy.

The 1745 Act did not apply to Ireland but the *Marine Insurance Act 1906* which repealed and replaced the 1745 Act does, and the 1906 Act retained the insurable interest requirement for marine policies. Although the 1906 Act is widely accepted as a codification of the general law of insurance, the sections that address insurable interest are probably limited to marine insurance.

5.05 The early 18th century concerns about marine insurance later extended to concerns over the emerging practice of insuring not just the ship and its cargo but also its captain's life⁶ and (a matter of even greater sensitivity at the time) the life of King George III.

¹ Buckley *Insurance Law* 3rd ed (Thomson Round Hall 2012) at paragraph 4-20.

² Law Commission of England and Wales and Scottish Law Commission *Consultation Paper on Insurance Contract Law: Post Contract Duties and Other Issues* (Law Com No. 201/Scottish Law Com No. 152, 2011) paragraph 11.94.

³ Merkin *Reforming Insurance Law: Is there a Case for Reverse Transportation? A Report for the English and Scottish Law Commissions on the Australian Experience of Insurance Law Reform* (Law Commission of England and Wales and Scottish Law Commission, 2007) at paragraphs 8.6 to 8.10.

⁴ See Buckley *Insurance Law* 3rd ed (Thomson Round Hall 2012), pp.178-186; Loshin "Insurance Law's Hapless Busybody: A Case Against the Insurable Interest Requirement" (2007-2008) 117 Yale LJ 474; and Atmeh "Regulation Not Prohibition: The Comparative Case Against the Insurable Interest Doctrine" (2011) 32(1) NJILB 93.

⁵ *Keith v The Protection Marine Insurance Company of Paris* (1882) 10 LR Ir 51.

⁶ This practice heralded the emergence of life insurance in general.

The insurable interest requirement was imported into life policies by the *Life Assurance Act 1774*,⁷ and applied to Ireland by the *Life Insurance (Ireland) Act 1866*.⁸ In a number of other common law jurisdictions the 1774 Act and comparable Acts have been interpreted as applying to insurance contracts generally, but the Irish courts have interpreted it as being confined to life insurance.⁹

5.06 The concern that insurance contracts involved a high degree of moral hazard and should never resemble gambling or wagering (which at that time was regarded as a significant social evil) resulted in the emergence of a general approach, reflected both in common law and legislation, that prohibited both gambling and any insurance contract that resembled gambling.

5.07 Thus, the courts developed the common law rule that all gaming and wagering contracts were illegal as being contrary to public policy.¹⁰ This rule is currently codified in section 36 of the *Gaming and Lotteries Act 1956*.¹¹ While neither party to a wager is required to show an interest in its subject matter, legislation has indirectly imposed on all forms of insurance contracts (including indemnity insurance) a requirement that an insured party must have an interest in the subject matter insured.¹²

(2) The nature and extent of the required insurable interest is not clear

5.08 Non-life indemnity insurance contracts are usually¹³ contracts to which the “indemnity principle” applies so that policyholders cannot recover more than they have lost.¹⁴ Since a policyholder with no interest in the subject matter insured cannot suffer a loss, the “indemnity principle” and “insurable interest” are concepts which appear to overlap to a certain extent.

5.09 In consequence, two separate and distinct principles of insurance law appear to serve one objective, namely, to limit the liability of insurers to the amount of the loss suffered. It is, therefore, questionable whether the concept of “insurable interest” adds appreciably to the principle of indemnity which enables claimants to be compensated only for the actual loss suffered.

Irish law permits only a policyholder with an interest in an insured event, (for example, the owner of the house or contents destroyed by fire) to recover on foot of an insurance contract. If the policyholder has no such insurable interest, then there is no loss that the insurer is required to indemnify.¹⁵

5.10 Life insurance is not a contract of indemnity (it is often referred to as contingency insurance), because it usually requires the insurer to pay a fixed sum on the death of an insured person. The concept

⁷ 14 Geo 3, c.48. See Merkin “Gambling by Insurance - A study of the Life Assurance Act 1774” (1980) 9 Anglo-Am L Rev 331.

⁸ 29 & 30 Vict., c.42.

⁹ *Church and General Insurance Co v Connolly* High Court (Costello J), 7 May 1981. Legh-Jones, Birds and Owen (eds), *MacGillivray on Insurance Law* 11th ed (Sweet & Maxwell, 2008), at paragraph 1-044 doubts the correctness of this decision, and notes at paragraph 1-030 that English case law interprets the 1774 Act as also applying to non-indemnity accident policies. Nonetheless, the decision in the *Church and General Insurance* case remains the most recent considered Irish decision on the scope of the 1774 Act.

¹⁰ See Clark *Contract Law in Ireland* 6th ed (Thomson Round Hall, 2008), pp.422-428.

¹¹ As discussed below, Head 82 of the *Scheme of a Gambling Control Bill 2013* proposes to reverse virtually completely the effect of section 36 of the 1956 Act by providing for the enforceability of gambling contracts.

¹² See the Law Commission of England and Wales and Scottish Law Commission *Issues Paper 4 on Insurable Interest* (January 2008) paragraphs 2.16, 2.12 and the Australian Law Reform Commission *Report on Insurance Contracts* (Report No. 20, 1982) paragraph 107.

¹³ Non-life non-indemnity contracts exist in which the consumer and the insurer enter into a contract that provides for a fixed value policy.

¹⁴ *Castellain v Preston* (1893) 11 QBD 380.

¹⁵ Legh-Jones, Birds and Owen (eds), *MacGillivray on Insurance Law* 11th ed (Sweet & Maxwell, 2008) at paragraph 1-014.

of “insurable interest” for life policies cannot, therefore, be said to arise from the nature of the contract; it arises only because of the statutory requirement in the 1774 Act.

5.11 While an insurable interest is required for life insurance and marine insurance contracts (under the 1774 and 1906 Acts) and for non-life insurance contracts (because of the “indemnity principle”), the nature and extent of what constitutes an insurable interest has not been clarified in case law and this has led to consequent statutory reform in many common law jurisdictions.

(a) Insurable interest in non-life indemnity insurance

5.12 Much of the case law which has sought to define insurable interest has arisen in the context of non-life insurance. The question was first authoritatively addressed by the UK House of Lords in 1806 in *Lucena v Craufurd*,¹⁶ in which Lord Eldon advocated a relatively narrow test; this was the “legal interest” test under which the policyholder is required to demonstrate not only actual loss but also that this arises from some legally enforceable right (whether legal, equitable or contractual) in the insured property.

Lord Eldon acknowledged that this narrow insurable interest test was specifically intended to prevent any wagering-type insurance policies from gaining further momentum at that time. Lord Eldon’s narrow test of insurable interest was codified in section 5(2) of the *Marine Insurance Act 1906*, which provides:

“In particular a person is interested in a marine adventure where he stands in any legal or equitable relation to the adventure or to any insurable property at risk therein, in consequence of which he may benefit by the safety or due arrival of insurable property, or may be prejudiced by its loss, or by damage thereto, or by the detention thereof, or may incur liability in respect thereof.”

5.13 That test was also approved by the UK House of Lords in *Macaura v Northern Assurance Co Ltd*.¹⁷ In that case the plaintiff was the only major shareholder in a company to which he had also sold timber on credit. He took out a fire insurance policy with the defendant to insure the timber and when it was destroyed by fire he claimed under the policy.

The defendant repudiated liability and the defendant claimed in an arbitration hearing that the claim was fraudulent, but this was dismissed by the arbitrator and the only defence then available was that the plaintiff had no insurable interest in the timber.

On appeal to the UK House of Lords, it was held that the plaintiff had no legal or equitable relationship to the company’s stock, that is the timber, and therefore did not have an insurable interest in it. As a result, the defendant insurance company was entitled to repudiate liability under the contract.

5.14 Although *Macaura* is the leading UK decision on insurable interest it has been noted that its effect has been diluted by a willingness on the part of the lower courts to treat the notion of insurable interest as an expanding concept.¹⁸

The Law Commission of England and Wales and Scottish Law Commission have also noted that the courts have “inched towards”¹⁹ a wider test, the “factual expectation” test,²⁰ which had been advocated by

¹⁶ (1806) 2 B & PNR 269. For a more detailed discussion of the historical case law on insurable interest, see Law Reform Commission *Consultation Paper on Insurance Contracts* (LRC CP 65 – 2011) paragraphs 2.09-2.23.

¹⁷ [1925] AC 619.

¹⁸ Lord Mance et al, *Insurance Disputes* 3rd ed (Informa Maritime & Transport, 2011) at paragraph 1.14.

¹⁹ Law Commission of England and Wales and Scottish Law Commission *Consultation Paper on Insurance Contract Law: Post Contract Duties and Other Issues* (Law Com No. 201/Scottish Law Com. No. 152, 2011) at paragraph 11.51.

²⁰ For the Canadian approach see *Kosmopoulos v Constitution Insurance Co.*, [1987] 1 SCR 2; see also MacIntosh “Insurable Interest: The Supreme Court of Canada adopts the Factual Expectancy Test” (1987-1988) 13 Can Bus LJ 226. Catzman “Reform of the Law Relating to Insurable Interest in Property - Some Thoughts on Chadwick v Gibraltar General Insurance” (1983-1984) 8 Can Bus LJ 114. For New Zealand see

Lawrence J in *Lucena v Craufurd*, under which the key question would be whether the policyholder in fact suffered some loss from damage to the subject matter, or stood to gain some advantage from its continued existence, so that a definite expectation or benefit would be sufficient.

5.15 This wider test of insurable interest, to which the English courts are “inching,” has also been adopted in a wide range of jurisdictions, including Australia, Canada and the USA.²¹ The narrow test in *Lucena* and in *Macaura* has been rejected, principally on the basis that it has the potential to defeat the reasonable commercial expectations of the parties²² and in its place the courts have substituted the wider factual expectation test.

5.16 In Ireland, although the courts have not expressly engaged in a choice between the narrow “legal interest” test or the wider “factual expectation” test the available case law suggests that the wider test is preferred. In *PJ Carrigan Ltd and Carrigan v Norwich Union Fire Society Ltd*²³ on facts closely resembling those in *Macaura*, the High Court (Lynch J) held that the requirement for an insurable interest had been met.

In *Carrigan*, the majority shareholder of the first plaintiff was the second plaintiff. The first plaintiff was the registered owner of a large house and the second plaintiff took out a fire insurance policy on the house and its contents. When the house was destroyed in a fire the plaintiff claimed under the policy but the defendant repudiated liability. On the issue of insurable interest, the Court held that the second plaintiff had a sufficient insurable interest by virtue of having the main beneficial interest, and possibly the sole beneficial interest, in the company.

5.17 Buckley has commented that, by contrast with *Macaura*, the High Court had little difficulty coming to this conclusion, thus appearing to favour the wider factual expectation test,²⁴ and it can be argued that this is consistent with general Irish contract law under which legitimate expectation has developed from the concept of promissory estoppel as a basis for recognising promises as enforceable.

(b) Insurable interest in life insurance

5.18 While Irish case law appears to favour the wider factual expectation test and may avoid the criticism levelled at English law (at least while the narrow test remains formally in place), the concept of insurable interest also gives rise to separate difficulties in the context of life insurance.

5.19 In life policies the requirement for an insurable interest derives from legislation. Section 1 of the *Life Assurance Act 1774*, as applied to Ireland by the *Life Insurance (Ireland) Act 1866*, declares “null and void” any such policy where the person whose life was insured “shall have no interest” in the policy. Subsequent case law determined that the insurable interest requirement for life policies must exist at the date of entry into the contract and is not required at the date of death,²⁵ (making it possible to assign, sell and buy these policies).

5.20 Section 2 of the 1774 Act required the names of all interested parties be listed in the policy, potentially making policies illegal on technical grounds. This difficulty was remedied by section 26 of the

also Long “The Concept of Insurable Interest and the Insurance Law Reform Act 1985” (1992-1995) 7 Auckland UL Rev 80.

²¹ For a more detailed analysis see the Law Reform Commission *Consultation Paper on Insurance Contracts* (LRC CP 65 – 2011) at paragraphs 2.24-2.33.

²² See Hasson “Reform of the Law Relating to Insurable Interest in Property - Some Thoughts on *Chadwick v Gibraltar General Insurance*” (1983-84) 8 Can Bus LJ 114.

²³ High Court, 11 December 1987.

²⁴ Buckley *Insurance Law* 3rd ed (Thomson Round Hall, 2012), paragraph 4-33.

²⁵ Legh-Jones, Birds and Owen (eds), *MacGillivray on Insurance Law* 11th ed (Sweet & Maxwell, 2008), at paragraph 1-034, citing *Dalby v The India and London Life Assurance Co* (1854) 15 CB 365.

Insurance Act 1989 which provides that a class of person expressed on the policy will serve to satisfy section 2 of the 1774 Act.²⁶

5.21 The 1774 Act does not define insurable interest (so that as with non-life insurance its meaning has, in general, come from case law), but section 3 indicates that, in general, there must be proof of a financial or pecuniary interest measured by the loss that would be suffered by the policyholder on the death of the life assured.²⁷ However a “mere expectancy or hope of future pecuniary benefit from the prolongation of the life insured or of the fulfilment by him of moral obligations owed to the assured, are insufficient to sustain an insurable interest.”²⁸

5.22 There are two classes of cases in which the law presumes the pecuniary interest and does not go into the extent of the sum assured. The first case is that of the interest of a policyholder in his or her own life,²⁹ which is based on the view that a person does not gamble on his or her own life to gain a pyrrhic victory by his or her own death.³⁰

The second exception is that a spouse who takes out a policy on his or her spouse’s life need not prove an insurable interest, because the interest is presumed to the extent of the amount insured by the policy.³¹ The rationale for this is the understanding that neither spouse is likely to indulge in “mischievous gaming” on each other’s lives.³² Because, at least in the State,³³ this common law presumption did not appear to extend to civil partners, cohabitantes or any other familial relationship, a series of legislative provisions have been enacted to deal with this.

5.23 English case law recognises other categories,³⁴ but this discretion underlines an absence of clarity. An insurable interest in a life can also be created or waived by statutory provisions. For example, legislation such as section 7(1) of the *Married Women’s Status Act 1957* has created statutory exceptions to ensure that children (as well as wives) who were clearly intended to benefit from a life policy can do so.³⁵

²⁶ Section 26(1) of the *Insurance Act 1989* provides: “Section 2 of the Life Assurance Act 1774, as applied by the Life Insurance (Ireland) Act 1866, shall not invalidate a policy of insurance for the benefit of unnamed persons from time to time falling within a specified class or description if the class or description is stated in the policy with sufficient particularity to make it possible to establish the identity of all persons who, at any given time, are entitled to benefit under the policy.” Section 26(2) of the 1989 Act provides that this applies whether the policy was made before or after commencement of the section. In Australia section 20 of the *Insurance Contracts Act 1984* abolished the requirement that persons benefitting from a policy need to be named within the policy document.

²⁷ Established categories under section 3 of the 1774 Act include for example: a creditor may insure the life of a debtor to the amount of the loan; a joint debtor may insure the life of a joint debtor to the amount of the debt; and an employer may insure the life of an employee to the extent of the value of the employee’s work while employed.

²⁸ Legh-Jones, Birds and Owen (eds) *MacGillivray on Insurance Law* 11th ed (Sweet & Maxwell 2008) at paragraph 1-070.

²⁹ *Wainwright v Bland* (1835) 1 Moo & R 481; 174 ER 165.

³⁰ *Griffiths v Fleming* [1909] 1 KB 805, at 821.

³¹ *Ibid.*

³² *Ibid.*

³³ Case law in other jurisdictions, such as the United States, has defined more widely the categories of insurable interest in family relationships, to include for example, children and grandchildren. See Legh-Jones, Birds and Owen (eds), *MacGillivray on Insurance Law* 11th ed (Sweet & Maxwell, 2008), at paragraph 1-104.

³⁴ See *Feasey v Sun Life Assurance of Canada* [2003] EWCA Civ 885; [2003] 2 All ER (Comm) paragraph 90.

³⁵ Section 7(1) of the *Married Women’s Status Act 1957* replaced section 11 of the *Married Women’s Property Act 1882*.

The O'Donoghue Report³⁶ criticised the overly restrictive nature of this aspect of insurable interest and recommended that insurable interest be extended to cover instances of adoption not already dealt with in the 1957 Act. This recommendation was implemented in section 163 of the *Adoption Act 2010* which included children adopted through inter-country adoption within section 7 of the 1957 Act.

The Report also recommended that the trustees of trust funds should have an insurable interest to insure where it would be commercially prudent to do so.

While it is common for trustees of pension schemes to take out policies on the lives of their members there still remains uncertainty surrounding the basis for insurable interest in group schemes. The Association of British Insurers in their submissions to the Law Commission of England and Wales and Scottish Law Commission argued that the law would be clearer if trustees of pension schemes were included within the category of those with unlimited insurable interest.

Such recommendations should now be considered in the light of further legislative recognition of other family relationships, notably civil partners and cohabitants (in the *Civil Partnership and Certain Rights and Obligations of Cohabitants Act 2010*) and the need to recognise the position of children born through assisted human reproduction (in the *Children and Family Relationships Act 2015*).

The available English case law suggests that these forms of family relationships may not currently be recognised as having an insurable interest. Instead, they are required by section 3 of the 1774 Act to have some financial or pecuniary interest in the proposed life to be insured, and they are limited in the amount that they can insure the proposed insured.

It is accepted that the problem can be resolved by assignment, in other words, one can take a policy out on one's own life and then assign it to one's partner, but this clearly adds complexity and expense to the process.

5.24 There is also the difficulty of recovering the sums insured when the courts incline towards giving the policyholder the amount lost rather than the value of the interest on the life assured, as of the date the policy was taken out. Indeed should the policyholder recover the sum of his or her loss (for example, through a separate policy of insurance) this will exhaust the entitlement.

The valuation of the interest causes particular difficulties in the context of "key employee" policies. Key employees are those considered so important to an organisation that the employer may seek to effect insurance on their lives as their loss would adversely affect the business. Case law suggests that the employer's insurable interest is measured by the notice period that the employer is entitled to rather than the anticipated business losses.³⁷

However as MacGillivray³⁸ points out, the value of an employee may only become apparent after the insurance has commenced and any attempts to fix a pecuniary value on the insurable interest are inherently uncertain thus highlighting the limiting effect the concept of pecuniary interest has on such policies.

5.25 The Law Commission of England and Wales and Scottish Law Commission have noted that it is typical practice to value a key employee at a figure of up to ten times the person's annual salary and they suggest that any such round figure estimate may be in breach of section 3 of the 1774 Act. They argue that any other estimate, based upon likely future business generated by the employee, would be an expectation interest rather than a pecuniary interest and thus fail to satisfy section 1 of the 1774 Act.³⁹

³⁶ *Final Report of the Committee of Inquiry into the Insurance Industry* (Prl.5530, 1976), discussed generally in Appendix C, below.

³⁷ *Simcock v Scottish Imperial Ins Co* (1902) 10 SLT 286.

³⁸ Legh-Jones, Birds and Owen (eds) *MacGillivray on Insurance Law* 11th ed (Sweet & Maxwell 2008) at paragraph 1-073 -1-074.

³⁹ Law Commission of England and Wales and Scottish Law Commission *Issues Paper 4: Insurable Interest* (2008) at paragraph 4.12(2).

B Insurable interest: Reform or Abolish

5.26 Against this background, two general options are open for consideration: (1) reform of the concept of insurable interest to remove uncertainty as to the general test to be applied and the inclusion of more categories of persons deemed to have an interest, or (2) abolition of the concept altogether.

In the Consultation Paper, the Commission provisionally recommended that the wider factual expectation test of insurable interest should be placed on a statutory footing⁴⁰ and that the categories of persons should be more broadly defined to include those who would benefit from the continued existence or safe guarding of the subject matter of the insurance or who may be prejudiced by its loss.⁴¹

5.27 Concern has been expressed that the proposed definition would require a consumer proposer to provide evidence to satisfy an insurer that the consumer would benefit from the continued existence or might be prejudiced by the loss of the subject matter of the insurance contract.

It has been argued that subjectivity would be introduced if the definition was to be so broadly defined and that it would be difficult to be objective in assessing the interest. Furthermore this proposal, if adopted, might enable a person to insure their neighbour's property, which could lead to the moral hazard concerns expressed by Lord Eldon in *Lucena v Craufurd*.

5.28 Some submissions received by the Commission recommended the abolition of the insurable interest requirement. Consultees suggested that while the provisional recommendations for reform of insurable interest would address specific matters such as the inclusion of civil partners or cohabitants and would alleviate related problems for pension trusts, they would do nothing to address issues in family trusts and those created by single premium investment bonds.

Consultees also underlined the growing international aspect of the financial services industry and the potential for Ireland to operate as a hub for investment and insurance products. It has been suggested that trade in the single premium investment bond market could be lost to countries which do not have restrictive rules on insurable interest. Attention was drawn to developments in the Isle of Man where the requirement of insurable interest for life assurance contracts was abolished.⁴²

It has been suggested that if reforms of the law on insurable interest were limited to those set out in the provisional recommendations, insurers may be disinclined to offer single premium investment bonds in Ireland because other jurisdictions such as the Isle of Man would be more facilitative. Some submissions indicated that there is now an increase in the use of marketing campaigns by states seeking to attract financial services industry by promoting facilitative legislation for savings and investment products.

5.29 In the Consultation Paper, the Commission provisionally recommended that in connection with life insurance, the following should be deemed to have an insurable interest in the life policy: spouses in relation to each other; civil partners in relation to each other; cohabitants in relation to each other; a child in relation to his or her parent or guardian; and a parent or guardian in relation to his or her dependent adult child.

The Commission also invited submissions as to whether, in connection with life insurance, the following should also be deemed to have an insurable interest in the life policy: a grandparent in relation to his or her grandchild; and siblings in relation to each other.

5.30 Similar categories were examined by the Law Commission of England and Wales and Scottish Law Commission in their 2008 Issues Paper although in their 2011 Consultation Paper they proposed a

⁴⁰ Law Reform Commission *Consultation Paper on Insurance Contracts* (LRC CP 65 – 2011) at paragraph 2.61.

⁴¹ *Ibid* at paragraph 2.60.

⁴² In the Isle of Man the requirement of insurable interest for life assurance contracts was abolished by section 4(2) of its *Life Assurance (Insurable Interest) Act 2004*. However, section 5 allows its Insurance and Pensions Authority to prescribe, by order, assurance contracts and classes of such contracts to which section 4 does not apply and which, accordingly, may be treated as void and illegal by reason that the policy holder did not have, at the time the contract was entered into, a specified insurable interest in the subject of the contract.

limited expansion to three categories: parents of a child under 18, cohabitants, and trustees of pension or group schemes.

5.31 The Commission has concluded that there are significant problems with creating additional categories of presumed interest as a means of alleviating the difficulties attributed to the 1774 Act. For example the proposal to extend the requirement to cohabitants requires consideration of whether the definition in the *Civil Partnership and Certain Rights and Obligations of Cohabitants Act 2010*, which outlined rights arising from the relationships of cohabitants, is appropriate in the context of a potentially long-term life assurance contract.⁴³

The 2010 Act provides for two distinct categories of cohabitant, namely “cohabitants” and “qualified cohabitants”. To come within the term “cohabitant” in the 2010 Act no minimum period of cohabitation is required but in determining whether or not two adults are cohabitants section 172 of the 2010 Act provides that all the circumstances of the relationship are to be taken into account and regard is to be had to seven specific factors.⁴⁴

5.32 It may be that, in the context of insurable interest, an insurer could use this list as a means of determining whether two people met the proposed expanded definition. Section 172(5) of the 2010 Act defines “qualified cohabitants” as parties who have been living together as a couple immediately before the end of the relationship for a period of at least five years or for at least two years if the couple were both parents of one or more dependent children.

One commentator has remarked that the use of the word “was” indicated that this category is only triggered when “the relationship must have ended, either by death or otherwise”.⁴⁵ In this respect neither definition in the 2010 Act can be regarded as being easy to apply and both would appear to require extensive proofs, and the question arises as to why a person would go to such lengths when they may take out a policy on their life and simply transfer it to their partner.

5.33 The concept of insurable interest has, in effect, been abolished in jurisdictions such as Australia with apparent success. However, other jurisdictions such as the United Kingdom retain it in some form.⁴⁶

(1) United Kingdom

5.34 The Law Commission of England and Wales and Scottish Law Commission, in their 2008 Issues Paper on Insurable Interest,⁴⁷ accepted the view adopted in the Australian *Insurance Contracts Act 1984* that the functions served by the requirement of insurable interest could be fully served by the indemnity principle. In their 2011 Consultation Paper on Insurable Interest,⁴⁸ however, the Commissions

⁴³ The definition in the 2010 Act is based largely on the recommendations in the Commission’s 2006 *Report on Rights and Duties of Cohabitants* (LRC-82-2006) and on the draft Cohabitation Bill attached to the Report.

⁴⁴ Section 172(2) of the 2010 Act provides that in determining whether or not two adults are cohabitants, the court shall take into account all the circumstances of the relationship and in particular shall have regard to the following: (a) the duration of the relationship; (b) the basis on which the couple live together; (c) the degree of financial dependence of either adult on the other and any agreements in respect of their finances; (d) the degree and nature of any financial arrangements between the adults including any joint purchase of an estate or interest in land or joint acquisition of personal property; (e) whether there are one or more dependent children; (f) whether one of the adults cares for and supports the children of the other; and (g) the degree to which the adults present themselves to others as a couple.

⁴⁵ Ryan *Civil Partnership and Certain Rights and Obligations of Cohabitants Act 2010* Annotated legislation (Round Hall, 2010) at 275.

⁴⁶ For a general overview of a number of jurisdictions see IBA Insurance Committee Substantive Project 2013 *The Legal Nature of Insurance Contracts*.

⁴⁷ Law Commission of England and Wales and Scottish Law Commission *Issues Paper 4: Insurable Interest* (2008).

⁴⁸ Law Commission of England and Wales and Scottish Law Commission *Consultation Paper on Insurance Contract Law: Post Contract Duties and Other Issues* (Law Com No. 201/Scottish Law Com No. 152, 2011).

accepted the view expressed by industry consultees that insurable interest is the “hallmark” of insurance contracts, and they therefore provisionally recommended that insurable interest should be retained, subject to a number of reforms. In the Commissions’ 2015 Issues Paper, in which they returned to review the topic in light of submissions made on the 2011 Consultation Paper, the Commissions remained of the view that insurable interest continues to serve a number of functions and they made a number of updated proposals for its reform.⁴⁹

In the 2011 Consultation Paper (and reiterated in the 2015 Issues Paper) the Law Commissions surmised that insurable interest fulfilled the following functions:⁵⁰

“(1) It provides a dividing line between gambling and insurance. This distinction is crucial for both regulatory and tax purposes, and for those communities where gambling is forbidden. Insurable interest thus is an important part of the definition of insurance.

(2) It guards against moral hazard. By setting limits on the contracts that insurers may enter into, it protects insurers from themselves – from writing insurance which is overly speculative, or which encourages wrongdoing. In Issues Paper 4, we pointed out that as a protection against murder and arson, the doctrine of insurable interest often lacks logic. For example, people are much more likely to kill a spouse (whose life can be insured) than an adult descendant (whose life cannot). Nevertheless, respondents still thought that the doctrine was a useful backstop.

(3) It protects the insurer from invalid claims. In theory, validity is a matter of policy wording: the contract should specify who can claim and in which circumstances. In practice, it is common for the policy to specify the subject matter of the insurance, without tying down the link between it and the insured. This is left to customary understandings, as upheld by court decisions specifying the type of insurable interest necessary for the type of insurance. Insurers feared that radical reform would interfere with these understandings. Claims could be made by a wider class of people, including those without close links to whatever has been insured.

(4) In an increasingly global market place it is used to define where insurance is located and therefore which regulatory or tax regime it falls within.”

5.35 The Law Commissions then proposed a statutory restatement to confirm that the requirement of insurable interest applies to all forms of insurance and if it is not met the policy would be void. This presumably is to clarify the difficulty triggered by the *Gambling Act 2005* which some have argued abolished the insurable interest requirement.⁵¹

See generally Lloyd’s Market Association Response to Issues Paper 4: Insurable Interest; see also Response by the City of London Law Society, Insurance Law Committee, to the Issues Paper 4: Insurable Interest.

⁴⁹ Law Commission of England and Wales and Scottish Law Commission *Reforming Insurance Contract Law: Issues Paper 10: Insurable Interest: updated proposals* (March 2015).

⁵⁰ Law Commission of England and Wales and Scottish Law Commission Consultation Paper on Insurance Contract Law: *Post Contract Duties and Other Issues* (Law Com No. 201/Scottish Law Com No. 152, 2011). at paragraph 10.12 (footnotes omitted).

⁵¹ When the UK enacted the *Gambling Act 2005*, thereby repealing section 18 of the *Gaming Act 1845* (the equivalent in the State being section 36 of the *Gaming and Lotteries Act 1956* which is set to be repealed, assuming the *Scheme of Gambling Control Bill* is enacted), the Law Commissions speculated that the insurable interest requirement in indemnity policies was inadvertently abolished: see Law Commission of England and Wales and Scottish Law Commission *Issues Paper 4 on Insurable Interest* (2008). While this view is not universally held it does bear consideration, as it is possible that the UK’s indemnity insurance market has, since the enactment of the 2005 Act, operated in effect without an insurable interest requirement and, like its Australian counterpart, does not appear to have been adversely affected by it: see *Response by Lloyd’s Market Association to the Law Commission and the Scottish Law Commission Issues Paper 4 on Insurable Interest* (2008), which questioned the effect of the *Gambling Act 2005* on insurance contracts, although that response paper recognised that the issue is complicated.

The Commissions accepted that the timing of the interest (whether it would have to be present at the time the contract is made, or whether it would be sufficient to have an interest at the time of the loss) would be dependent upon the type of insurance.

In relation to indemnity insurance and defining what would comprise a valid insurable interest for its purposes, the Commissions proposed either leaving the matter entirely to the courts, or partially codifying the existing common law by providing a non-exhaustive list of connections that would constitute an insurable interest.⁵²

In relation to life insurance, the Commissions proposed widening the category of those able to insure the life of another on the basis of financial loss beyond “a pecuniary interest recognised by law” to one based on a reasonable expectation of economic loss. They considered that this definition would assist those that are economically dependent, such as relatives or employers in respect of their key employees.

They also argued that such a test would reduce the need to widen the categories of “natural affection”, that is, those entitled to insure another person’s life without evidence of loss. They then proposed three possible extensions: (1) to children under 18 (in their 2015 Issues Paper, the Commissions have suggested that there should not be any cap on the amount involved); (2) to cohabitants; and (3) to the trustees of pension and other group schemes.

(2) Australia

5.36 In its 1982 *Report on Insurance Contracts* the Australian Law Reform Commission (ALRC) recommended, for non-life policies, abolition of insurable interest and, for life policies, by a majority,⁵³ that the categories of insurable interest should be extended. The abolition of insurable interest in non-life policies was implemented in section 18 of the *Insurance Contracts Act 1984*.

For life policies, insurable interest was retained in section 16 of the 1984 Act, and section 16(2) extended the categories of persons having an insurable interests as follows: (a) a body corporate has an insurable interest in the life of an officer or employee of the body corporate; (b) an employer has an insurable interest in the life of his employee and an employee has an insurable interest in the life of his employer; and (c) a person has an insurable interest in the life of a person on whom he depends, either wholly or partly, for maintenance and support.

5.37 Less than ten years later, it was accepted that this approach was flawed and that a significant amount of court time “was still being taken up with trying to work out whether de facto relationships [the Australian equivalent of cohabitants] would count or whether a person was likely to suffer a pecuniary or economic loss as the result of the death of another person.”⁵⁴

Section 16(2) of the 1984 Act was repealed in 1995⁵⁵ and section 18 of the 1984 Act was amended so that the original abolition of insurable interest in non-life indemnity policies was extended to life policies.

As a result of these changes the position in Australia is as follows. Section 16(1) of the 1984 Act provides:

“A contract of general insurance is not void by reason only that the insured did not have, at the time when the contract was entered into, an interest in the subject-matter of the contract.”

Section 17 of the 1984 Act provides:

⁵² Law Commission of England and Wales and Scottish Law Commission *Consultation Paper on Insurance Contract Law: Post Contract Duties and Other Issues* (Law Com No. 201/Scottish Law Com No. 152, 2011) at paragraph 12.40.

⁵³ The then Chairman of the ALRC, Mr Justice Kirby, disagreed with this and recommended in a minority view that insurable interest should be abolished in the context of life policies: Australian Law Reform Commission *Report on Insurance Contracts* (Report No. 20, 1982) at paragraph 146. This minority view was subsequently adopted: see below.

⁵⁴ See the Law Commission of England and Wales and Scottish Law Commission *Issues Paper 4: Insurable Interest* (2008), paragraph A.11.

⁵⁵ Australian *Life Insurance (Consequential Amendments and Repeals) Act 1995*.

“Where the insured under a contract of general insurance has suffered a pecuniary or economic loss by reason that property the subject matter of the contract has been damaged or destroyed, the insurer is not relieved of liability under the contract by reason only that, at the time of the loss, the insured did not have an interest at law or in equity in the property.”

5.38 The importance of moving towards an economic-based test was highlighted by the ALRC in its 1982 *Report on Insurance Contracts* when it gave the following example of the effect of section 17 in the Notes to the draft Bill appended to its Report:⁵⁶

“A is employed in his father’s business which is left to him under his father’s will. The father refuses to insure the property of the business, so A insures it in his own name. The property is destroyed by fire before the father dies. Under the existing law [that is, prior to the enactment of the 1984 Act] A would be prevented from recovering anything under the contract because he had no legal or equitable title to the property. Section 17 [of the draft Bill] allows him to recover the amount of his economic loss (up to the limit of the insurer’s liability under the contract) as a result of the destruction of the property.”

5.39 The essential difference between this approach and that of the Law Commission of England and Wales and Scottish Law Commission is that Australian law accepts that the functions of the insurable interest requirement are met by the indemnity principle. Indeed, as already noted this was the initial conclusion of the Commissions in 2008 before they revised their position in 2011 (and that revised position was retained in their 2015 Issues Paper).

5.40 The effect is that, in Australia, insurable interest is now a matter considered simply as an underwriting issue. It is dealt with by the insurer by means of a simple question to the proposed insured.

(3) *Insurable interest is not a necessary part of the general definition of an insurance contract*

5.41 Although some submissions received by the Commission argued that insurable interest should be abolished, other submissions argued for its retention on the ground that insurable interest was so ingrained in insurance contract law that to remove the requirement would encourage invalid claims.⁵⁷

5.42 While there is no statutory definition of “contract of insurance” in Irish law, the leading cases have outlined a number of important features which, as discussed below, have been taken into account by the financial regulators with responsibility for overseeing the insurance industry. The essence of an insurance contract is that it is aleatory, that is, it depends on an uncertain outcome, in which a sum of money (the premium) is given to another party (the insurer) on the basis of an event that may, or may not, occur. The leading Irish decision, *International Commercial Bank plc v Insurance Corporation of Ireland plc*,⁵⁸ concerned the distinction between a contract of insurance and a contract of guarantee. The High Court (Blayney J) noted that contracts of insurance are generally matters of speculation, where the person who wishes to be insured has knowledge as to the risk, and the insurer either has not that knowledge or else not the same knowledge as the insured; that the insurer, based on the risk stated by the insured, fixes a proper price for the risk to be undertaken; and that the insurer engages to pay the loss incurred by the insured in the event of certain specified contingencies occurring.⁵⁹

⁵⁶ Australian Law Reform Commission *Report on Insurance Contracts* (Report No. 20, 1982), Appendix, Notes to section 17 of draft Insurance Contracts Bill 1982.

⁵⁷ This is also the view expressed by the Law Commission of England and Wales and Scottish Law Commission, who have argued that insurable interest is a “useful tool” in protecting insurers from invalid claims, that is, claims made by a wider class of people, including those without close links to whatever has been insured, for example, third parties unrelated to the policy who have suffered demonstrable loss: see Law Commission of England and Wales and Scottish Law Commission Consultation Paper on *Insurance Contract Law: Post Contract Duties and other Issues* (Law Com No. 201/Scottish Law Com. No. 152, 2011), paragraph 10.12(3).

⁵⁸ [1991] ILRM 726.

⁵⁹ [1991] ILRM 726, at 734.

5.43 Blayney J also cited with approval the comment of Romer LJ in one of the leading English cases, *Seaton v Heath*, that “the substantial character of the contract and how it came to be effected”⁶⁰ are key factors in determining whether it is a contract of insurance or some other type of contract.⁶¹ This analysis is consistent with another leading English case, *Prudential Assurance v Inland Revenue*,⁶² in which the English Court of Appeal held that a contract of insurance must involve a contract for the payment of a sum of money, or for some corresponding benefit such as the rebuilding of a house or the repairing of a ship, and that the money becomes due on the happening of an event which must have an element of uncertainty about it.⁶³

5.44 The Court in *Prudential Assurance* also held that the event must be “prima facie adverse to the interest of the assured,”⁶⁴ although as the Law Commission of England and Wales and Scottish Law Commission have pointed out, the “interest” discussed in *Prudential Assurance* is not the same as the statutory concept of insurable interest in the 1774 Act, but rather “an interest in something so that one would be adversely affected if it were to be lost.”⁶⁵ Similarly, MacGillivray, when citing the *Prudential Assurance* case and other English case law, does not refer to insurable interest as an essential component of a contract of insurance and instead defines it as “one whereby one party promises in return for a money consideration to pay to the other party a sum of money or provide him with some corresponding benefit, upon the occurrence of one or more specified events” and a specified event “must be of a character more or less adverse to the interest of the person effecting the insurance”.⁶⁶

5.45 The Commission concludes from this that insurable interest is not an integral part of a contract of insurance, and that a contract is capable of being classified as an insurance contract without reference to the principle.

(4) *Insurable interest is not a requirement of the statutory insurance licensing regime, and is not required to distinguish insurance contracts from other types of financial services*

5.46 The Central Bank of Ireland is responsible for regulating financial services in the State, including the insurance industry, who must meet the licensing and regulatory requirements of the *Insurance Acts* and the *Central Bank Acts*, many of which derive from EU requirements and have been reformed and strengthened in the wake of the global economic crisis that emerged in 2008.⁶⁷ The Central Bank is empowered to license insurance undertakings to engage in life insurance and non-life insurance,

⁶⁰ *Seaton v Heath* [1899] 1 QB 782, at 792-793, cited in *International Commercial Bank plc v Insurance Corporation of Ireland plc* [1991] ILRM 726, at 736.

⁶¹ In the *International Commercial Bank* case, Blayney J pointed out that the wording of the contract at issue in that case corresponded closely to the precedent for a contract of guarantee in *Butterworth's Encyclopaedia of Forms and Precedents*, 4th ed, Vol.9, p.785 (which also included separate precedent clauses for insurance contracts, as does its more recent successors), and that it did not refer to the payment of a premium (although this was referred to in a separate cover note). On this basis, he concluded that it was a contract of guarantee.

⁶² [1904] 2 KB 658.

⁶³ *Ibid* at 662.

⁶⁴ *Ibid* at 663. The leading Scottish case, *Scottish Amicable Heritable Securities Association Ltd v Northern Assurance Co* (1883) 11 R 287, recognises the same defining characteristics of an insurance contract as the leading English cases. See Law Commission of England and Wales and Scottish Law Commission *Issues Paper 4: Insurable Interest* (2008) at paragraph 7.19.

⁶⁵ Law Commission of England and Wales and Scottish Law Commission *Issues Paper 4: Insurable Interest* (2008) at paragraph 7.20.

⁶⁶ Legh-Jones, Birds and Owen (eds) *MacGillivray on Insurance Law* 11th ed (Sweet & Maxwell 2008) at paragraphs 1.001-1.007, citing the *Prudential Assurance* case and other English case law.

⁶⁷ See Appendix C for further discussion.

and the relevant legislation sets out 18 specific classes of non-life insurance risk which licensed insurance undertakings may offer.⁶⁸

It is not a requirement for the licensing of an insurance undertaking that life insurance or any class of non-life insurance be entered into subject to an insurable interest. Similarly, while a number of detailed elements of insurance contracts are regulated under the Central Bank's *Consumer Protection Code 2012*, there is no requirement in the 2012 Code that insurance contracts should be subject to an insurable interest.

In carrying out its regulatory role to ensure that insurers comply with their statutory prudential and solvency requirements, the Central Bank has published the *Corporate Governance Code for Credit Institutions and Insurance Undertakings 2013*.⁶⁹ The 2013 Code emphasises that insurers must manage their exposure to risk appropriately, and it includes requirements concerning general internal corporate governance and the appointment of a Chief Risk Officer, who has distinct responsibility for the risk management function and for maintaining and monitoring the effectiveness of the insurer's risk management system. The 2013 Code emphasises that an insurer who moves away from insurance products into other types of financial products, such as credit derivatives, will alter the risk undertaken and agreed upon, and may require prior approval from the Central Bank. It is notable that, in setting out such detailed risk-related requirements, the 2013 Code does not discuss the role of insurable interest.⁷⁰ Rather, it is directed against minimising the risk involved in financial products that are highly speculative in nature.

5.47 In the UK, there is a similar emphasis on managing risk appetite and little reference to insurable interest. In 2014, the Financial Reporting Council (which is one of the UK's financial services regulators) issued its revised Financial Reporting Standard, FRS 103, for insurance contracts, which consolidates the accounting and reporting requirements for insurance undertakings in the United Kingdom, with which insurers licensed in Ireland also comply.⁷¹ FRS 103 defines an insurance contract as:

⁶⁸ The *European Communities (Non-Life Insurance) Framework Regulations 1994* (SI No.359 of 1994) lists 18 classes of non-life insurance risk to which they apply, which are based on the identical list in the Annex to Directive 73/239/EEC, the 1973 First EU Non-Life Directive, and now consolidated in Annex 1 of Directive 2009/138/EC, the 2009 Solvency II Framework Directive, which brings together in a single text 13 EU Insurance Directives: see Appendix C, fn3, for the list of the 18 classes of non-life insurance.

⁶⁹ The Code, along with an extensive list of other Codes and Guidance Notes, is available on the Central Bank's website, centralbank.ie.

⁷⁰ The Law Commission of England and Wales and Scottish Law Commission argued that the boundaries set by insurable interest protect insurers from themselves by preventing them from writing insurance that is overly speculative and thus encourages "efficient underwriting procedures". In particular the Commissions asserted by way of example that: "[o]ne of the alleged causes of the [post-2007 financial] crisis was the involvement of banks and investors in financial instruments... which did not require the parties to show a direct interest in the trigger events": see *Consultation Paper on Insurance Contract Law: Post Contract Duties and other Issues* (Law Com No. 201/Scottish Law Com No. 152, 2011), paragraphs 12.13 to 12.15. While an in-depth analysis of the post-2007 financial crisis is outside the scope of this Report, the Commission is not persuaded that the insurable interest requirement significantly contributed to preventing insurers from trading in speculative financial products and thus ensuring that they were largely unaffected by the crisis. The Law Commission of England and Wales and Scottish Law Commission did not support their position with any empirical evidence, and in their *Issues Paper 4 on Insurable Interest* (January 2008) reached the opposite conclusion (although the Commission concedes that this was published prior to the financial crisis). Further, the insurance industry in Australia did not suffer this fate despite the abolition of an insurable interest requirement 30 years ago in the *Australian Insurance Contracts Act 1984*.

⁷¹ Financial Reporting Council *FRS 103 Insurance Contracts Consolidated accounting and reporting requirements for entities in the UK and Republic of Ireland issuing insurance contracts* (Financial Reporting Council, March 2014).

“[a] contract under which one party (the insurer) accepts significant insurance risk from another party (the policyholder) by agreeing to compensate the policyholder if a specified uncertain future event (the insured event) adversely affects the policyholder”.⁷²

Appendix II of FRS 103 elaborates on the contents of the definition in detail by breaking it down into its six component parts, namely: (a) the term ‘uncertain future event’; (b) payments in kind; (c) insurance risk and other risks; (d) examples of insurance contracts; (e) significant insurance risk; and (f) changes in the level of insurance risk.

At no point is there a reference made to “insurable interest” and the FRC places emphasis on the insurance “risk” which it concluded to be the essence of an insurance contract.⁷³ The Financial Reporting Council defines an insurance risk as something “other than financial risk, transferred from the holder of a contract to the issuer. A contract that exposes the issuer to financial risk without significant insurance risk is not an insurance contract”.⁷⁴ Additionally an insurance risk “refers to risk that the insurer accepts from the policyholder. In other words, insurance risk is a pre-existing risk transferred from the policyholder to the insurer. Thus, a new risk created by the contract is not insurance risk”.⁷⁵

5.48 The UK’s Financial Conduct Authority (FCA, another UK financial services regulator) has also stated that “assumption of risk” by the insurer has become key in identifying what constitutes insurance for regulatory purposes.⁷⁶ By risk the FCA means a “pure risk,” in other words, one that carries a risk of loss only as opposed to a “specific risk” that carries the possibility of either a profit or loss. So for example contracts for differences such as credit derivatives (being contracts on which profit or loss can be made) have no requirements of loss or risk of loss and are therefore not contracts of insurance.

5.49 In 2015 the FCA issued the Perimeter Guidance Manual *Guidance on the Identification of Contracts of Insurance* (“PERG 6”).⁷⁷ PERG 6 explains that after taking into account the principles set out in the *Prudential* case, the FCA will then take account of the following in considering whether a contract constitutes a contract of insurance:⁷⁸

- more weight attaches to the substance, rather than form, of the contract;
- the substance of the insurer’s obligation determines the substance of the contract, and accordingly the insurer’s or policyholder’s intention is unlikely to be relevant; and
- the contract will be characterized as a whole and not according to its dominant purpose or the relative weight of its insurance content.

The FCA emphasised that each case will be considered on its own facts and merits.⁷⁹

5.50 In light of these regulatory approaches the Law Commission of England and Wales and Scottish Law Commission accepted that in terms of identifying insurance itself for regulatory purposes, the three key factors are: requirements of payment, uncertainty and interest. In this context, “interest” means that the insurable event has some adverse consequences for the consumer, and that this is different from the much narrower statutory and common law concepts of insurable interest.

5.51 Australia has proceeded since 1995 without a requirement for strict insurable interest, either for life or for general non-life insurance. Following abolition of the requirement it is still used by insurers for

⁷² *Ibid* at 45, which notes that insurance undertakings operating in Ireland also adhere to the FRC’s Financial Reporting Standards.

⁷³ *Ibid* at A2.2.

⁷⁴ *Ibid* at A2.8.

⁷⁵ *Ibid* at A2.12

⁷⁶ FSA Policy Statement 04/19 (July 2004).

⁷⁷ PERG 6 *Guidance on the Identification of Contracts of Insurance* (Release 158) (February 2015), Chapter 6.

⁷⁸ *Ibid* at paragraph 6.5.4.

⁷⁹ *Ibid* at paragraph 6.4.3.

underwriting purposes⁸⁰ and non-industry commentators have not identified any particular difficulties resulting from the removal of the requirement.⁸¹

In their submissions to the Law Commission of England and Wales and Scottish Law Commission, Lloyd's Market Association provided anecdotal evidence to the effect that abolition of the requirement had led to difficulties in Australia. In particular they asserted that it had led to an increase in fraudulent claims and a higher level of out of court settlements in non-marine business. They also contended that ongoing litigation continued in some areas, and that some claims were not being contested because of the difficulty of proving fraud. This information was not, however, supported by any substantiated evidence.⁸²

Other commentators have suggested that the Australian securitisation market for insurance policies benefited strongly as a result of the alteration of the insurable interest legislation in 1995. In this regard, they have observed that it has become one of the biggest markets operating outside of the United States.⁸³ In addition:

“observations and calculations have also laid to rest any concerns that the removal of the insurable interest requirement may have a detrimental impact on the profit margins of insurance companies; in fact, the figures for Australia have previously suggested that the Australian insurance market continues to grow in size and profit. In the light of these statistics, alongside the knowledge that the secondary market for life insurance policies generates significant domestic revenue, and the fact that the timing of insurable interest can *either* cater for the secondary market or the reduction of moral hazard, but not both, there is a strong case for the abolition of an otherwise unworkable doctrine.”⁸⁴

5.52 While financial regulators in both the United Kingdom and Ireland have referred to the case law on insurable interest in their statutory Corporate Governance Codes and Financial Reporting Standards for insurance undertakings, the concept of insurable interest has not formed a key element of such documents. Rather, they have emphasised the risk-based element of insurance and the need for effective internal governance arrangements to manage risk appetite. This has become increasingly the case in any such documents that have been revised and updated in the wake of the global economic crisis that emerged in 2008, which affected banks and other financial services such as insurance undertakings. It would also appear to the Commission that the abolition in Australia of the concept of insurable interest in consumer insurance contracts has not resulted in any adverse consequences.

(5) *Insurable interest and indemnity insurance*

5.53 A separate argument advanced for the retention of insurable interest as a key element of current insurance contract law is that it is centrally linked to the concept of indemnity in insurance contract law. It is true that, for example, a non-life property and fire insurance contract is a contract of indemnity because its main purpose is to shift the risk of large financial loss from the policyholder to the insurer. In the event of a claim, the insurer is to provide an indemnity for the policyholder's actual loss, “nothing less and nothing more.”⁸⁵

⁸⁰ Law Commission of England and Wales and Scottish Law Commission *Issues Paper 4 on Insurable Interest* (January 2008) paragraph A.11.

⁸¹ See Meggitt “Insurable interest – the doctrine that would not die” (2014) *Legal Studies*, relying on OECD figures (such as the OECD's *Insurance Statistics Yearbook 1999–2008*) to suggest that Australia's insurers were doing well prior to the global financial crisis.

⁸² Lloyd's Market Association Response to Issues Paper 4: Insurable Interest.

⁸³ Gajjar “The Doctrine of Insurable Interest in Life Insurance: A Fling of the Past or Till Death Do Us Part?” 127 *BILA* (footnotes omitted).

⁸⁴ *Ibid.*

⁸⁵ *St Albans Investment Co v Sun Alliance Insurance Ltd* [1983] IR 362, at 374 (O'Higgins CJ, citing in support Brett LJ in *Castellain v Preston* (1883) 11 QBD 380, at 386).

Where a claim is made under such a policy, a policyholder who is the owner of a home destroyed by fire is easily able to establish the actual loss against which the insurer has undertaken to provide indemnity, whereas this would be very difficult if the policyholder did not have such an identifiable financial interest. The indemnity nature of property insurance is clearly a concept in its own right, but the separate concept of an insurable interest is often superimposed on it in order to serve a different purpose, that is, to determine the existence and scope of the insurer's liability for the loss incurred.⁸⁶

5.54 An insurable interest is not, however, required in order to retain a clear definition of an insurance contract because while most non-life insurance is based on the indemnity principle, life insurance policies are usually based on the payment of a fixed amount on the death of the person insured. The fixed amount is usually not an actual loss sustained (such as future lost earnings).

Thus, in the context of life policies it is not usually possible to link insurable interest to indemnity, so that the concept of insurable interest is not a necessary prerequisite of the law, whether on grounds of policy to discourage a form of gambling, or to distinguish between insurance contracts and gambling contracts, or to underpin the connection with the indemnity principle.

5.55 An insurable interest remains a part of insurance contract law, and the statutory requirement in the *Life Assurance Act 1774* and related case law provides that it remains a requirement in non-life insurance.

The precise nature of what amounts to an insurable interest has, however, been criticised and many jurisdictions have either reformed it or abolished it entirely, taking account of changes in public policy since the requirement emerged in the 18th century.

(6) *How public policy on gambling has changed between the 18th and 21st century, and why insurable interest is not required to distinguish insurance contracts from gambling and wagering*

5.56 As discussed earlier in the Chapter, in response to the concern that some contracts of insurance reflected gambling and wagering practices rather than legitimate insurance, and reflecting the prevailing attitude in the 18th century that such activities were a significant social evil, a general approach emerged, both in common law and legislation,⁸⁷ that prohibited both gambling and any insurance contract that resembled gambling. Thus, the courts developed the common law rule that all gaming and wagering contracts were illegal as being contrary to public policy, which is currently codified in section 36 of the *Gaming and Lotteries Act 1956*.⁸⁸

5.57 However in the 21st century gambling is now seen as an economic activity to be regulated in much the same way as other comparable activities such as financial services, including insurance, and the *Gaming and Lotteries Act 1956* is thus now regarded as an unsuitable legislative framework.

In 2013 the Government published the *Scheme of a Gambling Control Bill*⁸⁹ which will replace the 1956 Act with a system of regulation that aims to achieve an appropriate balance between, on the one hand, encouraging commercial gambling (including casinos and online gambling) and, on the other, protecting vulnerable consumer gamblers.⁹⁰ The 2013 Scheme of a Bill also proposes that, in general, gambling contracts will in future be enforceable, thus replacing the long-standing ban on enforceability, currently set out in section 36 of the 1956 Act.⁹¹

⁸⁶ See Templeman "Reforming Insurable Interest", in Soyer (ed), *Reforming Marine and Commercial Insurance Law* (Informa, 2008), Chapter 8.

⁸⁷ See *Life Assurance Act 1774* as applied to Ireland by the *Life Assurance (Ireland) Act 1866*; it remains in force in the State.

⁸⁸ See Clark *Contract Law in Ireland* 6th ed (Thomson Round Hall, 2008), pp.422-428.

⁸⁹ The *Scheme of a Gambling Control Bill 2013*, available at justice.ie, derives from the 2006 Casino Committee Report *Regulating Gaming in Ireland*, also available at justice.ie.

⁹⁰ The proposals in the 2013 Scheme broadly resemble the regulatory regime in the UK's *Gambling Act 2005*.

⁹¹ Head 82 of the *Scheme of a Gambling Control Bill 2013*.

5.58 It has been suggested that, regardless of the change in policy in this area, the concept of insurable interest should be retained because it is necessary to distinguish insurance from gambling. It is true that under the current law insurable interest is a requirement that applies to insurance contract law only, but this difference is not a point of distinction. Insurance contracts and gambling contracts, while sharing certain attributes, can be clearly distinguished from each other without reference to the concept of insurable interest.

Insurance contracts and gambling contracts are both aleatory, that is, they both depend on an uncertain outcome in which a sum of money (the premium or the bet) is given to another party (the insurer or bookie) on the basis of an event that may, or may not, occur. Nonetheless, the differences are clear. In a betting contract, the risk of loss is created by the making of the bet, with both parties having an interest in losing the bet or winning the sum offered at the defined odds. The function of a consumer insurance contract, by contrast, is to protect the consumer in respect of loss arising from an interest (such as life, health or property) which the consumer possesses independently of the insurance contract.⁹²

5.59 The 2013 *Scheme of a Gambling Control Bill* indicates that gambling is set to be further regulated in great detail. The Scheme of the Bill necessarily defines the scope of the gambling activities to which it applies, including recent innovations such as spread betting that may also resemble some elements of insurance such as hedging risk. The definitions in the Bill of gambling activities and the contracts to which they apply will stand on their own, and they will not depend on the continued presence of the concept of insurable interest as a means of differentiating them from insurance contracts.

5.60 When the UK enacted the *Gambling Act 2005* thereby repealing section 18 of the *Gaming Act 1845* (the equivalent of section 36 of the *Gaming and Lotteries Act 1956* which is set to be repealed, assuming the *Scheme of Gambling Control Bill* is enacted) many commentators, including the Law Commission of England and Wales and Scottish Law Commission,⁹³ speculated that the insurable interest requirement in indemnity policies was inadvertently abolished.

While this view is not universally held⁹⁴ it does bear consideration, as it is possible that the United Kingdom's indemnity insurance market has operated effectively without an insurable interest requirement, and like its Australian counterpart, does not appear to be affected by it.

Gambling is now recognised as a legitimate activity with significant economic benefits which can be dealt with through statutory regulation. These matters are seen as consumer protection matters rather than moral hazard issues and attest to the fact that any insurable interest requirement, as a legislative proxy for counteracting socially undesirable contracts of speculation, has no part to play in modern Irish law.

(7) *Insurable interest is not necessary to deter moral hazard risks*

5.61 There are two aspects to this public policy consideration: preserving property and preventing murder. In other words it is designed to prevent the bringing about of the insured event, namely, the destruction of the property insured or the death of the life insured.

The essential idea is that a policyholder with an interest in a property or a relationship with the life insured will be less likely to attempt to bring about the insured event: "[I]f any person may insure, whether he has property or not, it may be a temptation to burn houses, to receive the benefit of the policy."⁹⁵ Similarly a stranger would have far less difficulty murdering the life insured if they were not known to them.

⁹² Legh-Jones, Birds and Owen (eds), *MacGillivray on Insurance Law* 11th ed (Sweet & Maxwell, 2008), at paragraph 1-012.

⁹³ Law Commission of England and Wales and Scottish Law Commission *Issues Paper 4 on Insurable Interest* (January 2008).

⁹⁴ See *Response by Lloyd's Market Association to The Law Commission and the Scottish Law Commission Issues Paper 4 on Insurable Interest* (January 2008) that questions the applicability of the *Gambling Act 2005* to insurance contracts, although they recognise that the issue is complicated.

⁹⁵ *Sadlers Company v Badcock* (1743) 26 ER 733, at 734.

(a) Moral hazard in general

5.62 The Commission considers that the application of the law on fraudulent misrepresentation or illegality are more likely than the concept of insurable interest to constitute effective barriers to an improperly constituted insurance claim. This is because a policyholder cannot recover on the foot of an insurance policy in respect of a loss caused by his or her own criminal or tortious act.⁹⁶ In *Michovsky v Allianz Insurance plc*,⁹⁷ the High Court found that the plaintiff had deliberately set fire to his property, and he was therefore prevented from collecting under his policy because the claim was fraudulent.⁹⁸ Since the plaintiff clearly had an insurable interest in the property as its owner, this suggests that it is through the application of fraud, illegality and related public policy considerations, including the principle that a cause of action must not arise from an immoral or unlawful act, *ex turpi causa non oritur actio*,⁹⁹ that moral hazard dangers are most effectively addressed.

5.63 Similarly, legislation directed at preventing individuals from profiting from criminal acts represents a more direct means of dissuading persons from engaging in criminal activity, while at the same time allowing due process to be observed.¹⁰⁰

5.64 The moral hazard argument is arguably more forceful in the context of life policies because without the insurable interest requirement it may be argued that any person could take out a life policy on the life of a complete stranger. The question is whether insurable interest actually deters murder or threats to life and, if so, whether it is apt for achieving this purpose.

5.65 As highlighted by the Australian Law Reform Commission (ALRC), as the owner of the policy pays the premiums this “provides a substantial inhibition against purely hypothetical or speculative insurance in another’s life.”¹⁰¹

As policies are readily assignable, it is common for strangers to benefit from the policies on the lives of others. The Law Commission of England and Wales and Scottish Law Commission concluded that it did not appear that homicide rates were influenced by the existence of insurable interest.¹⁰² Moreover, they pointed out that the relationship where murder is said to be most likely, marriage, creates an automatic unlimited insurable interest for the husband and wife in each other’s lives in any event. These policies can be kept up, even after an acrimonious divorce.¹⁰³

In fact someone who remains undeterred by the criminal sanctions associated with murder is unlikely to be deterred by the consideration of insurable interest. What serves to underline this argument is the “vague and largely unknown nature of the insurable interest doctrine” coupled with “the fact that insurers

⁹⁶ See generally the discussion of fraud in Chapter 3, above.

⁹⁷ [2010] IEHC 43.

⁹⁸ See generally *MacGillivray’s Insurance Law* 11th ed (Sweet & Maxwell 2008) Chapter 14.

⁹⁹ See also in the context of succession law, section 120 of the *Succession Act 1965*, which provides that a person guilty of murder, attempted murder or manslaughter is prohibited from succeeding to the estate of the deceased. The Commission is, at the time of writing (June 2015), reviewing section 120 of the 1965 Act: see Law Reform Commission *Issues Paper on Section 120 of the Succession Act 1965* (LRC IP 7-2014).

¹⁰⁰ See for example the *Proceeds of Crime Act 1996* (Section 2: interim orders), as amended by the *Proceeds of Crime (Amendment) Act 2005*, and the *Criminal Justice (Theft and Fraud Offences) Act 2001* (including section 6 of the 2001 Act: making a gain or causing a loss by deception).

¹⁰¹ Australian Law Reform Commission *Report on Insurance Contracts* (Report No. 20, 1982) paragraph 146. This was part of the original dissenting opinion of the then Chair of the ALRC, Mr Justice Kirby.

¹⁰² See also Davey “Dial M for moral Hazard? Incentives to murder and the Life Assurance Act 1774” (2014) 25 ILJ 120.

¹⁰³ Law Commission of England and Wales and Scottish Law Commission *Issues Paper 4 on Insurable Interest* (January 2008) paragraph 7.38.

have failed to positively enquire as to whether a valid interest exists at the time of the contract". In other words "nobody can be deterred by something he knows nothing about."¹⁰⁴

5.66 The Australian *Insurance Contracts Act 1984* as originally enacted retained the insurable interest requirement for life policies, but 10 years later it reversed this position and abolished the requirement.

It was stated that the courts' time was still being taken up with trying to work out whether *de facto* relationships would count or whether a person was likely to suffer a pecuniary or economic loss as the result of the death of another person.¹⁰⁵ Presumably the Australian legislature was also no longer convinced of the deterrent capabilities of the doctrine.

(b) Moral hazard and children

5.67 New Zealand followed suit in the context of life policies although its legislation provided for special circumstances regarding children.¹⁰⁶ In 1983, its Contracts and Commercial Law Reform Committee was concerned that children were more vulnerable than others to being killed by an evil parent or guardian for insurance proceeds on policies on their own lives. It argued that "[t]here is the belief that the amount a parent who insures his child's life should be entitled to recover should be limited in case an evil parent does not scruple to cause the death of a child for the sake of an insurance payment"¹⁰⁷

5.68 Section 67 of the New Zealand *Life Insurance Act 1908* provides that "no person may effect a policy on the life of a minor who is under the age of 16 years", but such a policy may be effected by any of the following: (a) the parents or guardians of the minor, (b) the spouse of that parent or guardian, or (c) any person who has obtained court consent to do so. The *Life Insurance Act 1908*, as amended by section 9 of the *Insurance Law Reform Act 1985*, provides for limitations on payments in respect of the death of minors under the age of 16.

The Contracts and Commercial Law Reform Committee was also concerned that young persons taking out life insurances on their own lives should be protected from oppression in the same way as they are protected when concluding any sort of contract. The Committee noted that there was uncertainty in the law as to whether a minor under 16 could, in any event, validly insure their own life. It recommended that: (a) a minor under 10 years of age should have no power to insure their life; and (b) the class of persons who may insure the life of a minor under 16 years of age, or collect on a policy on the life of such a minor, be limited by law. Consequentially and in order to implement these recommendations, sections 66A to 66D of the 1906 Act, as amended in 1985, further regulate insurance by minors.

5.69 This concern regarding minors was shared by the Law Commission of England and Wales and Scottish Law Commission who argued that where a parent has insured the life of a child under the age of 18 the insurance sum should be capped at a modest amount. The Commissions also commented:

"The limit would be per policy. We do not think that there is any realistic way of controlling people from taking out multiple policies on the same child. Indeed, parents may do so without any form of wrongdoing: a parent may be provided with cover under a work-related scheme, as an "add-on" to a bank account and again under a travel policy. If asked directly about other insurances that may provide cover for a child a parent may, in all honesty, not mention the first two simply because they are unaware that they do this. On the other hand, where a child died

¹⁰⁴ Gajjar "The Doctrine of Insurable Interest in Life Insurance: A Fling of the Past or Till Death Do Us Part?" 123 (BILA).

¹⁰⁵ Law Commission of England and Wales and Scottish Law Commission *Issues Paper 4 on Insurable Interest* (January 2008) paragraph A.11.

¹⁰⁶ An insurable interest is also not required for indemnity policies but it is still required for marine insurance and for non-indemnity non-life policies such as sickness and personal accident.

¹⁰⁷ New Zealand Contracts and Commercial Law Reform Committee *Aspects of Insurance Law (2)* (New Zealand Contracts and Commercial Law Reform Committee, 1983) paragraph 5.1.

in suspicious circumstances, the fact that the parents had large numbers of life policies may lead to questions being asked.”¹⁰⁸

5.70 In Ireland sections 50 and 51 of the *Insurance Act 1936*, as amended, already provide for a limited exception permitting parents, grandparents, step-parents, brothers, sisters and aunts or uncles, if the child resides with the aunt or uncle at the time when the policy is effected, to insure the lives of their children for limited amounts in connection with funeral expenses.

5.71 The Commission understands the concerns of the Law Commission of England and Wales and Scottish Law Commission and those expressed in New Zealand, but believes that moral hazard considerations can be effectively addressed without the need to retain any insurable interest requirement. Because public policy and common law illegality doctrines contain a degree of flexibility (in contrast to section 1 of the 1774 Act which declares the contract “to be null and void to all intents and purposes whatsoever”), individual facts and circumstances of borderline cases can be dealt with effectively by the courts.

(8) Conclusions and recommendations

5.72 The Commission takes the view that it should not be necessary for an insured consumer to prove that he or she has an “insurable interest” in a risk or event which is the subject of an insurance contract in order to recover a benefit in accordance with the terms of the contract.

5.73 Insurers are responsible for assessing the risk. Where they determine that a proposer does not have sufficient interest in a matter, then they do not have to sell them insurance.¹⁰⁹ However, where they determine otherwise it is inappropriate to allow them to avoid the contract after the manifestation of the claim because of the absence of an interest about which they were not concerned when they sold the insurance in the first place.

5.74 Since it would seem to be unusual (and commercially unwise) for an insurer to deny liability (notwithstanding the unenforceability of such a policy) insurance law appears to be out of line with modern commercial practice.

The Commission considers that it would be inappropriate to facilitate the evasion of obligations freely entered into by insurers with full knowledge and/or the opportunity to identify the particular interests of the parties at relevant times.

5.75 The requirement for the insured consumer to have an insurable interest in a life policy was intended to distinguish insurance from wagering, and to protect the person whose life is to be insured but modern life policies can no longer be regarded as analogous to “gaming” contracts and the policy justifications for the principle (that is, moral hazard), are no longer relevant. Further, the assignment of life policies and the existence of the Traded Endowment Policies Market themselves give rise to the risk of wrongdoing.

5.76 Even if a process of assimilation of the factual expectation test is underway, the obvious question remains, is there a role for the concept of insurable interest in the context of indemnity insurance? If it is accepted both that the original policy reasons for insurable interest no longer apply and that the underlying purpose of insurance is to shift the risk of pecuniary loss, then the requirement for insurable interest can be dispensed with altogether because its functions are effectively discharged by the principle of indemnity. For example since a policyholder usually has to show loss as a result of an event insured against before he or she can recover under the policy (the indemnity principle), it can be said that “proof of loss is equivalent to proof of interest.”¹¹⁰ The need for a definition of insurable interest is thus

¹⁰⁸ Law Commission of England and Wales and Scottish Law Commission Consultation Paper on *Insurance Contract Law: Post Contract Duties and other Issues* (Law Com No. 201/Scottish Law Com No. 152, 2011), paragraph 13.83

¹⁰⁹ In Australia the principle is still used for underwriting purposes: see Law Commission of England and Wales and Scottish Law Commission *Issues Paper 4 on Insurable Interest* (January 2008) paragraph A.11.

¹¹⁰ Sutton *Insurance Law In Australia* 3rd ed (1999) at 527.

replaced by the question of whether the assured has suffered any loss by the occurrence of the policyholder peril.¹¹¹

5.77 No compelling reason has been advanced for the retention of the historical concept of insurable interest in consumer insurance contracts and the Commission recommends its abolition and replacement with legislative provisions that apply the principle of indemnity but protect the interests of the parties to the contracts.

5.78 The question as to whether a person has a sufficient interest in taking out a policy of insurance should be a matter for the insurer to determine, that is, it should simply be one of a number of underwriting considerations.

5.79 The Commission acknowledges that an insurance contract should, in principle, indemnify a consumer against an identified and proven loss and should not provide a means or mechanism that would enable a consumer to profit from the outcome of a particular event.

5.80 All contracts of indemnity should, therefore, be excluded from the requirement of insurable interest and if a loss has been suffered, the lack of an insurable interest either at the date of the contract or at any time prior to the loss should not prevent recovery.

5.81 As the indemnity principle guarantees that a policyholder cannot recover more than they have lost,¹¹² a policyholder must have an interest in the subject matter insured at the time of the loss in order to prove they have suffered a loss and successfully claim under the policy. As previously discussed, the definition of this type of interest was generally considered in the context of the definition of insurable interest. The Commission recommends clarifying the definition of the indemnity interest, which is distinct from the insurable interest requirement.

5.82 The Commission recommends that a claim by a consumer under an otherwise valid contract of insurance should not be rejected by the insurer by reason only that the consumer does not have, or did not have at the time when the contract was entered into, an interest in the subject-matter of the contract.

5.83 The Commission recommends that where the consumer is required, because the contract of insurance is also a contract of indemnity, to have an interest in the subject-matter of the contract, the interest required should not extend beyond a factual expectation either of an economic benefit from the preservation of the subject matter, or of an economic loss on its destruction, damage or loss that would arise in the ordinary course of events.

5.84 The Commission recommends that an insurer should not be relieved of liability under the contract of insurance by reason only that the name(s) of the person(s) who may benefit under the contract are not specified in a policy document.

5.85 The Commission recommends that no provision of the *Life Assurance Act 1774*, as extended to Ireland by the *Life Insurance (Ireland) Act 1866*, should apply to a contract of insurance with which this Report is concerned.

¹¹¹ Merkin *Reforming Insurance Law: Is there a Case for Reverse Transportation? A Report for the English and Scottish Law Commissions on the Australian Experience of Insurance Law Reform* (Law Commission of England and Wales and Scottish Law Commission, 2007), paragraph 8.8.

¹¹² *St Albans Investment Co v Sun Alliance Insurance Ltd* [1983] IR 362, at 374 (O'Higgins CJ, citing in support Brett LJ in *Castellain v Preston* (1883) 11 QBD 380, at 386).

A The Privity Rule and Third Party Rights: General

6.01 The common law rule of privity of contract provides that only the parties to a contract have enforceable rights and obligations under that contract. Those who are not party to the contract (“third parties”) do not, in general, have enforceable legal rights under the contract even where the contract is intended to benefit them.¹ This general privity rule applies to insurance contracts.²

Third party interests are often affected by insurance contracts. Liability insurance, in particular, which indemnifies policyholders against the risk of incurring tortious liability to a third party, in particular liability in negligence,³ is now commonplace and includes motor insurance (which has been a compulsory statutory requirement for over 80 years), employers’ liability and public liability insurance.

However, because of the privity rule, a third party who suffers injury or loss caused by a person insured against that injury or loss may be unable to recover compensation from the insured person, or from the insurer because he or she is not a party to the contract of insurance.

6.02 The Commission, in its 2008 *Report on Privity of Contract and Third Party Rights*,⁴ proposed that the general privity of contract rule should be reformed to allow third parties to enforce rights under contracts made for their benefit, subject to the right of parties to contract out of the general statutory regime.

Those proposals broadly reflected the provisions in the English *Contracts (Rights of Third Parties) Act 1999*, which was designed to ameliorate the effect of the privity rule in England, and which is also subject to the right of parties to contract out of the general statutory regime. The 1999 Act, which applies to insurance contracts, allows a third party intended to benefit under the contract, that is, a party identifiable under the contract or expressly named in the contract, to enforce rights conferred on them by the contract.⁵ However by virtue of the contracting-out provision in the 1999 Act, most insurance contracts

¹ See generally Clark *Contract Law in Ireland* 6th ed (Round Hall, 2008), Chapter 17; Treitel *Chitty on Contracts Volume 1 General Principles* 29th ed (London Sweet & Maxwell, 2004), Chapter 18.

² *Murphy and Thers v Bower* (1866) 2 IR CL 506.

³ Buckley *Insurance Law* 3rd ed (Thomson Round Hall 2012) Ch.9; Lowry and Rawlings *Insurance Law, Doctrines and Principles* 2nd ed (Hart 2010) Ch. 14.

⁴ Law Reform Commission *Report on Privity of Contract and Third Party Rights* (LRC 88-2008).

⁵ In *Crowson v HSBC Insurance Brokers* [2010] Lloyd’s Rep IR 441, the English High Court considered whether a person who is not in a contractual relationship with an insurance broker may nevertheless have a right of action in tort and/or contract, where the insurance is arranged for that person’s benefit. Hughes Brickwork Ltd, of which the claimant was managing director, entered into a contract with the defendant brokers to arrange new liability insurance cover. The liability cover that had been arranged through the previous brokers had given the directors and officers liability cover but the defendants failed to renew or obtain this cover. The claimant alleged that the failure of the defendants constituted various breaches of a common law duty of care owed by the defendant brokers to him as a director of the company, the insured. The defendants argued that no duty of care was owed to the claimant, and that in addition the only contractual duty existed between the defendants and Hughes Brickwork Ltd. The English High Court (Master Bragge) held that it was arguable that a duty of care did exist under the *Contracts (Rights of Third Parties) Act 1999*. The Court held at 443 that “it is well arguable that the [1999] Act applies on the basis that if Mr Crowson is not a party to a contract (a third party) he can enforce a term of the contract because that is one which confers a benefit on him, namely

contain an express clause excluding the application of the Act, so the position remains largely as it is at common law.

6.03 There are two significant statutory exceptions to the application of the privity rule to contracts of insurance.⁶ They are:

- Section 62 of the *Civil Liability Act 1961* which provides that monies payable under an insurance policy to a deceased or insolvent policy holder in respect of a claim by a third party are to be used only to meet valid claims against the policyholder, are not assets of the policyholder, and cannot be used to satisfy the debts of the insured in insolvency or administration proceedings, that is, they are 'ring-fenced' to meet the third party's claims.⁷
- Section 76 of the *Road Traffic Act 1961* which enables a third party, who has suffered injury or damage as a result of a road traffic accident, to sue the insurer of a motor car involved in the accident directly in the circumstances defined in the section.

Subject to these statutory exceptions a third party who is entitled to be paid damages for personal injuries or loss under a court award or settlement, but is unable to recover them from the insured party who caused the injury or loss, has no general right to recover damages or other relief from the relevant insurer.

(1) Section 76 of the Road Traffic Act 1961

6.03 Irish road traffic legislation contains provisions that are intended to protect third parties. Part VI of the *Road Traffic Act 1961* provides for the compulsory insurance of motor vehicles.⁸ In respect of this compulsory insurance, section 76 of the 1961 Act enables a third party in a car accident (following the establishment of certain conditions) to sue the car owner's insurance company directly.⁹

insurance as a director. Further he would be a member of a class or answers to a particular description within section 1(3) [of the 1999 Act]."

⁶ For common law exceptions see Clark *Contract Law in Ireland* 6th ed (Round Hall 2008) at 513-531, which notes the limits to using the law of agency in insurance contracts.

⁷ These are not the only statutory exceptions but they are the most relevant to this Report. For a further statutory example see section 7 of the *Married Women's Status Act 1957* which provides that a policy of life assurance or endowment expressed to be for the benefit of, or by its express terms purports to confer a benefit upon, the spouse or child of the insured, is enforceable by that spouse or child by way of a statutory trust.

⁸ How road traffic victims are compensated when injured by uninsured drivers led to the conclusion of an agreement in 1955 between the Government and the motor insurance industry, under which the Motor Insurers' Bureau of Ireland provides for a scheme of compensation for loss or injury caused by an untraced or uninsured driver. This scheme, which has been amended many times since 1955, is funded via a levy on insurers: see www.mibi.ie. This national scheme has been supplemented by an EU-wide arrangement, now governed by Directive 2009/103/EC on civil liability in respect of the use of motor vehicles, the provisions of which now supersede national law in some instances. Thus, in *Churchill Insurance Co Ltd v Wilkinson* Case C-442/10, CJEU, 2 December 2011; [2012] EWCA Civ 1166, the Court of Justice of the European Union held that national law could not automatically exclude from the benefit of the 2009 Directive a person who had permitted an uninsured driver to drive his car and who also became a victim of the uninsured driver. On remittal to the English Court of Appeal, the Court held that in such a case it should apply a proportionate approach as to whether the insurer should be able to seek an indemnity from the owner who was also a victim of the uninsured driver. While the operation of the MIBI scheme and the 2009 Directive is outside the scope of this Report, the Commission notes that this proportionate approach is consistent with the recommendations on proportionate remedies in Chapter 3, above.

⁹ *Bus Éireann v Insurance Corporation of Ireland Plc* [1994] 2 ILRM 444; *Lynch v Lynch* [1996] ILRM 311; *Power v Guardian PMPA Insurance* [2007] IEHC 105.

The conditions include the absence of the car owner from the State, the inability to locate the insured party or “that it is for any reason just and equitable” to do so.¹⁰ Buckley notes that “[t]he right of action arises immediately when the injury is sustained and is not dependent on the establishment of liability of the vehicle owner, or user, or the liability of the insurer under the policy issued in respect of the vehicle occasioning the injury”.¹¹

6.04 Section 76(4) of the 1961 Act, which was intended to protect injured persons against the possibility of monies payable by insurers being used to offset debts of deceased or insolvent policyholders, was repealed and replaced by section 62 of the *Civil Liability Act 1961* which applies to insurance contracts generally.

Buckley notes that section 62 of the 1961 Act “is identical almost word for word with” section 76(4) of the *Road Traffic Act 1961*, and that the Oireachtas was “simply extending the protection it afforded to other persons injured in circumstances to which the Road Traffic Acts do not apply and liability for which is not compulsory insurable”.¹²

(2) Section 62 of the Civil Liability Act 1961

(a) Origins of section 62

6.05 Section 62 of the *Civil Liability Act 1961* provides:

“Where a person (hereinafter referred to as the insured) who has effected a policy of insurance in respect of liability for a wrong, if an individual, becomes a bankrupt or dies or, if a corporate body, is wound up or, if a partnership or other unincorporated association, is dissolved, moneys payable to the insured under the policy shall be applicable only to discharging in full all valid claims against the insured in respect of which those moneys are payable, and no part of those moneys shall be assets of the insured or applicable to the payment of the debts (other than those claims) of the insured in the bankruptcy or in the administration of the estate of the insured or in the winding-up or dissolution, and no such claim shall be provable in the bankruptcy, administration, winding-up or dissolution.”

Section 62 thus provides that monies payable under an insurance policy to a policyholder are not to be used to meet the claims of creditors but should be “ring fenced” to satisfy the insurance claim. Section 62 reflects the original wording of 76(4) of the *Road Traffic Act 1961* and is in effect an updated version of section 78(2) of the *Road Traffic Act 1933* which, although limited to motor vehicle liability insurance, was modelled to some extent on the UK *Third Parties (Rights against Insurers) Act 1930* which is set to be updated by the UK *Third Parties (Rights against Insurers) Act 2010*.¹³

6.06 Osborough has pointed out¹⁴ that the UK 1930 Act was enacted in response to the decision in *Hood’s Trustees v Southern Union General Insurance Co of Australasia Ltd*¹⁵ in which the English Court of Appeal held that the injured third party was not entitled to gain access to funds paid over by the insurer to an insured company which had become insolvent.

The Court held in *Hood’s* case that the injured third party had no right against either the insurer or the company’s liquidator to require the money paid in respect of the injured third party claim to be handed

¹⁰ Section 76(1)(d) of the 1961 Act.

¹¹ Buckley *Insurance Law* 3rd ed (Thomson Round Hall 2012) at paragraph 7-16. Order 91 of the *Rules of the Superior Courts 1986* stipulates the procedure to be adopted for initiating an application to the court under section 76.

¹² Buckley *Insurance Law* 3rd ed (Thomson Round Hall 2012) at paragraph 7-16.

¹³ At the time of writing (June 2015) the 2010 Act had not been brought into force because it did not cover the complete range of insolvency situations; this was remedied in the *Insurance Act 2015* and the the 2010 Act will come into force by the end of 2015.

¹⁴ See Osborough “The Regime of Protection for Road Accident Claimants” (1970) 5 *Irish Jurist (ns)* 217.

¹⁵ [1928] 1 Ch 793.

over to him. The money formed part of the assets of the company in liquidation, available for distribution among its general creditors, including the injured third party claimant, in the winding-up.

Osborough noted that remedial legislation “was swiftly introduced in England” in the form of the 1930 Act and that “similar action followed in Ireland” in the form of section 78(2) of the *Road Traffic Act 1933* which has since been replaced by section 62 of the 1961 Act.

6.07 Section 62 of the 1961 Act thus implements a legislative policy to separate insured debts from insolvency proceedings.¹⁶ In that respect it seeks to avoid the outcome in the *Hood’s Trustees* case, although unlike the UK 1930 Act which was enacted in response to that decision and on which section 62 was based, it does not expressly confer a direct right of action on a third party against a defendant’s insurers.

(b) Interpretation of section 62

6.08 In *Dunne v PJ White Construction Co Ltd and Payne*¹⁷ the issue of whether a third party had such a right under section 62 was not raised in the pleadings nor referred to in the High Court. In the Supreme Court, Finlay CJ, delivering the Court’s judgment, commented that since the issue had not been raised the Court had to deal with the case on the basis that the third party possessed such a right.

The Court expressed the view that it seemed an inevitable consequence of section 62 that a right of action in favour of the injured third party had been created, with the qualification that a full debate was required on this matter before it could be finally determined.

The Court held that the third party had the benefit of the presumption that the defendant’s insurance policy was good and that the onus of proving the existence of a right to rescind or repudiate the policy lay on the insurers.

Dunne was followed by the High Court in *McKenna v Best Travel Ltd*¹⁸ where Morris J expressed little doubt that a third party could maintain an action against an insurer, but that “unless and until the identity of the insurance company is revealed, no such action can be taken.”¹⁹

6.09 In *McCarron v Modern Timber Homes Ltd*²⁰ after the plaintiff was injured during the course of his employment, his employer went into liquidation. The plaintiff then brought a claim directly against his employer’s insurer. The insurer had refused the claim as the employer had failed to notify them of the claim in a timely manner or to provide information or assistance in relation to the claim, as required by the terms of the policy. At the time the plaintiff had joined the insurer as a co-defendant to the proceedings, he had not obtained any judgment or order against the employer.

Kearns P confirmed that section 62 created a right of action (thus overcoming the privity point), but also held that the existence and amount (quantum) of the liability must be established against the employer (the policyholder), either by action, arbitration or agreement, before the insurer can be sued under section 62. Any claim against an insurer, if brought in the same set of proceedings as those against the employer, must be stayed until the liability of the employer is first established.

6.10 In *Hu v Duleek Formwork Ltd and Aviva Direct Ltd*²¹ the High Court considered section 62 in similar circumstances, where an employee attempted to enforce a judgment against his employer’s insurer who had been joined to the proceedings when the employer went into liquidation. In this case the employee had secured judgment against their employer but damages had not been assessed. The proceedings were first issued against the employer and the insurer was subsequently added.

¹⁶ Law Reform Commission *Report on Privity of Contract and Third Party Rights* (LRC 88–2008) at paragraph 1.43.

¹⁷ [1989] ILRM 803.

¹⁸ [1995] 2 ILRM 471.

¹⁹ *Ibid*, at 473. See also *Stewart v McKenna & Ors* [2014] IEHC 301.

²⁰ [2012] IEHC 530.

²¹ [2013] IEHC 50.

The insurer had declined to cover the claim because the employer had breached a condition precedent of the insurance policy by failing to pay a policy excess of €1,000. The insurer also argued that there was no privity of contract between the parties and the only party entitled to challenge the decision to decline cover for the accident was the policyholder (the employer) and no challenge had been brought.

The insurer submitted that the purpose of section 62 was to ensure that monies intended to meet an insurance claim did not inadvertently end up in the general creditors' funds during a liquidation.

The employee (the third party) accepted that there was a valid repudiation of the claim by the insurer as a result of the breach. However the employee offered to remedy the breach by paying the excess.

Peart J concluded that the employee had no privity of contract with the insurer and therefore could not enforce the contract. This was particularly so given that the employee did not object to the assertion that the employer had breached the policy by failing to pay the excess. The Court held that the employee's claim disclosed no reasonable cause of action against the insurer and should be struck out.²²

6.11 In summary therefore, three difficulties have arisen which appear to require reform by the Oireachtas.

First, while the application of section 62 of the *Civil Liability Act 1961* is triggered by the death or bankruptcy of the policyholder or, in the case of a corporate body, its being wound up, a more extensive definition of insolvency may be required so as to reflect the different forms of insolvency, personal and corporate, which have come into existence since 1961.

Second, while it has been held that section 62 envisages a claim being made directly against the insurer where the section becomes applicable, it has also been held that proceedings cannot be brought against the insurer until the insured person's liability to pay the damages has been established. This may involve the third party in costly litigation which could be avoided by providing for the transfer in defined circumstances of the rights of the insured person under the contract of insurance to the third party.

Third, while section 76 of the *Road Traffic Act 1961* applies only where an approved policy of motor insurance is in force in respect of the third party's claim, it has been suggested that it should also apply to claims under other forms of liability insurance.

There are also ancillary but important difficulties arising from the operation of these provisions which are dealt with later in this chapter, particularly as to the rights of a third party to obtain certain information from the insurer or any person able to provide it.

(3) Reform of Third Party Rights in Insurance Contracts in Other Jurisdictions²³

(a) United Kingdom

6.12 Similar difficulties to those in part addressed by section 62 of the 1961 Act, and since recognised as in need of redress, were addressed by way of the *Third Parties (Rights against Insurers) Act 1930*.²⁴ The 1930 Act will be replaced in 2015 by the *Third Parties (Rights against Insurers) Act 2010*, as amended by the *Insurance Act 2015*.²⁵

²² Peart J added, [2013] IEHC 50 at paragraph 15: "If there was some arguable doubt still existing as to whether or not Aviva [the insurer] was entitled to repudiate liability, then the judgment of the Supreme Court in *Dunne v PJ White & Co Ltd* could be of assistance, given the remarks of Finlay CJ, albeit obiter in his judgment, that the onus fell upon the insurer to prove what it was alleging, namely that it was entitled to repudiate liability."

²³ For an overview of the approach to this issue from a multi-jurisdictional perspective, including Ireland, see: IBA Insurance Committee Substantive Project 2012 *Direct Third-Party Access To Liability Insurance* 23; and Law Commission of England and Wales and Scottish Law Commission *Third Parties – Rights Against Insurers* (Law Com No 272/Scot Law Com No 184, 2001).

²⁴ The 1930 Act applies to England, Wales, Scotland and, in part, to Northern Ireland.

²⁵ The 2010 Act was not brought into force as it was noted shortly after its enactment that it did not cover the complete range of insolvency situations; these omissions were, however, remedied by the 2015 Act and the 2010 Act, as amended, comes into force in 2015.

The 1930 Act operated to transfer the policyholder's rights under the insurance policy to the third party, enabling the third party to proceed directly against the insurer where the policyholder has become insolvent. The 2010 Act, which replaced the 1930 Act, identifies and cures a number of difficulties with the 1930 Act, many of which plague section 62 of the 1961 Act which although not a direct equivalent of the 1930 Act was, as noted above, enacted to address the same problem.

The 2010 Act enables third parties to bring claims directly against insurers without first being required to bring proceedings against the insured party to establish liability. It should be noted, however, that the liability of the insured to the third party will still need to be established before the rights under the insurance contract can be enforced against the insurer.

Third parties will also be able to step into the shoes of the insured party and fulfil conditions of the policy itself, such as notifying a claim or payment of an excess. The 2010 Act also clarifies the right to obtain information regarding the insurance position. The Commission discusses the detailed provisions of the 2010 Act in the Chapter, below.

(b) Australia

6.13 Section 48 of the *Insurance Contracts Act 1984* allows every person who is specified or referred to in a contract of general insurance (by name or otherwise) as being entitled to insurance cover to claim and recover a benefit in accordance with the terms of the contract even when the person is not a party to the contract.²⁶

Section 48 allows these beneficiaries to step into the shoes of the insured policyholder, thereby entitling them to the same rights and obligations under the contract as if they were the insured policyholder. In turn the insurer has the same defences to an action by the beneficiary as if they were defending an action against the insured policyholder.

Section 51 of the 1984 Act allows third parties to proceed directly against the insurer in circumstances where the policyholder (including a "third party beneficiary" policyholder) has died or cannot after reasonable inquiry be found, provided (a) the policyholder under a contract of liability insurance is liable in damages to another person and (b) the contract provides insurance cover in respect of the liability.

In these circumstances the third party "may recover from the insurer an amount equal to the insurer's liability under the contract in respect of the liability"²⁷ of the policyholder (including a "third party beneficiary" policyholder). This means that a third party can make a claim directly against an insurer in respect of a claim the third party has against either the policyholder or the third party beneficiary of the policy.

A third party also has direct access to insurance in the event of bankruptcy or insolvency respectively.²⁸

(c) New Zealand

6.14 Section 9 of the *Law Reform Act 1936* recognises the general right of a third party to claim directly against the insurer.²⁹ Where (a) a policyholder enters an insurance contract to indemnify themselves against a liability, and (b) on the happening of the insured event the amount of the liability will, (whether the amount was determined, or not) (c) be subject to an automatic "charge" created over the relevant insurance monies in favour of the third party.³⁰

²⁶ Section 11(1) of the 1984 Act.

²⁷ Section 51(1) of the 1984 Act.

²⁸ Some Australian States such as New South Wales recognise the general right of a third party to directly claim against the insurer: see section 6 of the *Law Reform (Miscellaneous Provisions) Act 1946* which is drafted in similar terms to the New Zealand provisions, discussed below.

²⁹ For problems associated with the legislation see New Zealand Law Commission *Some Insurance Law Problems* (New Zealand Law Commission, Report 46, 1998) section 2.

³⁰ Section 9(1) of the *Law Reform Act 1936*.

The “charge” applies notwithstanding the insolvency, bankruptcy, or winding up of the policyholder³¹ and is enforceable by way of a direct action against the insurer.³²

The third party will require leave of the court before they can initiate court proceedings directly against an insurer.³³ To grant leave, the court must be satisfied that: “(a) the third party has a prima facie claim against the insured; (b) the insured has a prima facie claim under the insurance policy; and (c) the insured is not a “perfectly good common law defendant” (that is, there are doubts as to the insured’s capacity to meet the claim).”³⁴

The third party will not require leave of the court before they can initiate court proceedings directly against an insurer in circumstances where the policyholder is insolvent, bankrupt, or winding up.³⁵

Where an injured third party can and does claim directly against an insurer, the parties have the same rights and liabilities as if the third party had sued the insured.³⁶

Every charge created by section 9 “shall have priority over all other charges affecting the said insurance moneys, and where the same insurance moneys are subject to 2 or more charges by virtue of this Part those charges shall have priority between themselves in the order of the dates of the events out of which the liability arose, or, if such charges arise out of events happening on the same date, they shall rank equally between themselves”.³⁷

(4) Conclusions

6.15 The Commission, in its 2008 *Report on Privity of Contract and Third Party Rights*,³⁸ recommended that the general privity of contract rules should be reformed in a manner consistent with the provisions of the English *Contracts (Rights of Third Parties) Act 1999*, which allows third parties to enforce rights under contracts made for their benefit.³⁹

While implementing this proposed reform could be of benefit in some insurance contract disputes,⁴⁰ the 2008 Report, reflecting the approach of the 1999 Act, recommended that parties should be free to contract out of the proposed general statutory regime.

Such a provision would allow insurers to continue to rely on the general privity of contract rules that prevent third parties from enforcing the terms of an insurance policy. As highlighted in 2006 by Professor Merkin,⁴¹ many insurance policies exclude the provisions of the 1999 Act so that the position of third parties in an insurance contract remain as it had been at common law.

While the Commission considers that the proposals contained in the 2008 Report would, in general, address many of the issues that arise in relation to insurance contracts, the model threatens to be ineffective by virtue of its “contracting out” provision.

³¹ Section 9(2) of the *Law Reform Act 1936*.

³² Section 9(4) of the *Law Reform Act 1936*.

³³ Section 9(4) of the *Law Reform Act 1936*.

³⁴ See IBA Insurance Committee Substantive Project 2012 *Direct Third-Party Access To Liability Insurance* at 80 paragraph 3(a).

³⁵ Section 9(4) of the *Law Reform Act 1936*

³⁶ Section 9(4) of the *Law Reform Act 1936*.

³⁷ Section 9(3) of the *Law Reform Act 1936*.

³⁸ Law Reform Commission *Report on Privity of Contract and Third Party Rights* (LRC 88-2008) paragraph 2.66.

³⁹ See also Kelly “Privity of Contract - The Benefits of Reform” (2008) JSIJ at 145, at 170.

⁴⁰ See *Crowson v HSBC Insurance Brokers* [2010] Lloyd’s Rep IR 441.

⁴¹ Merkin *Reforming Insurance Law: Is there a Case for Reverse Transportation? A Report for the English and Scottish Law Commissions on the Australian Experience of Insurance Law Reform* (Law Commission of England and Wales and Scottish Law Commission, 2007).

6.16 While Irish case law suggests that a third party may, where a policyholder is dead or insolvent, rely on the provisions of section 62 of the 1961 Act to proceed against an insurer with whom he or she enjoys no privity of contract, both liability and the quantum of the claim must first be established against the policyholder before the third party's claim against the insurer can be made.

Thereafter the courts may uphold a valid repudiation of the contract by the insurer on grounds of a breach of contract by the policyholder⁴² which the third party will be unable to remedy.

6.17 The original purpose of section 62 was to ring fence monies intended to be payable to a third party, in circumstances where they could be used otherwise (for example, insolvency). The Commission considers that there is an absence of certainty and clarity in the scope of section 62 of the 1961 Act if it is to be used in order to enforce third party rights and notes that the courts have struggled to give full effect to the section for that purpose.⁴³

Accordingly, the Commission considers that section 62 does not adequately address the practical difficulties faced by third parties seeking to enforce contractual rights in insurance contracts that are intended to benefit them.

B Specific Recommendations on Third Party Rights

(1) Definition of third party

6.18 For the purposes of this Chapter, a third party means a consumer as already defined in Chapter 1 of the Report who is, or may be, entitled to benefit, under the terms of a contract of insurance, whether by way of indemnity or as a person who incurs an injury or loss to which the contract of insurance applies.

This definition is intended to include a party who was intended to benefit from the protection of the policy should they be the subject of legal proceedings, as well as somebody who suffered an injury and was intended to be covered under the terms of the policy.

The Commission considers that nothing in the insurance contract should be interpreted as requiring the third party to be in existence either at the time the contract of insurance was entered into or at the time of assent to such a contract by another third party.

(2) Definition of insured person

6.19 Where a person is insured under a contract of insurance against a liability which the person (the "insured person") may incur to a third party, the Commission considers that, for the purposes of its proposals on third party rights, an "insured person" should be defined as (a) an individual, (b) a partnership or (c) any corporate body.

(3) Transfer of rights to third parties

6.20 In the High Court decision in *Power v Guardian PMPA*⁴⁴ Laffoy J articulated the distinction between section 76 of the *Road Traffic Act 1961* and section 62 of the *Civil Liability Act 1961*.

⁴² Buckley *Insurance Law* First Supplement to the 3rd ed (Thomson Round Hall 2014) paragraph 7-221.

⁴³ In the specific context of motor insurance, Regulation 3(5) of the *European Communities (Fourth Motor Insurance Directive) Regulations 2003* (SI No.651 of 2003), as amended, facilitate claims in cases where a person resident in one EEA state suffers loss or injury in a motor accident in another EEA state and the vehicle of the driver responsible for the accident is insured and normally based in an EEA state. Buckley suggests that in its original form the Fourth Motor Insurance Directive, which the 2003 Regulations implemented, "contemplated a direct right of action in all cases, irrespective of the place of the accident, the residence of the parties and the place in which the vehicle was based": see Buckley *Insurance Law* First Supplement to the 3rd ed (Thomson Round Hall 2014) paragraph 8-101 fn 193.

⁴⁴ [2007] IEHC 105.

She noted that section 76 facilitates litigation being brought directly by a non-contracting party to the contract of insurance against the insurer in relation to third party liability, against which the insured is obliged to have cover by virtue of the *Road Traffic Act 1961* itself.

By contrast, she noted that what section 62 of the 1961 Act does is that, where an insured against whom there is a claim in respect of which an indemnity exists, dies or becomes bankrupt, the proceeds of the indemnity are “ring-fenced” for the claimant and do not form part of the insured person’s estate which vests in his or her personal representative, in the case of death, or in the Official Assignee, in the case of bankruptcy.

Laffoy J therefore held that section 62 is only applicable when monies are actually payable under the policy of insurance. This meant that, in the case itself, the plaintiff’s invocation of section 62 was to no avail. The defendant’s defence was that the insurance in question did not cover any liability he incurred to the plaintiff as a result of the accident in question and, therefore, no monies were payable under his policy with the defendant in respect of that liability. Until the plaintiff could establish otherwise, section 62 had no application.

6.21 It has been noted that the limitation of section 76 of the 1961 Act to plaintiffs in cases of road traffic accidents appears arbitrary to a plaintiff who is, for instance, knocked down by a forklift at work as opposed to a car on his way to work.⁴⁵

Case law such as *Dunne* and *Hu*, discussed above, have underlined the deficiency in the wording of section 62 of the 1961 Act in that it does not expressly provide for the transfer of rights to a third party, even though the history of section 62, which can be traced back to the *Third Parties (Rights against Insurers) Act 1930*, indicates that the general purpose of section 62 is to provide for such a transfer of rights.

6.22 In that respect the Commission considers that a third party should, in specific and defined circumstances, enjoy the rights vested in the insured person under the contract of insurance and should be entitled to enforce those rights directly against the insurer.

(4) Third party’s rights should apply in specific circumstances

(a) Insured person is deceased or insolvent

6.23 Section 62 of the 1961 Act already provides limited relief to third parties where an insured person has died, is bankrupt or has gone into liquidation. In general the Commission favours the adoption of these categories, but is of the view that a more expansive definition of insolvency is required in light of the changes to the law since 1961.

In particular, the *Companies (Amendment) Act 1990* (whose provisions are now incorporated into the *Companies Act 2014*) introduced the concept of corporate examinership as an alternative to liquidation, and the *Personal Insolvency Act 2012* provides for non-judicial personal insolvency processes as an alternative to judicial bankruptcy.

A similar difficulty was recognised by the Law Commission of England and Wales and Scottish Law Commission in their 2001 Report *Third Parties: Rights against Insurers* which reviewed the *Third Parties (Rights against Insurers) Act 1930*.⁴⁶ In drafting their recommendations, which formed the basis for the *Third Parties (Rights against Insurers) Act 2010*, the 2001 Report endorsed the view of Bingham LJ that:

“The legislative intention was, I think, that... the provisions of the 1930 Act should apply upon an insured losing the effective power to enforce its own rights and dispose of its own assets.”⁴⁷

⁴⁵ Reidy and Fitzpatrick “Emerging Issues in insurance law; challenging times for insurers and accident victims” (24 September 2014) at paragraph 51.

⁴⁶ Law Commission of England and Wales and Scottish Law Commission *Third Parties – Rights against Insurers* (Law Com. No. 272/Scottish Law Com. 184, 2001) Chapter 2.

⁴⁷ *Ibid*, at paragraph 1.3.

In that respect the 2010 Act deals with a wider range of forms of insolvency that may affect a third party than was the case under the 1930 Act, including the UK equivalents of examinership and the non-judicial arrangements in the *Personal Insolvency Act 2012*.

At the time of writing the 2010 Act has not been brought into force because it did not cover the complete range of insolvency situations; this has been remedied by the *Insurance Act 2015* which will facilitate the coming into force of the 2010 Act by the end of 2015.⁴⁸

6.24 The Commission considers that a similar approach should be adopted in this jurisdiction and in that respect would include a definition of insolvency to reflect the different forms of insolvency, both individual and corporate, that have come into existence since 1961.

Thus, in the case of an individual, “insolvency” should be defined to mean entering into: a Debt Relief Notice, a Debt Settlement Arrangement or a Personal Insolvency Arrangement (under the *Personal Insolvency Act 2012*) or becoming bankrupt (under the *Bankruptcy Act 1988*). In the case of a corporate body, “insolvency” should mean entering into examinership, entering into receivership, or winding up. In the case of a partnership, “insolvency” should mean being dissolved.

(b) Insured person is missing or, where a company, has been dissolved

6.25 The triggering events for section 76(1)(d) of the *Road Traffic Act 1961* include the absence of the car owner from the State and the inability to locate the insured person.⁴⁹

6.26 The ALRC in its 1982 *Report on Insurance Contracts*⁵⁰ considered the potential difficulties faced by a third party where an insured person could not, after reasonable enquiry, be found. While recognising that an insurer may be prejudiced in defending a claim by a third party without the cooperation of an insured person, the ALRC felt that such prejudice may be exaggerated and pointed to circumstances where the insurer defends actions against a deceased insured person.

Section 51 of the Australian *Insurance Contracts Act 1984* allows a third party to recover from an insurer an amount equal to the insured person’s liability to the third party where the insured person has died or after reasonable enquiry cannot be found. Section 51 has been interpreted to include companies that have been dissolved.

6.27 In the Consultation Paper, the Commission provisionally recommended including a person that cannot be located. The Law Commission of England and Wales and Scottish Law Commission did not recommend the application of the new third party procedures to circumstances where insured persons were missing, accepting the view of consultees that this would make the evasion of liability by the insured too easy.⁵¹ However a 2004 Australian review of section 51, which has been in operation since 1984, did not produce similar objections.⁵²

The Commission in its 2013 *Report on Civil Law Aspects of Missing Persons*⁵³ defined a missing person as one who is observed to be missing from his or her normal patterns of life, where those who are likely to have heard from the missing person are unaware of his or her whereabouts and where the circumstances of the person being missing raise concerns for the person’s safety and well-being. The Commission considers that this definition is applicable to the context of this Report as to whether a person is “missing”.

⁴⁸ See Written Ministerial Statement (Thursday 25 April 2013) Ministry of Justice - “Third Parties (Rights against Insurers) Act 2010 - commencement.”

⁴⁹ Section 76(1)(d) of the 1961 Act.

⁵⁰ Australian Law Reform Commission *Report on Insurance Contracts* (Report No. 20)(1982).

⁵¹ Law Commission of England and Wales and Scottish Law Commission *Third Parties – Rights against Insurers* (Law Com. No. 272/Scottish Law Com. 184, 2001) at paragraph 2.5.

⁵² Review Panel *Report on the Review of the Insurance Contracts Act 1984 Final Report on second stage: Provisions other than section 54* (Australian Treasury, 2004) paragraphs 10.23 to 10.28.

⁵³ Law Reform Commission *Report on Civil Law Aspects of Missing Persons* (LRC 106-2013), at paragraph 1.13.

6.28 Section 51 of the 1984 Act has been interpreted by the Australian courts to also refer to the deregistration of a company.⁵⁴ The courts consider that “just as a person can disappear and not be found, so also can a corporation vanish by reason of deregistration of a corporation; and thus cannot be found”.⁵⁵

Under the UK 1930 Act, if an insured person was a dissolved company which had been struck off the register of companies, the third party had to take proceedings to restore it to the register in order to be able to sue it. The Law Commission of England and Wales and Scottish Law Commission recommended ending this process and the UK 2010 Act now provides that a corporate body which has been dissolved under the relevant sections of the UK *Companies Act 2006* comes within the scope of the 2010 Act.

In Ireland the *Companies Act 2014* provides that a company can be dissolved either through liquidation or through strike-off and that a company can be restored to the register following strike-off. In that respect the Commission agrees with the Australian position that just as a person can disappear and cannot be found, a company that has been dissolved or struck off the register of companies has disappeared and thus cannot be found. The Commission also agrees with the Law Commission of England and Wales and Scottish Law Commission that it is totally unnecessary to have to restore such a company to the register before a third party can pursue the insurer.

6.29 The Commission considers that: since section 76(1)(d) of the *Road Traffic Act 1961* already provides for circumstances where the “owner or user is not in the State, or cannot be found or cannot be served with the process of the court;” and since “missing persons” are already defined in the Commission’s 2013 Report; and in light of the decisions by Australia and the UK to include dissolved companies within the scope of their applicable legislation, the reform of third party rights envisaged in this Report should account for this.

6.30 The Commission considers that the envisaged reforms should include an insured person that “cannot be found”, and this is to include missing persons and companies that have been dissolved.

(c) Where for any reason it is just and equitable to do so

6.31 Section 76(1)(d) of the *Road Traffic Act 1961* also includes a power for the court to facilitate an action by a third party where it is for “any reason just and equitable” to do so. The Commission considers that such a provision may aid in circumstances where the insured “person” lacks capacity or fails or refuses to communicate with the third party who has suffered the injury or loss.⁵⁶

6.32 The Commission recommends that a third party should be defined for the purposes of this Report as a consumer who is, or may be, entitled to benefit under the terms of a contract of insurance, whether by way of indemnity or as a party who incurs an injury or loss to which the contract of insurance applies.

6.33 The Commission recommends that nothing should be interpreted as requiring that the third party be in existence either at the time the contract of insurance was entered into or at the time of assent to such a contract by another third party.

6.34 The Commission recommends that, for the purpose of third party rights in a consumer insurance contract only, an insured person should be defined to include: an individual, a partnership, or any corporate body.

6.35 The Commission recommends that where an insured person is insured under a contract of insurance against a liability which may be incurred to a third party, and where (a) the person has died, or cannot be found, or is insolvent, or (b) where for any other reason it appears to a court to be just and equitable to so order, the third party should enjoy the rights vested in the insured person under that contract of insurance and should be entitled to enforce those rights

⁵⁴ Mann and Lewis *Mann’s Annotated Insurance Contracts Act* 6th ed (Lawbook Co, 2014) at paragraph 51.50.

⁵⁵ Olsson J in *Norsworthy v SGIC* [1999] SASC 496 at 61, cited in Mann and Lewis *Mann’s Annotated Insurance Contracts Act* 6th ed (Lawbook Co., 2014) at paragraph 51.50.

⁵⁶ See the *Assisted Decision-Making (Capacity) Bill 2013*.

directly against the insurer, notwithstanding anything to the contrary in any enactment or rule of law, including the doctrine of privity of contract.

6.36 The Commission recommends that the term “cannot be found” means in the case of an individual a “missing person” as defined in the *Report on Civil Law Aspects of Missing Persons (LRC 106-2013)*, that is, a person who is observed to be missing from his or her normal patterns of life, where those who are likely to have heard from the missing person are unaware of his or her whereabouts and where the circumstances of the person being missing raise concerns for the person’s safety and well-being.

6.37 The Commission recommends that the term “cannot be found” includes, in the case of a company, an “insolvent company”; and that where such a company has been struck off the register of companies, the third party should not be required to restore it to the register before proceeding directly against the insurer.

6.38 The Commission recommends that “insolvency” for the purposes of third party rights should be defined as: (a) in the case of an individual, (i) entering into a Debt Relief Notice, (ii) entering into a Debt Settlement Arrangement, (iii) entering into a Personal Insolvency Arrangement, or (iv) becoming bankrupt; (b) in the case of a corporate body, (i) entering into examinership, (ii) entering into receivership, or (iii) winding up; and (c) in the case of a partnership, being dissolved.

6.39 The Commission recommends that in circumstances of bankruptcy or insolvency, moneys payable to a third party under the policy should be applicable only to discharging in full all valid claims by that third party against a person who is insured against that injury or loss in respect of which those moneys are payable, and no part of those moneys should be deemed assets of that person or applicable to the payment of the debts (other than those claims) of that person in the insolvency or in the administration of the estate of that person, and no such claim should be provable in the insolvency or in the administration of the estate of that person.

(5) A right to proceed directly against the insurer before establishing liability

6.40 The decisions in *McCarron* and *Hu*, discussed above, suggest that where claims are brought against insurers under section 62, both liability and the quantum of a claim should be determined in the underlying claim against the insured person before an insurer is joined to the proceedings or before separate proceedings are brought against the insurer.

In order to avoid these requirements section 1(3) of the UK *Third Parties (Rights against Insurers) Act 2010* provides that:

“The third party may bring proceedings to enforce the rights against the insurer without having established the relevant person’s liability; but the third party may not enforce those rights without having established that liability.”

6.41 While the insured person’s liability must be established before those rights can actually be enforced, this can be achieved by a declaration of the court, or by a judgment, settlement or arbitration award. This removes the need for multiple sets of proceedings by allowing the third party to resolve all issues relating to its claim against the insurer within those proceedings, which should reduce associated costs.

6.42 In respect of any “conflicts of interest” argument, the Law Commission of England and Wales and Scottish Law Commission commented that an insurer, faced with the apparent “conflict” between, on the one hand, denying the insured person’s liability by denying negligence and, on the other hand, denying cover by alleging fraud, could simply plead alternative defences.⁵⁷

6.43 In the *Dunne* case, discussed above, judgment for damages in negligence was entered against the insured person in default of a defence, because the insured person had gone into liquidation prior to

⁵⁷ Law Commission of England and Wales and Scottish Law Commission *Third Parties – Rights against Insurers* (Law Com. No. 272/Scottish Law Com. 184, 2001), paragraphs 3.16 to 3.17.

the judgment. *Prima facie*, however, an insurer will have some advantage when required under section 62 to defend a claim from a third party because it can deny both the insured person's liability and its own liability to indemnify whereas an insured person will be likely to find the claim difficult to defend because of death, bankruptcy or liquidation.

6.44 The Commission acknowledges the need to reduce litigation costs and repetitious proceedings (especially where a plaintiff has suffered a loss and is seeking to remedy that loss) and that joinder of an insurer to a claim by a third party against an insured person can often significantly reduce the costs of litigation.

However the Commission acknowledges that an insured person's liability must be established during the course of those proceedings before those rights of the third party can be enforced.

6.45 The Commission recommends that third parties should be entitled to issue proceedings directly against insurers before the liability of the relevant insured person has been established, but that the insured person's liability must be established during the course of those proceedings before those rights of the third party can be enforced.

(6) A right to the disclosure of certain information

6.46 A third party may not generally have the opportunity to investigate fully the insurer's justification for refusal of a claim and will be placed in the difficult position of having to proceed with a formal claim, incurring all the attendant costs, against an insurer without knowing the basis for an insurer's refusal to indemnify the insured person.

6.47 This difficulty was highlighted in *McKenna v Best Travel Ltd.*⁵⁸ In that case the plaintiff claimed damages from the defendant, a travel agent, for personal injuries sustained on a holiday to Israel booked by the plaintiff through the defendants. The plaintiff claimed that the defendant had acted negligently or in breach of contract in failing to warn the plaintiff that the situation prevailing in Israel at the relevant time made visits by tourists unsafe.

The defendant was in voluntary liquidation and the plaintiff sought from its liquidator details of the defendant's insurer with a view to relying on section 62 of the 1961 Act to pursue the insurer for the plaintiff's loss. The liquidator did not provide this information and the Master of the High Court made an order for discovery of all documents in the defendant's possession, power or procurement disclosing the identity of the defendant's insurer. The defendant appealed this order to the High Court.

In the High Court, Morris J expressly approved the views of the Supreme Court in *Dunne* but also held that the right of a third party to maintain an action against an insurer may be limited and that the identity of the insurer must be known or no such action can be taken.

This decision was based on the limits that then applied to discovery. Order 31, rule 12(1) of the *Rules of the Superior Courts 1986* limited discovery at that time to documents "relating to any matter in question". Morris J stated:

"It is in my view well settled that it is only documents which would support or defeat an issue that arises in the existing action which are required to be discovered or should be made the subject matter of an order for discovery"⁵⁹

As none of the issues raised by the plaintiff in the pleadings related to the insurers of the defendant, he held that an order for discovery of documents identifying the defendant's insurers should not be made. In expressing his reluctance to make such a finding, Morris J asked that the particular issue of information disclosure should be addressed:⁶⁰

"I recognise that there should be a procedure which would require this information to be revealed. It is, in my view, clear that s.62 [of the 1961 Act] gives a right of action to the plaintiff

⁵⁸ [1995] 2 ILRM 471.

⁵⁹ [1995] 2 ILRM 471, 474.

⁶⁰ *Ibid* at 580.

in circumstances such as this and it is clear that this right is set at nought if no procedure exists for obtaining the information as to the identity of the insurers. I recognise that an application for discovery is a quick and relatively inexpensive method of obtaining this information. However, on the authorities it is not an order that should be made.”

While Order 31, rule 12 of the *Rules of the Superior Courts 1986* has subsequently been substituted by the *Rules of the Superior Courts (No.2) (Discovery) 1999*⁶¹ and by the *Rules of the Superior Courts (Discovery) 2009*,⁶² the amended provisions still retain the requirement that discovery is limited to documents “relating to the matter in question” which suggests that the difficulties highlighted by Morris J for third parties seeking to identify an insurer for the purposes of section 62 of the 1961 Act are still present.

6.48 In *Hu*, a third party’s solicitor had been informed that the insurer (Aviva) had declined cover. No reason was provided in the letter of advice. It was argued that if the third party had been made aware earlier that an excess payment of €1,000 had not been paid by the insured person or the liquidator, the third party would have exerted pressure on the insured person or the liquidator (possibly by court order), to ensure that the payment was made. Alternatively, it was argued, the third party would have endeavoured to discharge that payment himself in order to ensure that his claim would be met under the policy.

Dismissing the claim the High Court (Peart J) held that in order to establish negligence, it must be proven that a duty of care is owed to the third party and that there has been a breach of that duty causing loss and damage to the third party. No such duty had been established and the Court was unaware of any other case where such a duty had been established between an insurer and a third party against an insured person.

(a) United Kingdom

6.49 The *Third Parties (Rights against Insurers) Act 2010* provides for the following in connection with disclosure of information to third parties:

- a third party, who reasonably believes that an insured person who falls within the 2010 Act (for example, an insured person who is insolvent) is legally liable to the third party, may by notice in writing request from the insured person information relating to the insurance contract;⁶³
- a third party may also, in circumstances that fall within the 2010 Act (for example, involving an insured person who is insolvent), by notice in writing request information relating to the insurance contract from any other person who is able to provide such information;⁶⁴ and
- if the information sought is not given to the third party within 28 days of receipt of notice, the third party may apply to the court for an order requiring compliance with the duty to inform.⁶⁵

6.50 The information that can be sought by a third party is limited to the following.⁶⁶

“(a) whether there is a contract of insurance that covers the supposed liability or might reasonably be regarded as covering it;

(b) if there is such a contract –

(i) who the insurer is;

(ii) what the terms of the contract are;

⁶¹ *Rules of the Superior Courts (No.2) (Discovery) 1999* (SI No. 233 of 1999).

⁶² *Rules of the Superior Courts (Discovery) 2009* (SI No. 93 of 2009).

⁶³ Schedule 1, paragraph 1(1) of the 2010 Act.

⁶⁴ Schedule 1, paragraph 1(2) of the 2010 Act.

⁶⁵ Schedule 1, paragraph 2 of the 2010 Act.

⁶⁶ Schedule 1, paragraph 1(3) of the 2010 Act.

- (iii) whether the insured has been informed that the insurer has claimed not to be liable under the contract in respect of the supposed liability;
- (iv) 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;
- (v) 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;
- (vi) whether there is a fixed charge to which any sums paid out under the contract in respect of the supposed liability would be subject.”

(b) Australia

6.51 Section 41 of the *Insurance Contracts Act 1984*, as amended by the *Insurance Contracts Amendment Act 2013*, provides that in the context of liability insurance where an insured person or third party has made a claim under the contract, they may at any time, by notice in writing given to the insurer, require the insurer to inform them in writing of:

- “(a) whether the insurer admits that the contract applies to the claim; and
- (b) if the insurer so admits, whether the insurer proposes to conduct, on behalf of the claimant, the negotiations and any legal proceedings in respect of the claim made against the claimant.”⁶⁷

Where the insurer does not, within a reasonable time after being given such notice, inform an insured person or third party that they admit that the contract of liability insurance applies to the claim and that they propose to conduct on their behalf the negotiations and any legal proceedings in respect of the claim made against them, then:⁶⁸

- “(c) the insurer may not refuse payment of the claim; and
- (d) the amount payable in respect of the claim is not reduced by reason only that the claimant breached the contract.”⁶⁹

(c) Conclusion and Recommendation

6.52 The Commission considers that in order to give full effect to the protection offered to third parties, they should be entitled to certain information about the insurance policy held by an insured person. To ensure that such requirements are not excessively onerous on insurers and to dissuade speculative litigation, the duty to inform should be limited to the type of information specified in the 2010 Act.

A third party should not be limited to seeking disclosure of information regarding the insurance policy from the insurer but should also be entitled to seek information from persons or bodies corporate that are able to provide such information, including an insured person, former officers of the wound up insured person, liquidators of an insured person and insurance intermediaries.

A person receiving the notice for the disclosure of information must be required to respond within a specified number of days (the 2010 Act specifies 28 days).⁷⁰ The person receiving the notice must provide the relevant information or explain why this is not possible.

In circumstances where the information is no longer within the person’s control, the third party must be provided with details, if possible, about where to locate the information.⁷¹ If the person fails to comply, the third party should be entitled to obtain a court order to compel compliance.⁷²

⁶⁷ Section 41(2) of the *Insurance Contracts Act 1984*.

⁶⁸ Section 41(3)(a)(b) of the *Insurance Contracts Act 1984*.

⁶⁹ Section 41(3)(c)(d) of the *Insurance Contracts Act 1984*

⁷⁰ Schedule 1, paragraph 2(1) of the 2010 Act.

6.53 The Commission recommends that where a third party reasonably believes that an insured person has incurred a liability to him or her, that third party should be entitled, by way of written notice, to seek information from the insurer or from any person who is able to provide it concerning: (a) the existence of an insurance contract that covers the supposed liability or might be regarded as covering it, (b) if there exists such a contract who the insurer is, (c) the terms of the contract and (d) whether the insurer has informed the consumer that it intends to refuse liability under the contract in respect of the person's supposed liability.

(7) Conditions affecting transferred rights

6.54 Submissions received since the publication of the Consultation Paper raised concerns about the frequent use of excess conditions in contracts of insurance. Often the payment of an excess to an insurer is made a condition precedent to the provision of indemnity as a whole, which would entitle an insurer to repudiate liability where the insured person has not paid the excess.

In the circumstances discussed in this Chapter, such as where the insured person is insolvent, it is unlikely that such an excess will have been paid. Additionally, strict notice conditions requiring an insured person to notify insurers promptly of any insurable event are also likely to have been breached by such an insured person.

It would appear that these types of breaches would permit an insurer to avoid liability even in circumstances where a third party has the right to issue proceedings directly against the insurer. The Commission is of the opinion that a third party, who is entitled to pursue an insurer directly, should also be entitled to fulfil any conditions of the policy.

This would mean that an insurer would not be entitled to repudiate liability to a third party merely because an excess for the claim has not been paid by the insured person, and the insurer would be required to satisfy any claim above the amount of the excess. Similarly a condition that requires the insured person to notify an insurer directly of a "policyholder event", where such notification requirements form part of the insurance contract, could be discharged by the third party.

Equally, however, in general an insurer should be able to rely on any defence it would have been entitled to rely on against an insured person. For example, an insured person's pre-contractual misrepresentation will affect a third party claim although the third party never made the misrepresentation. This is because in its claim against the insurer the third party would be subject to the same policy terms, indemnity limit and excess as the insured person.

6.55 In the UK this approach was adopted in section 9 of the *Third Parties (Rights against Insurers) Act 2010*⁷³ which provides that anything done by a third party which, if done by the insured person would have amounted to fulfilment of a condition of the insurance contract, is to be treated as if done by the insured person. However the 2010 Act recognises that there are three instances where a third party would find difficulty in fulfilling the requirements of a condition in place of an insured person. In that respect the 2010 Act provides that :

- the rights transferred to the third party are not subject to a condition requiring information or assistance to be provided to the insurer if the condition cannot be fulfilled because the insured person is an individual who has died or a corporate body that has been dissolved;⁷⁴
- a condition requiring the insured person "to provide information or assistance to the insurer does not include a condition requiring the insured to notify the insurer of the existence of a claim under the contract of insurance;"⁷⁵ and

⁷¹ Schedule 1, paragraph 2(2) of the 2010 Act.

⁷² Schedule 1, paragraph 2(3) of the 2010 Act.

⁷³ Law Commission of England and Wales and Scottish Law Commission Report *Third Parties (Rights against Insurers)* (Law Com. No. 272/Scottish Law Com. 184, 2001) , Chapter 5. See also Bullimore "The Third Parties (Rights Against Insurers) Act 2010: unanswered questions and rights of set-off" [2012] LMCLQ 382.

⁷⁴ Section 9(3) of the 2010 Act.

- the rights transferred to the third party are not subject to a condition requiring the “prior discharge” by the insured person of the insured person’s “liability to the third party”.⁷⁶ (commonly known as a “pay-first” clause).

6.56 Section 10 of the 2010 Act also allows the insurer to set off any liabilities incurred by the insured person in favour of the insurer against any liability owed by the insurer to the third party. The effect is to allow third parties to claim against insurers even though the insured person may not have paid an excess or may have failed to pay premiums under the contract, while allowing the insurer to set-off the funds owing to them as a result of these failings against any indemnity owed to the third party.

6.57 The Commission considers that it is necessary to ensure that a third party’s rights against an insurer are sufficiently protected and cannot be denied by an insurer seeking to rely solely on the terms of a contract with their insured parties. Similarly in resisting any action by a third party an insurer should be entitled to raise any defences available both to it and to the insured parties.

The Commission in that respect also concurs with the approach taken to the three exceptions provided for in section 9 of the UK *Third Parties (Rights against Insurers) Act 2010*.

6.58 The Commission recommends that a third party should owe the same obligations to the insurer as the insured person and may discharge the insured person’s obligations under the contract whereupon anything that would have amounted to, or contributed to, fulfilment of a condition of the insurance contract should be treated as if done by the insured person.

6.59 The Commission recommends that the insurer should have the same defences to such an action as the insurer would have in an action by the insured person.

6.60 The Commission recommends that the insurer should be entitled to set off any liabilities incurred by the insured person in favour of the insurer against any liability owed by the insurer to the third party.

6.61 The Commission recommends that the rights of the third party should not be subject to a term in the insurance contract requiring the insured person to provide information or assistance to the insurer if that term cannot be fulfilled because the insured person has died or cannot be found; and that a “term requiring the insured person to provide information or assistance to the insurer” should not include a term requiring the insured person to notify the insurer of the existence of a claim under the consumer contract of insurance.

6.62 The Commission recommends that the rights of the third party should not be subject to a term in the insurance contract requiring the prior discharge by the insured person of the insured person’s liability to the third party.

(8) Voluntarily-incurred liabilities

6.63 The Law Commission of England and Wales and Scottish Law Commission, in their 2001 Report *Third Parties: Rights Against Insurers*, indicated that there was some doubt as to whether the *Third Parties (Rights Against Insurers) Act 1930* applied to a liability voluntarily undertaken by an insured person.⁷⁷

The Report suggested for example that if a person who had taken out a legal expenses insurance policy failed to pay fees due to his or her solicitor and then became insolvent, the solicitor would not be able to sue the legal expenses insurer directly under the 1930 Act for the fees owed. The Law Commissions reasoned that this view would also apply to insurance for other voluntarily incurred expenses, such as

⁷⁵ Section 9(4) of the 2010 Act.

⁷⁶ Section 9(5) of the 2010 Act.

⁷⁷ See Law Commission of England and Wales and Scottish Law Commission Report *Third Parties (Rights against Insurers)* (Law Com. No. 272/Scottish Law Com. 184, 2001) , paragraphs 1.20 to 1.21; 2.38 to 2.44. See *Tarbut v Avon Plc* [2001] 2 All ER 503 which held that the *Third Parties (Rights against Insurers) Act 1930* did not apply to claims for legal expenses insurance.

health or car repair insurance and consequentially recommended that any new legislation should allow for the recovery of such voluntarily incurred liabilities.

Subsequent to the publication by the Commissions of their Report, the Court of Appeal in *Re OT Computers Ltd (In Administration)*⁷⁸ held that, contrary to the analysis in the 2001 Report, the 1930 Act applied “generally to liabilities including contractual liabilities both in debt and for damages and was not restricted to tortious liabilities and contractual liabilities that were akin to tortious liabilities.”⁷⁹ Nonetheless, to avoid any doubt on this matter, section 16 of the UK’s *Third Parties (Rights against Insurers) Act 2010* provides that a third party may make a direct claim against an insurer even if the insurance contract covered liabilities voluntarily incurred by the insured.

6.64 The Commission considers that it is important, to avoid any doubt, that for the purposes of the proposed provisions on third parties, there should be no distinction between cases where liabilities are voluntarily or involuntarily incurred. A third party should be able to make a direct claim against the insurer even if the insurance covered liabilities voluntarily incurred by the insured person.

Many liability insurance policies contain clauses, however, that specifically exclude claims that have arisen as a result of agreement. The Commission accepts that where such an exclusion applies to the insured person, it will also apply to a third party claiming directly against an insurer. The third party cannot benefit from better terms than were originally contractually agreed by the insured person.

6.65 **The Commission recommends that where a consumer contract of insurance refers to a liability which the insured person may incur to a third party, this includes a liability that is or was incurred voluntarily by the insured person and that a third party may make a direct claim against the insurer in such a case.**

(9) Two or more claimants

6.66 Section 76(2) of the *Road Traffic Act 1961* accounts for circumstances where there is more than one third party claimant in respect of the same event, as follows:

“Where, in respect of any one act of negligence or any one series of acts of negligence collectively constituting one event, there are two or more claimants and the total of the sums claimed for damages for injury to property or for which judgment has been recovered for damages for such injury exceeds the sum which the insurer or guarantor has insured or guaranteed, the liability, as regards each claimant, of the insurer or guarantor in relation to such damages shall be reduced to the appropriate proportionate part of the sum insured or guaranteed.”

6.67 The Commission considers the inclusion of such a provision to be appropriate.

6.68 **The Commission recommends that where, in respect of any one act of negligence or any one series of acts of negligence collectively constituting one event, there are two or more claimants and the total of the sums claimed for damages for injury to property or for which judgment has been recovered for damages for such injury exceeds the sum which the insurer or guarantor has insured or guaranteed, the liability, as regards each claimant, of the insurer or guarantor in relation to such damages should be reduced to the appropriate proportionate part of the sum insured or guaranteed.**

⁷⁸ [2004] EWCA Civ 653; [2004] Ch. 317.

⁷⁹ [2004] EWCA Civ 653; [2004] Ch. 317, 317.

CHAPTER 7 SUBROGATION

A Overview of subrogation

7.01 The word subrogation means substitution.¹ In insurance law subrogation entitles an insurer to “step into the shoes” of its policyholders in order to provide indemnity and secure its own rights as insurer.²

Subrogation applies to indemnity insurance only, and not to life insurance. It was intended to prevent “double recovery” by policyholders and a consequent profit, contrary to the concept of indemnity which is to compensate for actual loss only.

In road traffic personal injury claims, subrogation permits insurers to step into the shoes of policyholders and to defend or settle claims made against them and to bring claims on their behalf. Similarly, if a policyholder brings a claim under a house fire policy, the insurer can reclaim any sum that the policyholder would be entitled to recover from a third party.³

In indemnity insurance, subrogation plays an important role but various reviews of insurance contract law suggest that it can give rise to difficulty in some circumstances, including:

- specific family relationships;
- employer-employee relationships; and in
- the control of litigation.

B Specific reforms of subrogation

(1) Family relationship settings

7.02 Supposing a visiting family member damages valuable furniture in a home by fire, the householder would ordinarily wish to make a claim for the damage under his or her household fire insurance policy. If the householder makes such a claim, subrogation permits the insurer, having made a payment under the policy, to step into the shoes of its policyholder and to recover that payment from the visiting family member, who in all probability is not insured for this.

The householder may not wish this to happen, so the effect of subrogation is that it may result in unfair pressure being placed on a policyholder not to make what is a perfectly valid claim under the insurance policy in the first place. This consequence of subrogation has led to reviews of its operation in the family setting.

¹ Buckley *Insurance Law* 3rd ed (Thomson Round Hall 2012), at pp.186-200.

² Legh-Jones, Birds and Owen (eds), *MacGillivray on Insurance Law* 11th ed (Sweet & Maxwell 2008) paragraph 22-036.

³ This was also the position in cases of claims for damage to property caused intentionally, such as through arson, brought under the *Malicious Injuries Act 1981*. Until the enactment of the *Malicious Injuries (Amendment) Act 1986*, which restricted claims under the 1981 Act to very limited instances, such as arising from a riot, local authorities were required to compensate property owners for all damage to property caused maliciously. If the property owner was also insured and made a claim under the policy, the insurer was entitled to recover the relevant amount that would have been paid under the 1981 Act, and its statutory predecessors. Thus in *Doyle v Wicklow County Council* [1974] IR 55, which involved a case of malicious injuries to property, the Supreme Court noted that “all claims of the insured arising out of any ground of legal responsibility vest in the insurer by subrogation.”

(a) Australia

7.03 The Australian Law Reform Commission (ALRC) in its 1982 *Report on Insurance Contracts*⁴ noted that, as in the example just given, household insurance policies often cover only the members of the policyholder's family who are actually living in the house at the time of the loss but not family members living elsewhere or visiting relatives or friends.

7.04 The ALRC concluded that it was not appropriate that subrogation rights should be available in such a case, and recommended that it should not apply where because of family, or other personal relationships, the policyholder could not reasonably be expected to bring a claim against the person who caused the loss.

It also considered that subrogation should not be permitted in motor insurance where a person in a close family or other relationship is driving a vehicle with the consent of the owner.

The ALRC also recommended that in such cases the policyholder should remain free to exercise his or her rights or to assign them to the insurer after the occurrence of a loss, but "should not be required or invited to do so as a condition of the receipt of a direct or indirect benefit from the insurer."⁵

7.05 Section 65 of the Australian *Insurance Contracts Act 1984* implemented these recommendations. It limits insurers' rights of subrogation against persons who the policyholder has not pursued and might reasonably be expected not to pursue because of:

- "(i) a family or other personal relationship between the insured and the third party; or
- (ii) the insured having expressly or impliedly consented to the use, by the third party, of a road motor vehicle that is the subject-matter of the contract."

Section 65 does not apply where the conduct of the third party giving rise to the loss was serious or wilful misconduct; or occurred in the course of or arose out of the third party's employment by the policyholder.

The insurer's rights of subrogation are effectively limited to the extent that the third party has insurance in respect of his or her liability to the policyholder. Section 65 provides that a subrogation action cannot proceed if the relevant third party was not insured⁶ and, to prevent its avoidance, removes an insurer's ability to receive an assignment of the policyholder's rights.⁷

(b) Principles of European Insurance Contract Law (PEICL)

7.06 The authors of PEICL have observed that, while the group of protected persons varies from jurisdiction to jurisdiction, the majority of national laws prevent insurers from exercising subrogation rights against third parties in close relationships with the policyholder.⁸

This is because insurance is often taken out with the object of protecting particular interests, for example, close family members such as the policyholder's spouse, children, and parents as well as persons living with the insured in the same household.⁹

The rationale for this restriction of subrogation is that the insurer should not be able to recover from parties against whom the insured would have brought no claim.¹⁰

⁴ Australian Law Reform Commission *Insurance Contracts* (Report No. 20,1982) Chapter 3.

⁵ *Ibid* paragraph 305.

⁶ Section 65(3) of the 1984 Act.

⁷ Section 65(5) and (6) of the 1984 Act.

⁸ Basedow et al (eds), *Principles of European Insurance Contract Law* (Sellier, 2009) at 259 paragraph N8.

⁹ *Ibid* at 259-60 N8 to N9 (references to Articles of various civil codes omitted).

¹⁰ *Ibid* at 259-60 N7.

(c) Conclusion and Recommendation

7.07 In the Consultation Paper the Commission provisionally recommended that subrogation rights should be limited in cases involving claims between family members and invited submissions as to the precise form this should take.¹¹

Submissions received were broadly supportive of this approach, but some observed that insurers should not be prevented from exercising subrogation rights where, for example, a family member has deliberately set fire to the family home and has means against which the insurer may recover.

The Commission accepts that the proposed reforms should take account of this legitimate proviso, and recommends that the restrictions to subrogation in the family relationships setting should be modelled on the approach in section 65 of the Australian *Insurance Contracts Act 1984*.

7.08 **The Commission recommends that the subrogation rights of insurers to recover payments from persons in family or other personal relationships with consumers should be modified. The modification should apply where an insurer is liable under a contract of insurance in respect of a loss and where, but for this modification, the insurer would be entitled to be subrogated to the rights of the consumer against some other person, and the consumer has not exercised those rights and might reasonably be expected not to exercise those rights by reason of (a) a family or other personal relationship between the consumer and the other person, or (b) the consumer having expressly or impliedly consented to the use, by the other person, of a motor vehicle that is the subject matter of the contract. The modification should not apply where the conduct of the other person that gave rise to the loss was serious or wilful misconduct. The modification would mean that where the other person is not insured in respect of that other person's liability to the consumer, the insurer would not have the right to be subrogated to the rights of the consumer against the other person in respect of the loss. It also would mean that where the other person is so insured, the insurer would not, in the exercise of the insurer's rights of subrogation, recover from the other person an amount that exceeds the amount that the other person may recover under the other person's contract of insurance in respect of the loss.**

(2) Employer-employee setting: *Lister v Romford Ice*

7.09 The extent of the right of an insurer to subrogate against an employee whose negligence has caused an injury or loss, in respect of which the insurer has indemnified the employer, was established in English law in 1956 by the 3-2 majority decision of the UK House of Lords in *Lister v Romford Ice and Cold Storage Co Ltd*.¹²

Lister concerned an insurer who was held entitled to be subrogated to the right to sue an employee of the policyholder who had injured a fellow worker in the negligent carrying out of employment duties. Because the contract of employment did not give the negligent employee an express or implied right to be indemnified by the employer for the negligent carrying out of contractual duties, the insurer invoked subrogation rights without the consent of the employer because an insurer can conduct subrogated litigation in the name of the policyholder.

7.10 The majority decision in *Lister* was immediately criticised because of the breadth of its effect, and it led to the appointment in 1957 of a UK Government Committee to study its effect on employer-employee relations. In its 1959 Report,¹³ the Committee noted that, earlier that year, the Association of British Insurers (ABI) had issued a circular to its members (often referred to as a "gentleman's agreement") not to enforce subrogation rights against employees "unless the weight of evidence clearly indicated (i) collusion, or (ii) wilful misconduct on the part of the employee against whom a claim is made."¹⁴

¹¹ Law Reform Commission *Consultation Paper on Insurance Contracts* (LRC CP 65 – 2011) paragraph 10.101.

¹² [1957] AC 555.

¹³ See Gardiner "Report of the Inter-Departmental Committee" (1959) 22 MLR 652.

¹⁴ British Insurance Association *Circular to Members*, 23 October 1959 (Circular No 89/59).

In 2006, when the Law Commission of England and Wales and Scottish Law Commission were scoping their project on insurance contract law reform, they indicated that there was support for “tidying up” the 1959 ABI circular but that this was not a priority issue and therefore was not included in their project.¹⁵

7.11 In Ireland, while there is no direct equivalent of the 1959 ABI circular, most employer’s liability insurance policies contain a comparable provision to the effect that the insurer will, at the request of the policyholder (the employer), not exercise this right against a negligent employee.¹⁶

In two Supreme Court decisions, *Sinnott v Quinnsworth Ltd and Durning*¹⁷ and *Zurich Insurance Co v Shield Insurance Co Ltd*,¹⁸ the majority decision in *Lister* was not approved and the policy underlying *Lister* was rejected in favour of an approach based on equitable principles. In effect, the minority view in *Lister* was followed, and this view has also been taken by Lord Denning MR in the English Court of Appeal in *Morris v Ford Motor Co Ltd*.¹⁹

In *Sinnott* the plaintiff, an employee of the defendant company Quinnsworth, was very seriously injured in a traffic accident while in a car driven by Durning (also an employee of Quinnsworth), when both of them were travelling to another Quinnsworth outlet. The car being driven by Mr Durning was owned by Quinnsworth which had taken out car insurance with Zurich Insurance. Quinnsworth had employer’s liability insurance with Shield Insurance and this policy was also relevant because the car crash in which Mr Sinnott had been injured occurred during the course of his employment.

7.12 In *Sinnott* the Supreme Court held that Mr Durning had been 100% liable as driver for Mr Sinnott’s injuries. Because there were two insurance policies involved, the Supreme Court also dealt with the question of indemnity between Mr Durning and Quinnsworth. Counsel for Mr Durning argued that he was entitled to an indemnity from his employer, Quinnsworth.

The Supreme Court, whose decision on this issue was delivered by McCarthy J, held that Mr Durning was not entitled to indemnity from Quinnsworth but, since Quinnsworth had taken out valid applicable motor insurance, it was not barred from claiming an indemnity from Mr Durning.

Observing that *Lister* had been a majority decision, McCarthy J added that “[i]t is important to note the reasoning underlying the dissenting opinions.”²⁰ He added that Lord Denning MR in the English Court of Appeal in *Morris v Ford Motor Co Ltd*²¹ had declared that “*Lister v Romford* was an unfortunate decision” and that it would be preferable to approach the matter on the basis of what would be “just and equitable.”

Rejecting the approach in *Lister* in favour of the equitable approach of Lord Denning MR in the *Morris* case, McCarthy J concluded that the case should be decided “according to the principles of equity. A modern adaptation of these principles would, surely, be that those insuring against Road Traffic Act liability should pay the damages in respect of such liability.”²²

As a result of the decision in *Sinnott*, Zurich paid the full amount of damages awarded under Mr Durning’s car insurance policy and then, in the *Zurich* case, sought a 50% contribution from Shield Insurance on the basis that there had been double insurance.

¹⁵ Law Commission of England and Wales and Scottish Law Commission *Insurance Contract Law Analysis of Responses and Decisions on Scope* (2006) at paragraph 3.24. The Commissions stated they would return to subrogation as a separate topic if time allowed after they had completed work on the matters included in the insurance contract law project.

¹⁶ Buckley *Insurance Law* 3rd ed (Thomson Round Hall 2012) paragraph 4-68.

¹⁷ [1984] ILRM 523.

¹⁸ [1988] IR 174.

¹⁹ [1973] EWCA Civ J0327-1; [1973] 1 QB 792, at 801: see below.

²⁰ [1984] ILRM 523 at 537.

²¹ [1973] EWCA Civ J0327-1; [1973] 1 QB 792 at 801.

²² [1984] ILRM 523 at 538.

The question in issue focused on whether the two policies indemnified the same loss. The High Court and Supreme Court held that they did not, and Zurich's claim was dismissed.

Delivering the leading judgment in the *Zurich* case McCarthy J reiterated what he had said in *Sinnott*. He noted that the effect of the argument made by Zurich Insurance would be that the negligent car driver, Mr Durning, would be personally liable to indemnify one of the insurance companies at least to 50% of the amount in question and he was satisfied that Irish law did not have such an effect. He said:²³

“Happily, the employees of Quinnsworth, and indeed, any other employees including those of insurance companies, who drive company cars and give lifts in the course of work to fellow employees, are not faced with such dire consequences.”

7.13 The Supreme Court decisions in both the *Sinnott* and *Zurich* cases indicate no enthusiasm for the full-blooded application of *Lister*, but favour an approach to subrogation based on equitable principles as suggested by Lord Denning MR in *Morris v Ford Motor Co Ltd*.²⁴ This judicial approach reflects the approach in the ABI 1959 circular as well as good insurance practice in Ireland, as incorporated into most employer's liability policies.

This also reflects the approach in most other jurisdictions which have come to reject the majority approach in *Lister*. However, while the Commission considers that it is unlikely that Irish courts would apply the majority view in *Lister*, it should be pointed out that the remarks of McCarthy J in *Sinnott* were probably *obiter dicta*. In *Lister*, the majority were of the view that an insurer was entitled because of its right of subrogation to sue an employee in the name of the employer for negligent driving causing injury to a third party where the driving by the employee was not covered by insurance. Nothing of the sort happened in *Sinnott* and *Zurich Insurance* where the negligent driving of an employee and the vicarious liability of his employer were both covered by insurance with different insurers. Unsurprisingly, the insurers covering the negligent driving were ultimately found liable for all the damages, a conclusion which did not depend in any way on either the majority or dissenting minority view in *Lister* being applied.

7.14 The Australian Law Reform Commission's 1982 *Report on Insurance Contracts*²⁵ rejected the majority view in *Lister v Romford Ice*. As a result, section 66 of the Australian *Insurance Contracts Act 1984* provides that the insurer cannot be subrogated to the rights of the insured against the employee where (a) the rights of an insured under a contract of general insurance in respect of a loss are exercisable against a person who is the insured's employee; and (b) the conduct of the employee that gave rise to the loss occurred in the course of, or arose out of, the employment and was not serious or wilful misconduct.

7.15 A 2001 Report of the Queensland Law Reform Commission²⁶ considered *Lister* in the context of vicarious liability generally, including the kind of circumstances that arose in the *Sinnott* and *Zurich* litigation, and concluded that the rule allowed an employer who is vicariously liable for the tort of an employee to shift the responsibility to the employee.²⁷ It summarised the main objections to the *Lister* rule as follows:

- it is contrary to the promotion of good industrial relations as it exposes employees to potential litigation by employers;²⁸
- it does not represent the expectations of employers and employees²⁹ because it would be generally expected that an employee who commits a tort which causes loss or injury during the course of his or her employment would expect to be covered by the employer's insurance;

²³ [1988] IR 174.

²⁴ [1973] 1 QB 792, at 801.

²⁵ Australian Law Reform Commission *Report on Insurance Contracts* (Report No. 20, 1982), at 189.

²⁶ Queensland Law Reform Commission *Vicarious Liability* (Report No. 56, December 2001).

²⁷ *Ibid* at 109.

²⁸ *Ibid* at 91.

- it operates unfairly because it makes an employee pay the damages awarded against an employer in circumstances where an insurance policy is in place to cover such a loss;³⁰
- it may operate unfairly against a plaintiff because if the defendant employer has a right of indemnity against the employee, a court may be unduly lenient towards the defendant;³¹ and
- it operates unfairly in that an employee sued by the plaintiff might be able to benefit from any insurance policy held by the employer on behalf of the employee, but if that same employee is sued jointly with the employer, the employee could become liable if the insurer exercises its right of subrogation.³²

7.16 The 2001 Report was generally supportive of the approach in section 66 of the 1984 Act but criticised the exceptions for “serious or wilful misconduct” on the ground that they were “too restrictive”³³ because such a provision only extends protection to acts that can be categorised as “non-serious.” This was recognised in a number of Australian jurisdictions³⁴ which opted to limit the employer’s subrogation rights further.³⁵

7.17 The *Lister* rule has also been rejected in Canada. For example, in *Douglas v Kinger*,³⁶ the Court of Appeal for Ontario held that the nature of the employment relationship is such that the employer would expect the employee to perform his or her tasks with reasonable care and the employee would expect the employer to take reasonable care for his or her safety. In addition, both would know that accidents happen, whether as a result of defective equipment provided by the employer, as a result of the employee’s carelessness in the use of that equipment or for some other reason. In that case, the employee was a young person earning a modest wage. The Court in that case found that the employer would have been aware that it was unlikely that the employee would have the financial resources to compensate for a loss, whereas the employer would have insurance to guard against any such loss. The Court added that “[o]n this view of the parties’ expectations, representations and reliance, it would be neither just nor fair to impose the loss on the respondent.”

7.18 Similarly Article 10:101(3) of the *Principles of European Insurance Contract Law* (PEICL) provides that an insurer is not entitled to exercise rights of subrogation against an employee of the policyholder (or insured) except where the insurer proves that the loss was caused by the employee (a) intentionally or (b) recklessly and with knowledge that the loss would probably result.

(a) Conclusion and Recommendation

7.19 The Commission does not consider that the 1959 ABI circular (a “gentleman’s agreement”) is a sufficient alternative to legislative reform, and is in agreement with the conclusion in the 2001 Report of the Queensland Law Reform Commission that such an agreement could lead to uncertainty since it relies on the good faith of insurers.³⁷

²⁹ *Ibid* at 92.

³⁰ *Ibid*.

³¹ *Ibid*.

³² *Ibid*.

³³ *Ibid* at 110.

³⁴ *Ibid* at pp.95-98.

³⁵ *Ibid* at 114.

³⁶ 2008 ONCA 452, at paragraphs 52 and 54 of the judgment. To the same effect see *Portage La Prairie Mutual Insurance Company v MacLean* 2012 NSSC 341, in which the Nova Scotia Supreme Court held that an insurer has no right of subrogation against an employee who caused a fire in her employer’s premises.

³⁷ Queensland Law Reform Commission *Vicarious Liability* (Report No 56 December 2001) at 107.

In the Consultation Paper the Commission provisionally recommended that subrogation rights should be limited where employer-employee relationships exist. Case law including the *Sinnott* and *Zurich* cases and the comparable analysis by the Queensland Law Reform Commission support that view.

The Commission is of the view that an employee who commits a tort in the course of, or arising out of, the employment relationship should not be held liable to indemnify his or her employer in respect of that liability. Therefore an employer who is vicariously liable for the tort of an employee will not be able to shift the responsibility of the liability to the employee.

The Commission has also considered whether there should be any restrictions on the protection offered to employees, and has concluded that it is not reasonable that an employer (or the employer's insurer) be liable in all circumstances for a tort committed by an employee. In the Commission's view an employee who engages in intentional misconduct should not be protected from the consequences of their actions.

The authors of the PEICL provide for such an exception where an insurer proves "that the loss was caused by such a person intentionally or recklessly and with knowledge that the loss would probably result".³⁸ The Commission favours the wording in PEICL (which reflects the terminology already adopted in recommendations throughout this Report) rather than the wording in section 66 of the Australian 1984 Act, which as noted above has been subject to some criticism.

7.20 The Commission recommends that an insurer should not be entitled to exercise rights of subrogation against an employee of an insured employer except when it proves that the loss was caused by such a person intentionally or recklessly and with knowledge that the loss would probably result.

(3) Distribution of recovered funds

7.21 Where money is recovered from a third party through a subrogation action, and in particular where the recovery is less than the overall loss, the question arises as to who is entitled to the money, and how much of it.

Originally at common law, an insurer's right to reimbursement from third party sources did not arise until after the policyholder had been fully compensated for the loss. In *Driscoll v Driscoll*³⁹ an insurer, having paid out in respect of damage to an insured property, sought to be reimbursed from an amount recovered by the policyholder from a lessee under a covenant to repair.

The insurer contended that whatever sum was recovered by the policyholder should go to reimburse insurers, irrespective of whether the policyholder had been fully indemnified in respect of the loss. The policyholder, on the other hand, maintained that he was not obliged to contribute anything to the insurer until he was fully compensated and the High Court held that this was correct.

7.22 Following the 1993 UK House of Lords decision in *Napier and Ettrick v Kershaw*,⁴⁰ Merkin suggests⁴¹ that the common law operates on a "recover down basis" with the assumption being that the insurance is to be treated as having been placed in layers so that the highest layer insurer bears the lowest risk and thus benefits from the subrogation recovery first. Accordingly, if the assured obtains a policy for £1000 in excess of a deductible of £100, and suffers a loss of £1500 only £800 of which is recoverable from the third party, the £800 is allocated first to the assured for his uninsured loss as the notional top layer insurer (£400), then to the insurers (£400), with the deductible being borne by the assured. Therefore where a policy is subject to an excess, it was held in *Napier* that the insurer has

³⁸ See Article 10:101(3) of the PEICL.

³⁹ [1918] 1 IR 152.

⁴⁰ [1993] AC 713. It has since been accepted, in *Lonrho Exports Ltd v Exports Credits Guarantee Department* [1999] Ch 158, 179, that the decision of the UK House of Lords in *Napier* was a restatement of the general law on the rights of insurers in respect of recovery.

⁴¹ Merkin *Reforming Insurance Law: Is there a Case for Reverse Transportation? A Report for the English and Scottish Law Commissions on the Australian Experience of Insurance Law Reform* (Law Commission of England and Wales and Scottish Law Commission, 2007), paragraph 8.20 (footnotes omitted).

priority to recover from the third party before the policyholder can seek to recover the amount of the deductible.

7.23 In the Irish context, Buckley has commented that the exclusion of certain types and amounts of loss from the cover provided by the policy had the effect of varying the insured's rights, not only as to the amount recoverable against the insurer, but also as to the total amount that the insured can recover from the insurer and third parties. The insured, having agreed to accept a deductible under the policy, was not entitled to be indemnified in respect of that deductible out of recoveries obtained from a third party until the insurer was indemnified in full under their right of subrogation.⁴²

In other words a policyholder is not entitled to be indemnified against a loss which he has agreed to bear. Therefore the total amount that a policyholder can recover from the insurer and the third party is limited by the terms of the policy.

7.24 Likewise an insurer cannot recover more under the doctrine of subrogation than it has paid. In *Yorkshire Insce Co Ltd v Nisbet Shipping Co Ltd*,⁴³ the insurer paid its policyholder £72,000 but due to currency devaluation received £127,000. The English High Court held that the insurer had to pay the surplus to the policyholder. Furthermore in circumstances where the policyholder is compensated by the party responsible before the insurer has paid the claim, the insurer may deduct the equivalent amount from the claim,⁴⁴ and where the policyholder receives a payment direct from the wrongdoer after they have already been compensated by the insurer, the insurer is entitled to recover the amount of that payment.⁴⁵

(a) Canada

7.25 Other jurisdictions have sought to clarify these rules through legislation. In particular in Canada, both British Columbia and Alberta sought to govern the position where the net amount recovered after deducting the costs of recovery is not sufficient to provide a complete indemnity for the loss or damage suffered. In British Columbia section 28.7(2) of the *Insurance Amendment Act 2009* extends the right of subrogation absent full indemnity to virtually all types of insurance policies and provides that:

“If the net amount recovered after deducting the costs of recovery is not sufficient to provide a complete indemnity for the loss or damage suffered, that amount must be divided between the insurer and the insured in the proportions in which the loss or damage has been borne by them respectively.”⁴⁶

(b) Australia

7.26 A comprehensive approach to this issue was adopted in Australia when section 67 of the *Insurance Contracts Act 1984* was amended by the *Insurance Contracts Amendment Act 2013* on foot of the 2004 review of the 1984 Act.⁴⁷

Section 67, as amended, provides a detailed description of how the proceeds of recovery actions are to be divided between the insurer and the policyholder. Thus, the party that funded the action is entitled to be reimbursed for the administrative and legal costs of doing so and where both the insurer and the policyholder contributed to the action, they are both to be fully reimbursed or, in circumstances where there are insufficient funds, reimbursed on a *pro rata* basis.

⁴² Buckley “Subrogation: Have Insurers’ Rights Been Extended?” (2000) 7 CLP 22 at 23.

⁴³ [1962] 2 QB 330.

⁴⁴ *Hamilton v Mendes* (1761) 2 Burr 1198.

⁴⁵ By an action for money had and received: see Ellis *Modern Irish Commercial and Consumer Law* (Jordans 2004) paragraph 30.13, fn 25.

⁴⁶ See also section 546(4) of the Alberta *Insurance Amendment Act 2008* which largely reflects the wording of the British Columbia text.

⁴⁷ Review Panel *Report on the Review of the Insurance Contracts Act 1984 Final Report on second stage: Provisions other than section 54* (Australian Treasury, 2004) paragraphs 11.14-11.30.

Where there are remaining funds after the costs have been paid, these funds are to be divided based upon which party funded the recovery action. Where the insurer funded the action, once it has recovered the amount paid to or on behalf of the policyholder, anything left over must be paid to the policyholder up to the full amount of its loss.⁴⁸

Where the policyholder funded the action, the order of recovery is reversed.⁴⁹ Where the action is funded jointly, they are both entitled to the same amounts as referred to above or to reimbursement on a *pro rata* basis where there are insufficient funds to reimburse them in full.⁵⁰

Any excess or windfall recovery is to be distributed to both parties in the same proportions as they contributed to the administrative and legal costs of the recovery action.⁵¹ Any “interest should be divided fairly between the parties, having regard to the amounts that each has recovered and the periods of time for which each party lost the use of their funds.”⁵²

(c) Conclusion and Recommendation

7.27 The Commission considers that it would be appropriate to provide in detail for how the funds recovered in such actions should be distributed between the relevant parties. In the interests of clarity and certainty the Commission favours a codification of the common law “recovery down” principle, and considers that the approach in section 67 of the Australian *Insurance Contracts Act 1984*, as amended in 2013, provides a suitable legislative model for this purpose.

7.28 The Commission recommends the application of the common law “recovery down” principle and the enactment of legislation providing for the distribution of funds recovered by subrogation accordingly.

(4) Contractual provisions

7.29 Insurers are entitled to expect that they will not be unduly prejudiced in the exercise of their subrogation rights by any action of the policyholder. Equally, an insurer must be cautious in the exercise of its rights not to harm or prejudice in any way any remaining rights of the policyholder.⁵³

The authors of PEICL echo these expectations,⁵⁴ and Article 10:101(2) provides that where a policyholder “waives a right against” a third party that prejudices the insurer’s right of subrogation, the policyholder must forfeit their entitlement to indemnity in “respect of the loss in question”. However it also provides that the insurer cannot exercise their rights of subrogation to the detriment of the policyholder.

Where a policyholder enters into a binding agreement to forfeit all or some of a potential claim against a third party, this will trigger the forfeiture of the claim to indemnity under the policy. However this forfeiture will only apply to the particular loss in question.⁵⁵

7.30 Section 68 of the Australian *Insurance Contracts Act 1984* provides that where a contract of insurance contains a clause that excludes or limits the insurer’s liability, in circumstances where the policyholder is party to an agreement that excludes or limits their right to recover from a person other than the insurer in respect of the loss, the insurer cannot rely on such a clause unless it has clearly informed the policyholder in writing, before the contract of insurance was entered into, of the effect of the provision.

⁴⁸ Section 67(2) of the 1984 Act.

⁴⁹ Section 67(3) of the 1984 Act.

⁵⁰ Section 67(4), (5) and (6) of the 1984 Act.

⁵¹ Section 67(7) of the 1984 Act.

⁵² Parliament of Australia House of Representatives *Insurance Contracts Amendment Bill Explanatory Memorandum* at 51 paragraph 1.184.

⁵³ Corrigan and Campbell *A Casebook of Irish Insurance Law* (Oak Tree Press 1995) at 58.

⁵⁴ Basedow et al (eds), *Principles of European Insurance Contract Law* (Sellier, 2009) at 256 paragraph C7.

⁵⁵ *Ibid* at 256 paragraph C7.

7.31 The Commission has concluded that section 68 of the Australian 1984 Act suitably provides a basis on which to recommend that insurers will not be unduly prejudiced in the exercise of their subrogation rights by any action of their policyholders, while also ensuring that policyholders are given appropriate notice that meets their legitimate contractual expectations.

7.32 The Commission recommends that where a consumer contract of insurance includes a provision that has the effect of excluding or limiting the insurer's liability in respect of a loss because the consumer is a party to an agreement that excludes or limits a right of the consumer to recover damages from a person other than the insurer in respect of the loss, the insurer may not rely on the provision unless the insurer clearly informed the insured in writing, before the contract of insurance was entered into, of the effect of the provision.

(5) Third parties

7.33 In Australia, following a recommendation of the 2004 Review Panel Report,⁵⁶ the *Insurance Contracts Act 1984*, as amended by the *Insurance Contracts Amendment Act 2013*, provides that, for the purposes of subrogation, a reference to a policyholder includes a reference to a third party.

Accordingly, the same principles of subrogation apply whether the person being indemnified is the policyholder or a third party to whom the indemnity cover extends.

Insurers paying the claims of third parties would want to be subrogated to the rights of these third parties against any other party from whom recovery of the claims monies can be made. By extension these third parties should then be afforded the same rights and benefits to which the policyholders are entitled in respect of these subrogated actions.

7.34 The Commission concurs with this approach which is consistent with the reforms to third party rights⁵⁷ recommended elsewhere in this Report.

7.35 The Commission recommends that for the purposes of subrogation a reference to a consumer includes a reference to a third party.

⁵⁶ Review Panel Report on the Review of the Insurance Contracts Act 1984 Final Report on second stage: Provisions other than section 54 (Australian Treasury, 2004) paragraphs 11.31-11.34.

⁵⁷ See Chapter 6 above.

CHAPTER 8 POST-CONTRACTUAL DUTIES

A The Post-Contractual Duty of Good Faith

8.01 As discussed in Chapter 2, the principle of good faith in insurance contracts was first set out in the 18th century case *Carter v Boehm*.¹ The mutual nature of the principle was codified in section 17 of the *Marine Insurance Act 1906* which provides that:

“A contract of marine insurance is a contract based upon the utmost good faith, and, *if the utmost good faith be not observed by either party*, the contract may be avoided by the other party.” (emphasis added)

The continuing nature of the duty of good faith, in particular its relationship with the claims process, was highlighted in *Fagan v General Accident Fire & Life Assurance Corp plc*² where the High Court held that:

“the duty to exercise the utmost good faith... continues throughout the relationship up to and including the making of a claim on foot of a policy.”

Nonetheless, much of the case law has focused on the pre-contractual duty of policyholders to provide insurers with particular information before entering into an insurance contract.³ Therefore much of the jurisprudence has centred on the policyholder’s obligations and not the insurer’s corresponding obligations.

Whilst there has been judicial attention in Ireland to the obligations of insurers and the duty of good faith which rests upon them,⁴ the Commission believes that legislative reform is required to balance the corresponding obligations of consumer policyholders and insurers.

Reference to a principle of good faith at the post-contractual stage of consumer insurance contracts can cause confusion for policyholders, while its abolition coupled with legislative measures defining the respective duties of insurers and consumer policyholders will more precisely identify what is implicit in the principle. This approach also has the benefit of being consistent with the Commission’s recommendations in Chapters 2 and 3 concerning reform of the respective duties of both parties at the pre-contractual stage.

8.02 The Commission recommends the abolition in consumer insurance contracts of the post-contractual principle of good faith and its replacement with specified statutory duties and obligations.

B The Duties Prior to the Manifestation of the Claim

8.03 Once a contract of insurance has been concluded, the relationship between the policyholder and the insurer is predominantly governed by its contents, by the Central Bank’s *Consumer Protection Code 2012* and, to the extent that they are applied as a matter of good insurance practice, by Insurance Ireland’s codes of practice.

¹ (1766) 3 Burr 1905, discussed at paragraph 2.01, above.

² High Court (Murphy J), 19 February 1993.

³ These are set out in sections 18 and 20 of the 1906 Act, and are said to be specific examples of the more general duty.

⁴ Discussed in detail in Chapter 2, above.

Breaches of some terms of a contract of insurance can result in varying consequences for the policyholder. Many terms are simply called “conditions” in the contract but they may be fundamental terms of the contract which confer on the insurer a right to repudiate the contract in the event of breach.

Determining the status of a condition is essential to establishing an insurer’s rights when there is a breach of that condition. Depending on its status, the remedies can range from a right to terminate the policy, or a refusal to pay a claim. A number of cases have turned upon whether or not a “condition” has been expressed in the policy to be a condition precedent to the liability of insurers.⁵

The presence of that type of condition within the contract will entitle an insurer to repudiate liability for loss but not to avoid the policy.⁶ Furthermore unless the non-compliance has been trivial or has been waived expressly or impliedly, insurers are not obliged to show that they were prejudiced by the non-compliance.⁷

(1) Payment of the premium

8.04 Once the contract has been made, the principal obligation on a policyholder is to pay the premium. The consequences of non-payment are usually governed by the terms and conditions of the policy, and insurers generally provide that failure to pay the premium terminates the contract.

The Commission considers that a consumer should be required to pay the premium within a reasonable time or in accordance with the terms of the contract, provided those terms meet the requirements concerning unfair or otherwise onerous terms, discussed in Chapter 9, below. This complements the recommendation in Chapter 10, below, that this obligation and the consequences that flow from its breach must be brought to the attention of the proposer prior to the commencement of the contract.

8.05 The Commission recommends that a consumer should be under a duty to pay the premium within a reasonable time or in accordance with the terms of the contract, provided those terms meet the requirements concerning unfair or otherwise onerous terms.⁸

(2) Aggravation or reduction of the risk

(a) Relevant time

8.06 Contracts of insurance are based on the assessment of a risk at the time the contract is concluded. Insurers expect (and hope) that there will be no aggravation of the insured risk during the term of the policy (or indeed that the risk will not manifest itself), while policyholders expect to be able to proceed with their affairs safe in the knowledge that should anything go wrong they are covered under their insurance policy.

Although during the term of the policy the danger associated with the risk may increase or decrease, such variations do not affect the validity of the policy, as Pollock CB confirmed in *Baxendale v Harvey*.⁹

“The insurer, when it has had notice of the risk, is not entitled to any notice by reason of the increase in danger. A person who insures may light as many candles as he pleases in his house, though each additional candle increases the danger of setting the house on fire.”

This reflects a general common law principle that, in the absence of specific provision in the contract of insurance, an increase in the risk after the contract has been concluded has no effect on the insurer’s obligations to pay under the contract.¹⁰ Therefore while the duty of good faith between the policyholder and the insurer persists after the conclusion of the contract, there is no common law duty to disclose

⁵ Relating to matters arising after a loss has occurred.

⁶ Such conditions relate to premium payments, dispute resolution, loss notification, claims procedure and precautions to avoid loss.

⁷ See *Gaelcrann Teo v Payne* [1985] ILRM 109 and *Capemel Ltd v Lister* [1989] IR 319.

⁸ The requirements concerning unfair or otherwise onerous terms are discussed in Chapter 9, below.

⁹ (1859) 157 ER 913.

¹⁰ Smith “The Effect of Subsequent Increases of Risk on Contracts of Insurance” [2009] LMCLQ 366, 387. There is significant debate about whether an exception exists and Smith assesses this in this article.

changes in the risk insured after the contractual period has begun.¹¹ In *New Hampshire Insurance Co v Mirror Group Newspapers Ltd*,¹² the English Court of Appeal held that:

“The obligation of good faith... does not... apply so as to trigger positive obligations of disclosure of matters affecting the risk during the currency of the cover except in relation to some requirement, event or situation provided for in the policy to which the duty of good faith attaches.”¹³

(b) Alteration of circumstances

8.07 Insurers sometimes attempt to define and qualify the risk insured by the inclusion of terms, such as warranties and exclusion clauses that govern the “alteration of circumstances.” For example the policy under consideration by the English Court of Appeal in *Kausar v Eagle Star Insurance Co Ltd*¹⁴ contained the following clause:

“You must tell us of any change of circumstances after the start of the insurance which increases the risk of injury or damage. You will not be insured under the policy until we have agreed in writing to accept the increased risk.”

Saville LJ commented:¹⁵

“all that this condition does is to state the position as it would exist anyway as a matter of common law, namely that without the further agreement of the insurer, there would be no cover where the circumstances had so changed that it could properly be said by the insurers that the new situation was something which, on the true construction of the policy, they had not agreed to cover. The mere fact that the chances of an insured peril operating increase during the period of the cover would not, save possibly in the most extreme of circumstances, enable the insurers properly to say this, since the insurance bargain is one where, in return for the premium, they take upon themselves the risk that an insured peril will operate. In calculating that premium it is for the insurers to assess the chances of insured perils operating; and the fact that they may (in hindsight) have got this assessment wrong does not begin to establish that what has happened falls outside the cover they have agreed to give”.

Therefore, following an aggravation of the risk, in order for insurers to avoid meeting their obligations under the contract (that is, avoid paying the claim), they must prove that the change altered the subject matter insured rather than the risk insured. There is a difference between an increase in the risk and a change in the risk whereby a policyholder is entitled to increase the risk but not to change the nature of the risk.

8.08 Although *Kausar* was to an extent distinguished by the English Court of Appeal itself in *Ansari v New India Assurance Ltd*,¹⁶ that distinction appears to turn on the inclusion of the word “material”¹⁷ in

¹¹ Usually contracts of insurance run on an annual basis and it is upon their renewal that the duty of disclosure is reactivated (and the policyholder is expected to disclose any material matter that would affect relevant decisions of the “prudent insurer”).

¹² [1996] CLC 1692. See also Rose “Informal asymmetry and the Myth of Good Faith” [2007] LMCLQ 181, 215, which argues that there should be no legal duty of disclosure after a contract has been concluded.

¹³ See also *Hussain v Brown (No.2)* [1996] 1 Lloyd’s Rep 627.

¹⁴ [2000] Lloyd’s Rep IR 154.

¹⁵ *Ibid* at 156-157. See also *Swiss Reinsurance Co v United India Insurance Co Ltd* [2005] EWHC 237 (Comm), at paragraph 35, in which the English High Court restated the distinction between a material alteration and a mere change in risk, which does not entitle the insurer to terminate the contract.

¹⁶ [2009] EWCA Civ 93; [2009] 2 All ER (Comm) 926.

¹⁷ *Ibid* at paragraph 6. The clause in that case was: “This insurance shall cease to be in force if there is any material alteration to the premises or business, or any material change in the facts stated in the proposal form or other facts supplied to the insurer.”

the contractual clause (something which was absent from the clause in *Kauser*). This appears to imply that a well-drafted clause could potentially widen the basis upon which a Court would consider that a change in the risk might provide an insurer with grounds to discharge the policy.

In *Ansari*, the policyholder maintained that the insured premises were protected by an automatic sprinkler. However, following a fire it was discovered that the sprinkler system was turned off and there was no supply of water to the premises.

The Court ruled that “material”, when used in alteration of risk clauses, does not have the same meaning as it has in relation to facts and circumstances that must be disclosed to the insurer before the inception of the policy.¹⁸ However, finding in favour of the insurer, the Court held that a “material change” referred to changes of a kind that take the risk outside that which was in the “reasonable contemplation of the contracting parties” when the policy was issued.

Therefore while the subject matter (the building) remained the same, there was a material difference between a building with a working automatic sprinkler and one without.

(c) Other Jurisdictions

8.09 Most European countries¹⁹ make some provision for policy change in the event of a significant aggravation of risk during the insurance period. One of the reasons for the difference in approach between the civil and common law jurisdictions is that in Europe insurance contracts tend to run for long periods, whereas in Ireland and the UK contracts tend to be renewed every 12 months.²⁰

(i) Principles of European Insurance Contract Law (PEICL)

8.10 The PEICL sets out rules governing the use of such clauses rather than recommending their abolition or compulsory retention. Accordingly, Article 4:201 provides that contracts of insurance that contain clauses pertaining to the aggravation of the risk insured:

“shall be without effect unless the aggravation of risk in question is material and of a kind specified in the insurance contract.”

However an aggravation due to “natural wear and tear” of, for example, the property insured, or the “increasing age of the person insured in life assurance,” would not be considered material.²¹

What is envisaged by the aggravation of risk being “of a kind specified in the contract of insurance”, is to ensure that a policyholder’s attention is drawn to what the insurers consider to be an aggravation of the risk.²²

Any clause that governs the notification requirements triggered by the aggravation of the risk are governed by Article 4:202 of the PEICL. These requirements are based on the premise that for insurers to

¹⁸ *Ibid* at paragraph 41.

¹⁹ See Clarke “Aggravation of Risk during the Insurance Period” [2003] LMCLQ 109 for an overview of the developing European position.

²⁰ Therefore it was unsurprising that Article 4 of the proposed 1979 Directive on Insurance Contracts (which as discussed in Appendix C, below, subsequently lapsed), being modelled on the approach in the French Civil Code, required a policyholder after a contract has been concluded to “declare to the insurer any new circumstances or changes in circumstances of which the insurer has requested notification in the contract.” Failure by the policyholder to fulfil this obligation would have the same consequences as failure to disclose information originally; in other words they would depend on whether the policyholder acted innocently, improperly or with the intention to deceive the insurer. In assessing this proposal in 1980 the Law Commission of England and Wales concluded that the “continuing adjustment of the premium to the risk is inappropriate for annual contracts and wholly inappropriate for life insurance, to which indeed the proposed Directive itself does not apply.” See Law Commission of England and Wales *Insurance Law: Non-Disclosure and Breach of Warranty* (Law Com No.104, 1980).

²¹ Basedow et al (eds), *Principles of European Insurance Contract Law* (Sellier, 2009) at 182 paragraph C4.

²² *Ibid* at 182 paragraph C4.

be in a position to decide how to respond to an aggravation of risk, they must be made aware that it has occurred.

They also ensure that policyholders are given a reasonable amount of time in which to respond, and can do so in a reasonable manner (although what is perceived to be reasonable depends on the particular circumstances).²³ The authors of the PEICL explain that:²⁴

“When the aggravation of risk is one intentionally brought about by a policyholder, the time may be relatively short. When the aggravation of risk has not been brought about by the policyholder but by forces of nature or by a third party, which may be the case of increased risk of flooding or subsidence for example, the time may well be longer, even though these are changes of which policyholders are likely to be aware”.

Article 4:202 acknowledges that breach of the duty of notification on the part of policyholders will not necessarily have serious consequences for insurers, and that the intention behind it is to ensure that the legal consequences of breach will be related and proportionate to the breach.

Therefore, the PEICL seeks to ensure that an insurer cannot consider itself discharged upon the occurrence of a post-contractual increase in risk; rather it seeks to limit an insurer’s freedom to avoid the contract in such circumstances.

(ii) Law Commission of England and Wales and Scottish Law Commission

8.11 In a 2010 Issues Paper,²⁵ the Law Commission of England and Wales and Scottish Law Commission commented that the approach taken in the PEICL is very different to the approach in the United Kingdom (which reflects the position in Ireland) under which insurers are expected to specify precisely risks for the duration of the contract of insurance, and whereby an insurer that does not exclude a particular risk must cover it despite any clause to the contrary.

8.12 Under the approach used in the PEICL, where for example an insured car is subsequently modified the insurer would not have to meet a claim for the theft of that modified car but might still be liable for a proportion of the loss (that is if, had it known of the modifications, it would have continued to insure the car for an increased premium).

However in the United Kingdom it is for an insurer to decide whether to include or exclude modified cars. Where an insurer does not exclude modified cars from coverage under the policy then they would be expected to cover them, despite the inclusion of a clause in the contract of insurance requiring notification of alterations in the risk.²⁶

Following this analysis, the Law Commission of England and Wales and Scottish Law Commission rejected the PEICL approach for the following reasons:

- in a market based on annual renewals there is no need for the parties to continue to bargain over changes in the risk;
- notification clauses could introduce unwanted uncertainty because it is often unclear what must be notified;
- when entering into an insurance contract, the onus is on the insurer to define the risk it is covering. If the risk falls within the policy, it should be covered;
- most clauses requiring the policyholder to notify specific changes should be written as exclusions, which, as express terms of the policy, should be subject to the test of fairness under

²³ *Ibid* at 184 paragraph C2.

²⁴ *Ibid* at 184 paragraph C3.

²⁵ Law Commission of England and Wales and Scottish Law Commission *Issues Paper 7 on The Insured’s Post-contract Duty of Good Faith* (July 2010) paragraph 6.44.

²⁶ *Ibid*.

the *Unfair Terms in Consumer Contracts Regulations 1999*, the UK equivalent of the *European Communities (Unfair Terms in Consumer Contracts) Regulations 1995*.

(d) Conclusion and Recommendations

8.13 A mere alteration of the risk is insufficient at common law to permit an insurer to refuse a claim made by a consumer and a general contract clause requiring notification of a risk will be interpreted in that way.

However, if there is a change in the subject matter of the contract and circumstances have so changed that it can properly be said by the insurer that the new situation is something which, on the true construction of the policy, it had not agreed to cover the claim may be refused. The terms of an insurance contract must clarify what is to be excluded from cover (for example, if a modified car is not to be covered, the policy should explicitly state so).

8.14 The Commission takes the view that a general duty on consumers to disclose an increase in the risk insured would introduce uncertainty into the market creating a situation where the insurer would be perpetually re-evaluating the risk and the consumer would have no peace of mind in respect of their purchased policy.

Although PEICL makes provision for clauses that govern the aggravation of the risk this appears overly complex for a one year policy, which is the norm in this jurisdiction.

8.15 Insurers are well-placed to identify and assess risks and to modify and limit exposure by way of contract clauses, conditions and exclusions. Insurers who wish to be notified of changes of circumstances can make this an express term of the policy and therefore subject to the *European Communities (Unfair Terms in Consumer Contracts) Regulations 1995*, which implemented the 1993 Directive on Unfair Terms in Consumer Contracts.²⁷

8.16 The Commission concludes that due to the annual renewal of consumer insurance contracts it is inadvisable to impose a general duty on consumers to disclose an increase in the risk insured.

8.17 The Commission recommends that an insurer may refuse to honour a contract of insurance where there is a change in the subject matter of the contract and circumstances have so changed that it can properly be said by the insurer that the new risk is something which, on the true construction of the policy, it did not agree to cover.

8.18 The Commission recommends that an “alteration of risk” clause should only apply in circumstances where the subject matter of the contract of insurance has altered.

8.19 The Commission recommends that an “alteration of risk” clause should be void where it purports to apply where there is a modification of the risk insured only.

8.20 The Commission recommends that any clause in an insurance contract that refers to a “material change” should be interpreted as referring to changes that take the risk outside that which was within the reasonable contemplation of the contracting parties when the policy was concluded.

8.21 The Commission recommends that an insurer who intends to exclude certain matters from coverage shall do so explicitly in writing prior to the commencement of the contract.

²⁷ SI No. 27 of 1995, discussed in Chapter 9, below.

C Duties During Claims Handling

(1) The policyholder's obligations

(a) Claims co-operation

8.22 Once a claim manifests itself, policyholders are generally required to notify the insurer of the happening of the insured event, and to co-operate with the requests of the insurer during the process of investigation and settlement of the claim. These general obligations are usually governed by a "claims notification condition" and a "claims co-operation condition," which sometimes appear collectively as a "claims condition."

8.23 Such a condition was discussed in the Supreme Court in *Superwood Holdings plc v Sun Alliance and London Insurance plc*.²⁸ The initial words of the condition were:

"On the happening of any damage in consequence of which a claim is or may be made under this policy the Insured shall forthwith give notice thereof in writing to the first named of the Insurers..."²⁹

The policyholder was thus required on the happening of the insured event to give appropriate notice immediately. The condition continued:

"and shall with due diligence do and concur in doing and permit to be done all things which may be reasonably practicable to minimise or check any interruption of or interference with the business or to avoid or diminish the loss ..." ³⁰

The policyholder was therefore expected to mitigate its loss, and the condition continued:

"and in the event of a claim being made under this policy shall not later than thirty days after the expiry of the indemnity period or within such further time as the Insurers may in writing allow, at his own expense deliver to the Insurers in writing a statement setting forth particulars of his claim together with details of all other insurances covering the damage or any part of it or consequential loss of any kind resulting therefrom."³¹

8.24 This required the policyholder, not later than 30 days after the expiry of the indemnity period or such other time as the insurers might allow, at his or her own expense to deliver to the insurers a statement of claim in writing setting out the particulars of the claim advanced. The condition then continued:

"The Insured shall at his own expense *also* produce and furnish to the Insurers such books of account and other business books, vouchers, invoices, balance sheets and other documents, proofs, information, explanation and other evidence as may *reasonably* be required by the Insurers for the purpose of investigating or verifying *the claim* together with (if demanded) a statutory declaration of the truth of the claim and of any matters connected therewith."³²
(emphasis added)

The policyholder was also required, at its own expense, to provide books of account, and other matters required by the insurers. In that respect the Supreme Court concluded that the insurer was entitled to make reasonable requests for documents supporting the claim so as to investigate or verify the claim after the statement of claim.³³ The final sentence of the condition provided that:

²⁸ [1995] 3 IR 303.

²⁹ *Ibid* at 317.

³⁰ *Ibid*.

³¹ *Ibid*.

³² [1995] 3 IR 303 at 317.

³³ [1995] 3 IR 303 at 347.

“No claim under this policy shall be payable unless the terms of this condition have been complied with and in the event of noncompliance therewith in any respect any payment on account of the claim already made shall be repaid to the insurers forthwith.”³⁴

This provision contemplated payments on account when the terms of the condition had not been met. It provided that if such payments were made they were to be repaid if the condition was not complied with.

The claims co-operation condition is relatively uncontroversial and in general tends to impose reasonable requirements on the policyholder, for example:

- deliver a claim in writing within a stated period;
- provide such proof of loss as is required;
- take all reasonable steps to minimise the loss; and
- co-operate fully with the insurer in the investigation of the loss and make available all documentation, records and information required by the insurer.

However different types of insurance policies attract different requirements. For instance liability insurance policies, in addition to requiring the policyholder to co-operate with the investigation and the defence of a third party claim, also prohibit the policyholder from making any admission of liability or offer to settle without the consent of the insurer.

8.25 The authors of PEICL in Article 6:102 set out the obligations of a policyholder in respect of a claims co-operation clause as follows:

“(1) The policyholder, insured or beneficiary, as appropriate, shall cooperate with the insurer in the investigation of the insured event by responding to reasonable requests, in particular for

- information about the causes and effects of the insured event;
- documentary or other evidence of the insured event;
- access to premises related thereto.

(2) In the event of any breach of para.1 and subject to para. 3, the insurance money payable shall be reduced to the extent that the insurer proves that it has been prejudiced by the breach

(3) In the event of any breach of para.1 committed with intent to cause prejudice or recklessly and with knowledge that such prejudice would probably result, the insurer shall not be obliged to pay the insurance money.”

8.26 It is important that a policyholder co-operate with their insurer when making a claim. It is reasonable that an insurer should be able to request and receive documentary and other information connected to the claim.

The authors of PEICL considered that there should be limitations on what an insurer should be entitled to and suggested that they should be permitted to make “reasonable requests.”

The comments accompanying Article 6:102 state that the duty does not extend to more “intrusive matters,” for example, giving insurers access to financial information or submission to examination under oath.³⁵

If a policyholder does not co-operate with an insurer it is appropriate that he or she should be penalised but they should not forfeit their entire claim where an insurer has not been prejudiced by the failure. A reduction in the amount to be paid, reflecting the absence of co-operation and its effect upon the insurer’s interests, should be contemplated.

³⁴ [1995] 3 IR 303 at 318.

³⁵ Basedow et al (eds), *Principles of European Insurance Contract Law* (Sellier, 2009) at 213 paragraph C2.

8.27 The Commission recommends that consumers should cooperate with their insurers in the investigation of insured events by responding to reasonable requests honestly and with reasonable care.

(b) Timeframes

8.28 Claims notification conditions have sometimes attracted controversy.³⁶ One of the problems commonly associated with them are the timeframes prescribed for notice to the insurer on the happening of an insured event.

While some of these conditions indicate specific timeframes, such as three days, some include vague terminology such as “immediately”, “within a reasonable time”, “forthwith” or “as soon as possible” and therefore it often falls to the courts to determine their meaning.

8.29 In *Layher Ltd v Lowe*³⁷ the English Court of Appeal held that if a condition required notification of a claim to be made “immediately”, it was relevant to consider the situation immediately after the manifestation of the risk.

8.30 In the absence of such a condition MacGillivray comments that the policyholder will be obliged to “give notice within a reasonable time as part of his obligation to act with good faith towards his insurer”.³⁸

8.31 While the purpose of such conditions is to enable insurers to assess the claim within a reasonably short period of time after its alleged manifestation, reliance on vague and indefinable concepts of time can lead to difficulties and time is deemed not to run until it is clear that the insurer may be involved.³⁹

8.32 Article 6:101 of PEICL deals with the notice of an insured event as follows:

“(1) The occurrence of an insured event shall be notified to the insurer by the policyholder, the insured or the beneficiary, as appropriate, provided that the person obliged to give notice was or should have been aware of the existence of the insurance cover and of the occurrence of the insured event. Notice by another person shall be effective.

(2) Such notice shall be given without undue delay. It shall be effective on dispatch. If the contract requires notice to be given within a stated period of time, such time shall be reasonable and in any event no shorter than five days.

(3) The insurance money payable shall be reduced to the extent that the insurer proves that it has been prejudiced by undue delay.”

On the occurrence of the insured event the policyholder is required to notify the insurer “as appropriate” and without “undue delay”, provided that “the person obliged to give notice was or should have been aware of the existence of the insurance cover and of the occurrence of the insured event”.

If the contract requires notice to be given within a specific period of time, that time must be reasonable and in any event “no shorter than five days.”

8.33 The authors of the PEICL considered that since it is insurers who usually raise “breach of notice” as a ground for refusing the claim, they should be required to prove that they were prejudiced by the breach.

³⁶ *Gamble v The Accident Assurance Company* (1870) IR 4 CL 204.

³⁷ 58 Con LR 42 at 44. See also *Andrews Construction Ltd v Lowry Piling Ltd* [2010] IEHC 276 for a discussion of the meaning of “as soon as is reasonably possible” in the context of section 27 of the *Civil Liability Act 1961*.

³⁸ Legh-Jones, Birds and Owen (eds) *MacGillivray on Insurance Law* 11th ed (Sweet & Maxwell 2008) at 533 paragraph 19.034, cited in Buckley *Insurance Law* 3rd ed (Thomson Round Hall 2012) paragraph 5-146.

³⁹ *Smellie v British General Insurance Co* [1918] WC & Ins. Rep. 233, cited in Buckley *Insurance Law* 3rd ed (Thomson Round Hall 2012) paragraph 5-147.

They suggested that the penalty for a breach of this condition should be a reduction in the amount payable to the extent that the insurer can prove that it has been prejudiced by the undue delay, and insurers will then not be in a position to withhold total payment based solely on the breach.

Despite difficulties caused by conditions that contain indefinable terminology such as “as soon as possible” the Commission appreciates that there are circumstances where an insurer will need to be informed of a loss “as soon as possible” (in order to ensure for example that the loss is mitigated), and considers that any time period should be reasonable.

Where a policyholder has taken an unreasonable amount of time to notify an insurer of the manifestation of a claim, that insurer should be required to prove that it has been prejudiced by the policyholder’s breach of the notification clause in order to reduce or avoid payment of the claim.

8.34 The Commission recommends that the consumer should be required to notify the insurer of the occurrence of an insured event within a reasonable time or in accordance with the terms of the contract, provided those terms meet the requirements concerning unfair or otherwise onerous terms.⁴⁰

8.35 The Commission recommends that where non-compliance with a specified notification period does not prejudice an insurer, the insurer should not be entitled to refuse liability under the claim on that ground alone.

(2) Insurer’s Obligations: Processing a claim and offer of settlement

(a) General statutory duties of the Consumer Protection Act 2007

8.36 Section 41 of the *Consumer Protection Act 2007*⁴¹ provides that a trader (which includes an insurer) shall not engage in any “unfair commercial practice.”

Section 42 provides that an insurer shall not engage in a misleading commercial practice which includes the misleading “handling of consumer complaints.”

More specifically, section 55(3)(d) provides that an insurer shall not engage in either of the following in relation to a consumer’s⁴² claim on an insurance policy:

- “(i) requiring the consumer to produce documents irrelevant to the validity of the claim;
- (ii) persistently failing to respond to the consumer’s correspondence on the matter, in order to dissuade the consumer from exercising contractual rights in respect of that claim.”

(b) Requirements of the Consumer Protection Code 2012

(i) General principles

8.37 The Central Bank’s *Consumer Protection Code 2012* contains a number of general principles with which an insurer must comply. These include that in all its dealings with customers⁴³ the insurer:

- acts honestly, fairly and professionally in the best interests of its customers and the integrity of the market;
- acts with due skill, care and diligence in the best interests of its customers;
- makes full disclosure of all relevant material information, including all charges, in a way that seeks to inform the customer;
- corrects errors and handles complaints speedily, efficiently and fairly;

⁴⁰ The requirements concerning unfair or otherwise onerous terms are discussed in Chapter 9, below.

⁴¹ The 2007 Act implemented Directive 2005/29/EC on unfair commercial practices: see also Chapter 9, below.

⁴² Section 2(1) of the 2007 Act defines a consumer as a natural person, whether in the State or not, who is acting for purposes unrelated to the person’s trade, business or profession.

⁴³ The term “customer” means any person to whom a regulated entity provides or offers to provide a product or service the subject of this Code, and any person who requests such a product or service.

- does not exert undue pressure or undue influence on a customer.

(ii) Processing of an insurance claim

8.38 Chapter 7 of the *Consumer Protection Code 2012* deals with processing an insurance claim. It states that an insurer “must endeavour to verify the validity of a claim received from a claimant prior to making a decision on its outcome.”⁴⁴ It then provides that an insurer must have in place a written procedure for the effective and proper handling of claims.⁴⁵ At a minimum, the procedure must provide that:

- where an accident has occurred and a personal injury has been suffered, a copy of the Personal Injuries Assessment Board Claimant Information Leaflet is issued to the claimant as soon as the regulated entity is notified of the claim;
- where the potential claimant has been involved in a motor accident with an uninsured or unidentified vehicle or with a foreign registered vehicle, the regulated entity must advise the potential claimant to contact the Motor Insurance Bureau of Ireland (MIBI);
- where a claim form is required to be completed, it is issued to the claimant within five business days of receiving notice of a claim;
- the regulated entity must offer to assist in the process of making a claim, including, where relevant, alerting the claimant to policy terms and conditions that may be of benefit to the claimant;
- a record must be maintained of all conversations with the claimant in relation to the claim; and
- the regulated entity must, while the claim is ongoing, provide the claimant with updates of any developments affecting the outcome of the claim within ten business days of the development. When additional documentation or clarification is required from the claimant, the claimant must be advised of this as soon as required and, if necessary, issued with a reminder on paper or on another durable medium.⁴⁶

8.39 Paragraphs 7.9 to 7.15 govern the qualification and quantification of the claim. In particular they provide that an insurer “must ensure that any claim settlement offer made to a claimant is fair, taking into account all relevant factors, and represents the regulated entity’s best estimate of the claimant’s reasonable entitlement under the policy”.⁴⁷

The *Guidance Note* accompanying the Code states that, in determining whether or not a settlement offer is fair, consideration should be given to a number of factors, including but not limited to the following:

- any evidence submitted by the claimant (or any third party acting on his or her behalf) to support the value of the claim;
- the evidence made known to the insurer or evidence that should be reasonably available to the insurer; and
- the procedures used by the insurer in determining the monetary amount of compensation offered.⁴⁸

(iii) Timeframe

8.40 The 2012 Code provides that within 10 business days of making a decision in respect of a claim, an insurer must inform the claimant of the outcome of the investigation and explain the terms of the

⁴⁴ Provision 7.6 of the 2012 Code.

⁴⁵ Provision 7.7 of the 2012 Code.

⁴⁶ Provision 7.7 (a) to (f) of the 2012 Code.

⁴⁷ Provision 7.15 of the 2012 Code.

⁴⁸ Central Bank of Ireland *Consumer Protection Code 2012 Guidance* (Central Bank of Ireland, December 2011) paragraph 5.5.

offer of settlement, if any.⁴⁹ When making such an offer the insurer must ensure that the following conditions have been satisfied:

- the insured event has been proven, or accepted by the regulated entity;
- all specified documentation has been received by the regulated entity from the claimant; and
- the entitlement of the claimant to receive payment under the policy has been established.

In general when a policyholder is not the beneficiary, an insurer must advise them at the time that settlement is made, of the final outcome of the claim including the details of the settlement. Where applicable, the policyholder must be informed that the settlement of the claim will affect future insurance contracts of that type.

An insurer must allow a claimant at least ten business days to accept or reject the offer.⁵⁰ The insurer is then required to discharge the claim “within ten business days” from the date the claimant has agreed to accept the offer, “once the appropriate amount has been agreed subject to finalisation of legal costs, where applicable”. In respect of a method of direct settlement, the insurer must discharge the claim “without delay.”⁵¹

(c) Insurance Ireland’s Code of Practice

8.41 Insurance Ireland’s *Code of Practice on Life Assurance: Duty of Disclosure* states: “Payment of claims will be made without avoidable delay once the insured event has been proved and the entitlement of the claimant to receive payment has been established, but in any event not later than one month after such agreement.”⁵²

8.42 It also states that “An insurer will not unreasonably reject a claim.”⁵³

(d) United Kingdom

8.43 The UK Financial Conduct Authority’s *Insurance Conduct of Business Sourcebook* (ICOBS) states:

“An insurer must:

- (1) handle claims promptly and fairly;
- (2) provide reasonable guidance to help a policyholder make a claim and appropriate information on its progress;
- (3) not unreasonably reject a claim (including by terminating or avoiding a policy); and
- (4) settle claims promptly once settlement terms are agreed.”⁵⁴

8.44 The Law Commission of England and Wales and Scottish Law Commission in their 2014 Report recommended that every contract of insurance should contain an implied term to the effect that an insurer should be obliged to pay claims within a reasonable time. A reasonable time “includes a reasonable time to investigate and assess the claim”, however, what is reasonable will depend on all the

⁴⁹ Provision 7.15 of the 2012 Code.

⁵⁰ Provision 7.17 of the 2012 Code provides: “Where the claimant waives this right and accepts the settlement offer within this timeframe, the insurer must retain a record of this decision. This provision does not apply in the case of surrender or encashment of life assurance investment policies or to claims on life assurance protection policies where the settlement amount is set out in the policy terms and conditions and/or the policy schedule.”

⁵¹ Provision 7.18 of the 2012 Code.

⁵² Insurance Ireland *Code of Practice on Life Assurance: Duty of Disclosure*, paragraph 3(d).

⁵³ *Ibid* paragraph 3(a).

⁵⁴ ICOBS 8.1.1R2. This is the case regardless of whether the policyholder is a business, a consumer, a human person or a legal person.

relevant circumstances.⁵⁵ The following were given as examples of things that may need to be taken into account:

- the type of insurance,
- the size and complexity of the claim,
- compliance with any relevant statutory or regulatory rules or guidance,
- factors outside the insurer's control.

The Law Commission of England and Wales and Scottish Law Commission recommended that where the insurer can show that there were reasonable grounds for disputing the claim (whether as to the amount of any sum payable, or as to whether anything at all is payable) the insurer will not have breached the implied term merely by failing to pay the claim (or the affected part of it) while the dispute is continuing.

However the "conduct of the insurer in handling the dispute may be a relevant factor in deciding whether that term was breached and, if so, when."⁵⁶

8.45 The Commissions recommended that failure to meet this obligation should result in an insurer's liability to pay damages for any foreseeable loss which results. While many of the recommendations in the 2014 Report were implemented in the UK *Insurance Act 2015* this recommendation on payment of the claim within a reasonable period was not included in the 2015 Act.

(e) PEICL

8.46 The authors of the PEICL in Article 6:103 advocate that the insurer should "take all reasonable steps to settle a claim promptly."

Article 6:103(2) of PEICL contains a presumption that claims have been accepted unless an insurer "rejects a claim" or "defers acceptance of a claim by written notice giving reasons for its decision within one month after receipt of the relevant documents and other information." However, in such circumstances the authors of the PEICL explicitly state that "mere suspicion of fraud would not normally be a valid reason" for doing so.⁵⁷

Regarding the timeframe for the payment of the claim Article 6:104 of PEICL states:

"(1) When a claim has been accepted the insurer shall pay or provide the services promised, as the case may be, without undue delay.

(2) Even if the total value of a claim cannot yet be quantified but the claimant is entitled to at least a part of it, this part shall be paid or provided without undue delay.

(3) Payment of insurance money, whether under para. 1 or para. 2, shall be made no later than one week after the acceptance and quantification of the claim or part of it, as the case may be."

(f) Conclusion and recommendations

8.47 There are no statutory rules in Ireland that relate to the time in which a claim should be settled and paid, although important provisions on claims settlement are included in the Central Bank's *Consumer Protection Code 2012*. The Commission in the Consultation Paper invited submissions as to the period of time within which an insurer should meet valid claims.

The submissions received have convinced the Commission that stipulating a specific timeframe would be unhelpful because of the complexity and circumstances affecting individual claims. However to have no time measurement at all, particularly in circumstances where the relevant claim is straightforward, would be undesirable.

⁵⁵ Law Commission of England and Wales and Scottish Law Commission Report *Insurance Contract Law: Business Disclosure; Warranties; Insurers' Remedies For Fraudulent Claims; and Late Payment* (Law Com No.353/Scot Law Com No.238, 2014) paragraph 27.5.

⁵⁶ *Ibid* paragraph 28.48.

⁵⁷ Basedow et al (eds), *Principles of European Insurance Contract Law* (Sellier, 2009) at 216 paragraph C3.

The Commission takes the view, like the Law Commission of England and Wales and Scottish Law Commission, that claims should be settled and discharged within a reasonable time, defined as a reasonable time to investigate and assess the claim dependent on all relevant circumstances.

8.48 While the *Consumer Protection Code 2012* refers to 10 business days in respect of the insurer informing the policyholder of the outcome of their decision, it does not refer to the length of time taken to make the decision in the first place.

8.49 In circumstances where a claimant has accepted the insurer's offer, the insurer must discharge the claim within 10 business days from that date, but this timeframe is qualified as it only begins "once the appropriate amount has been agreed subject to finalisation of legal costs, where applicable." Where the "appropriate amount" is in dispute, it is unclear whether the insurer is entitled to retain all of the claim money until the dispute is resolved.

8.50 The authors of PEICL suggest that "[e]ven if the total value of a claim cannot yet be quantified but the claimant is entitled to at least a part of it, this part shall be paid or provided without undue delay".⁵⁸ The Commission concludes that the introduction of this approach may balance the rights of the parties during negotiations regarding the "appropriate amount."

8.51 The Commission recommends that insurers should be under a duty to handle claims promptly and fairly.

8.52 The Commission recommends that insurers should not engage in either of the following practices in relation to consumers' claims on their insurance policies: (i) requiring consumers to produce documents irrelevant to the validity of their claims; or (ii) persistently failing to respond to consumers' correspondence on the matter, in order to dissuade consumers from exercising contractual rights in respect of their claims.⁵⁹

8.53 The Commission recommends that an insurer should pay any sums due to the consumer in respect of the claim within a reasonable time.

8.54 The Commission recommends that, where it is not possible to quantify the total value of the claim within a reasonable time but where part of the total value has been quantified, the insurer should pay that part to the consumer within a reasonable time.

D Disputed Claims

(1) Investigating a disputed claim

(a) The Consumer Protection Code 2012

8.55 The *Consumer Protection Code 2012* provides that when an insurer decides to decline a claim it must provide reasons for that decision to the claimant and details of any internal appeals mechanisms on paper or on another durable medium.

Chapter 10 of the Code requires that an insurer must have written procedures in place for the effective handling of errors that affect consumers.

The Code states that these procedures must provide for the following: (a) the identification of the cause of the error; (b) the identification of all affected consumers; (c) the appropriate analysis of the patterns of the errors, including investigation as to whether or not it was an isolated error; (d) proper control of the correction process; and (e) escalation of errors to compliance/risk functions and senior management.⁶⁰

The insurer must resolve all errors speedily, and no later than six months after the date the error was first discovered, including: (a) correcting any systems failures; (b) ensuring effective controls are implemented

⁵⁸ Article 6:104(2) of the PEICL.

⁵⁹ This recommendation is derived from section 55(3)(d) of the *Consumer Protection Act 2007* which applies to a consumer defined as an individual: see Chapter 9, below.

⁶⁰ Provision 10.1 of the 2012 Code.

to prevent any recurrence of the identified error; (c) effecting a refund (with appropriate interest) to all consumers who have been affected by the error, where possible; and (d) notifying all affected consumers, both current and former, in a timely manner, of any error that has impacted or may impact negatively on the cost of the insurance service or the value of the product provided, where possible.⁶¹

Where an error which affects consumers has not been fully resolved within 40 business days of the date the error was first discovered, the insurer must inform the Central Bank, on paper or on another durable medium, within five business days of that deadline.⁶²

An insurer may not benefit from any balance arising out of a refund which cannot be repaid or in respect of an error; and an insurer must maintain a log of all errors that affect consumers.⁶³

(b) EIOPA Guidelines on Complaints-Handling by Insurance Undertakings

8.56 The *Consumer Protection Code 2012* was being finalised when, in 2012, the European Insurance and Occupational Pensions Authority (EIOPA) published *Guidelines on Complaints-Handling by Insurance Undertakings*⁶⁴ under its general statutory mandate to provide regulatory guidance for all insurers operating within the EU. This mandate derives from Article 16 of the 2010 EU Regulation which established the EIOPA as part of the European Central Bank.⁶⁵

8.57 Thus, the EIOPA Guidelines require the relevant national regulatory body to ensure that insurance undertakings:

- have in place a written complaints management policy;
- have a complaints management function which enables complaints to be investigated fairly;
- internally register complaints in accordance with national timing requirements in an appropriate manner;
- provide information on complaints and complaints-handling to the competent national authorities or ombudsman;
- analyse complaints-handling data on an ongoing basis to ensure that they identify and address any recurring or systemic problems, and potential legal and operational risks;
- on request or when acknowledging receipt of a complaint, provide written information regarding their complaints-handling process;
- publish details of their complaints-handling process in an easily accessible manner, for example, in brochures, pamphlets, contractual documents or via the insurance undertaking's website;
- provide clear, accurate and up-to-date information about the complaints-handling process, which includes:
 - details of how to complain (e.g. the type of information to be provided by the complainant, the identity and contact details of the person or department to whom the complaint should be directed); and

⁶¹ Provision 10.2 of the 2012 Code.

⁶² Provision 10.3 of the 2012 Code.

⁶³ Provisions 10.4 and 10.5 of the 2012 Code.

⁶⁴ European Insurance and Occupational Pensions Authority *Guidelines on Complaints-Handling by Insurance Undertakings* (June 2012), available at eiopa.europa.eu.

⁶⁵ Regulation (EU) No.1094/2010 establishing a European Supervisory Authority (European Insurance and Occupational Pensions Authority). Article 16(3) of the EIOPA Regulation provides that national regulatory authorities and financial institutions “shall make every effort to comply with guidelines and recommendations.” The EIOPA forms part of the EU’s Single Supervisory Authority which was established under the auspices of the European Central Bank in the wake of the global financial crisis that emerged in 2008.

- the process that will be followed when handling a complaint (e.g. when the complaint will be acknowledged, indicative handling timelines, the availability of a competent authority, an ombudsman or alternative dispute resolution (ADR) mechanism, etc.);
- keep the complainant informed about further handling of the complaint;
- seek to gather and investigate all relevant evidence and information regarding the complaint;
- provide a response without any unnecessary delay or at least within the time limits set at national level. When an answer cannot be provided within the expected time limits, the insurance undertaking should inform the complainant about the causes of the delay and indicate when the insurance undertaking's investigation is likely to be completed; and
- when providing a final decision that does not fully satisfy the complainant's demand (or any final decision, where national rules require it), include a thorough explanation of the insurance undertaking's position on the complaint and set out the complainant's option to maintain the complaint e.g. the availability of an ombudsman, ADR mechanism, national competent authorities, etc. Such decision should be provided in writing where national rules require it.

8.58 In 2013, the Central Bank confirmed to the EIOPA that Chapter 10 of the *Consumer Protection Code 2012* already reflects the requirements of the 2012 EIOPA Guidelines.⁶⁶

(2) Reports prepared and information discovered after a claim is made

8.59 While the common law duty of utmost good faith (*uberrima fides*), discussed in Chapter 2,⁶⁷ above, continues after the conclusion of the insurance contract, there is no general post-contractual duty of disclosure that corresponds to the pre-contractual duty of disclosure. Indeed, in *Manifest Shipping v Uni-Polaris (The Star of the Sea)*,⁶⁸ the English High Court (Tuckey J) noted that the duty of utmost good faith ceases once an insurer has declined to indemnify a claim. He added that it must be assumed that the insurer has good reasons to decline and that the parties then become adversaries, and that there is good reason why adversaries should not be under a duty to provide ammunition to one another.

8.60 It might indeed appear inconsistent with an adversarial contest that there should be disclosure of information between the insurer and the insured, especially because as noted below such information would ordinarily be regarded as privileged. Nonetheless, precisely such disclosure has formed a routine part of personal injuries litigation for many years without adversely affecting the general adversarial approach to such cases.

(a) Privileged investigative reports

8.61 Legal advice privilege attaches to advices issued by solicitors and counsel, and the Commission makes no proposal to disturb this important aspect of civil litigation.

8.62 Litigation privilege protects documents containing communications which have been prepared in contemplation of litigation or after litigation has commenced. Investigative reports commissioned by insurers after a claim has been filed are generally protected by litigation privilege.

In *Silverhill Duckling Ltd v Minister for Agriculture*⁶⁹ the High Court (O'Hanlon J) approved the test set out by the UK House of Lords in *Waugh v British Railways Board*⁷⁰ that litigation privilege attaches to a

⁶⁶ The full text of the Central Bank's reply to the EIOPA confirming compliance with the 2012 Guidelines is available at <https://eiopa.europa.eu/en/publications/eiopa-guidelines-new/guidelines-on-complaints-handling-by-insurance-undertakings/index.html>.

⁶⁷ As noted in paragraph 2.04, the duty of utmost good faith in insurance contract law is to be distinguished from the related, but distinct, "good faith" requirement now included in general consumer protection legislation, which is discussed in Chapter 9, below.

⁶⁸ [1995] 1 Lloyd's Law Rep 651 at 667.

⁶⁹ [1987] IR 289.

⁷⁰ [1980] AC 521.

document such as a report if the “dominant purpose” for which it was commissioned was litigation that was either apprehended or threatened.⁷¹

8.63 In the specific context of an insurance claim, the High Court (O’Hanlon J) held in *PJ Carrigan Ltd v Norwich Union Fire Society Ltd*⁷² that litigation privilege attached to a report from loss adjusters which the defendant insurer had sought immediately after the plaintiffs had made a claim under a fire policy. Privilege was claimed in respect of that report when litigation commenced. The Court accepted that, while the report would have assisted the defendant insurer to evaluate the claim in terms of financial loss (which would not have attracted litigation privilege), they had also immediately viewed the claim with some suspicion.

The dominant purpose for commissioning the report was therefore to know whether any evidence available at the scene of the fire supported their suspicions and they were therefore contemplating the possibility of a showdown and litigation with the plaintiffs. On that basis, although no litigation was threatened at the time the report was commissioned, it was apprehended by the defendant insurer and since this constituted a dominant purpose in looking for the report, litigation privilege attached to it and the Court therefore refused discovery of it.⁷³

Similarly, in *Rhatigan v Eagle Star Life Assurance Co*⁷⁴ after the plaintiff had made a claim under a life insurance policy, the defendant insurance company had carried out an investigation and decided to repudiate liability for misrepresentation and non-disclosure. The High Court (Cooke J) held that where the payment otherwise due under the policy is a substantial sum, the insurer will inevitably have to take into account the likelihood of the repudiation being contested by litigation. Thus, the decision to repudiate is so likely to provoke litigation that the investigation by the insurer that led to that decision must be characterised as a step taken in apprehension of litigation.⁷⁵

(b) Pre-trial disclosure in personal injuries claims

8.64 Until the 1990s, litigation privilege attached to expert reports prepared in contemplation or apprehension of a personal injuries claim. While both parties were in possession of such reports, neither side had access to the other’s reports so that pre-trial settlement negotiations, in particular as to quantum, were often not based on all the available information. This in turn led to delayed settlements at the “door of the court” with the consequent significant costs involved in preparing the full case for trial. As Delany and McGrath point out, the desirability of introducing a mechanism for pre-trial disclosure of reports had been emphasised by the judiciary in a number of cases⁷⁶ and provision for this was enacted in section 45 of the *Courts and Court Officers Act 1995*.

Order 39, rule 46 of the *Rules of the Superior Courts 1986*, as inserted by the *Rules of the Superior Courts (No.6) (Disclosure of Reports and Statements) 1998* sets out the detailed arrangements under section 45 of the 1995 Act, which include the mandatory pre-trial disclosure and exchange of prescribed expert reports and documents that would previously have attracted litigation privilege. These provisions are limited to personal injuries claims.

⁷¹ [1987] IR 289, at 294.

⁷² [1987] IR 618.

⁷³ [1987] I.R. 618, at 620.

⁷⁴ [2013] IEHC 139.

⁷⁵ *Ibid* at paragraph 17. The Court held, at paragraph 18 of the judgment, that the same principle applies to communications which come into existence in such circumstances between an insurer and its re-insurer, given that the re-insurer will be exposed to potential liability if inadequate steps of investigation are adopted or the wrong decision on repudiation is taken.

⁷⁶ Delany and McGrath *Civil Procedure in the Superior Courts* 3rd ed (Round Hall 2012) paragraph 28-48. (footnotes omitted).

(c) Conclusion and Recommendation

8.65 It is undesirable that an insurer during the course of an investigation into a claim should discover information that would benefit a consumer, but fail to reveal it on grounds of privilege with resultant prejudice to the interests of the consumer. It is equally undesirable that a consumer, having made a claim, should withhold information that he or she has discovered that would impact on the claim and fail to reveal it with resultant prejudice to the interests of the insurer.

The Commission considers that if such information goes to the essence of the claim then it should be disclosed on a mutual basis.

A parallel can be drawn with the provision for mandatory pre-trial disclosure and exchange of reports under section 45 of the *Courts and Court Officers Act 1995*, and the Commission concludes that such a provision, suitably adapted, would make good sense in the insurance setting. Such mutual disclosure could make an important contribution to claims settlements within a reasonable period because they would be based on all the information that is available to both parties; in some instances it would also avoid costly and lengthy litigation.

Rather than prescribing in detail the types of reports or documents that should be disclosed (as is the case under Order 39, rule 46 of the *Rules of the Superior Courts 1986* in personal injuries claims) the Commission considers that it should be provided that both the insurer and consumer must disclose to each other any information discovered during the course of the investigation of a claim that goes towards the validity of the claim. This is to emphasise that the purpose of this provision is not to add unnecessary expense in the claims management process but rather to ensure that significant information that goes to the heart of a claim is available and must be disclosed to both sides.

8.66 The Commission recommends that an insurer must disclose to its consumer policyholders any information discovered during the course of the investigation of claims, and consumer policyholders must disclose to insurers any information of which they become aware after making a claim, where that information goes to the validity of the claim; and that this mutual obligation to disclose applies even where any such information would otherwise be subject to litigation privilege.

(3) Late Payment of Claims

8.67 Buckley points out that a policy of insurance is a promise by an insurer to pay out on the happening of a specified event to prevent an insured sustaining loss,⁷⁷ so that when an insurer unreasonably refuses to pay a valid insurance claim or unreasonably delays payment the insurer is in breach of contract, including the duty of good faith.

Good insurance practice, as reflected in the Insurance Ireland *Code of Practice on Life Assurance: Duty of Disclosure*, is that the policyholder is entitled to recover the sum of money that the insurer should have paid under the policy and (usually) interest on the outstanding sum.⁷⁸

The late payment of a claim can, however, cost a consumer policyholder more than interest. For example, without compensation a policyholder may have been unable to repair property and/or their business may have failed. In addition, a policyholder may also have suffered physical inconvenience or emotional distress as a result of the insurer's action or inaction and such a policyholder might wish to seek compensatory damages for these consequential non-pecuniary losses.

⁷⁷ Buckley *Insurance Law* 3rd ed (Thomson Round Hall 2012) paragraph 7-49.

⁷⁸ Insurance Ireland's *Code of Practice on Life Assurance: Duty of Disclosure* provides, at paragraph 3(d), that "when the payment of a claim is delayed more than two months, the insurer will pay interest on the cash sum due, or make an equivalent adjustment to the sum, unless the amount of such interest would be trivial. The two month period will run from the date of the happening of the insured event (i.e. death or maturity) or, in the case of a unit linked policy, from the date on which the unit linking ceased, if later. Interest will be calculated at a relevant market rate from the end of the two month period until the actual date of payment."

(a) Current law prevents recovery of general damages for late payment: “hold the insured harmless” principle

8.68 In general contract law an innocent injured party may pursue a wrongdoer for such consequential losses,⁷⁹ but in indemnity insurance this does not appear to be the case. English law⁸⁰ provides that there can be no cause of action in respect of wrongful late payment or non-payment of monies due on a policy of indemnity insurance.⁸¹ This exception to the ordinary principles of contract law developed as a result of what has been described as the “legal fiction”⁸² that an insurer’s primary obligation is to “hold the insured harmless” against the insured peril.

This has been interpreted to mean that an insurer’s contractual obligation is to prevent the loss rather than to compensate for it. Accordingly a payment under the policy is already deemed a payment in damages and, as the law does not provide for damages for failure to pay damages, the policyholder cannot sue for consequential loss suffered.

8.69 In *Sprung v Royal Insurance Co Ltd*⁸³ the English Court of Appeal affirmed this approach and rejected the argument that a policyholder could claim in damages arising out of the insurer’s failure to pay out promptly on a policy. The Court held that the insurer, if in breach of contract, is answerable only to the policyholder by way of interest.

This view was applied by the High Court (Carroll J) in *Kerry Tree (Technology) Ltd v Sun Alliance and London Insurance Co.*⁸⁴ The plaintiff company claimed damages against the defendant insurer on the ground that its imposition of unreasonable duties on the plaintiff to mitigate loss before paying under its insurance policy claim had caused the company’s failure. The defendant insurer relied on the decision in *Sprung* that no such claim for damages for late payment of damages can be made. The High Court agreed and applied *Sprung*, although the rationale for this was not analysed in detail.

8.70 Other jurisdictions do not share this approach. Scottish courts have rejected the view that the obligation on an insurer is to “hold harmless” the policyholder so that it cannot therefore be required to pay damages, preferring instead to hold that the insurer has an obligation to pay a valid claim once it has had the opportunity to investigate its validity.⁸⁵ This is also the position in Australia, Canada and the United States.⁸⁶

⁷⁹ *Hadley v Baxendale* (1845) 156 ER 145.

⁸⁰ The UK House of Lords decision in *President of India v Lips Maritime Corp* [1988] AC 395, 495 is authority for the proposition that there “is no such thing as a cause of action in damages for late payment of damages.” This reasoning was applied by the English High Court (Hirst J) in *Ventouris v Mountain (The Italia Express) (No.2)* [1992] 2 Lloyd’s Rep 281.

⁸¹ Campbell “The nature of an insurer’s obligation” [2000] LMCLQ 42. The paper largely argues that such a concept of the insurer’s obligation, although largely accurate in relation to liability insurance, is misconceived in relation to property insurance.

⁸² Law Commission of England and Wales and Scottish Law Commission *Insurance Contract Law: Business Disclosure; Warranties; Insurers’ Remedies For Fraudulent Claims; and Late Payment* (Law Com No.353/Scot Law Com No.238, 2014) paragraph 25.8 and see pages 249 to 302 for a general discussion.

⁸³ [1999] 1 Lloyd’s Rep. 111.

⁸⁴ [2001] IEHC 144.

⁸⁵ See *Strachan v Scottish Boatowner’s Mutual Insurance Corporation* [2010] SC 367 and Law Commission of England and Wales and Scottish Law Commission *Consultation Paper on Insurance Contract Law: Post Contract Duties and other Issues* (Law Com No. 201/Scot Law Com No. 152, 2011) paragraphs 2.65-2.66 for a detailed discussion.

⁸⁶ Law Commission of England and Wales and Scottish Law Commission *Issues Paper 6 on Damages for Late Payment* (March 2010) Appendix A.

(b) Consequential non-pecuniary loss is also not recoverable under current law

8.71 As to the separate question of consequential non-pecuniary loss, which is also not recoverable under current law, if general contract law rules concerning remoteness of damages were to be applied these would influence a decision on what could (or should) be recoverable.

In the case of property insurance, which may be described as a purely commercial contract, a policyholder is unlikely to recover damages for mental distress arising out of the manner in which an insurer has made a late payment or wrongly rejected such a claim.

Where, however, the contract in question has a predominantly non-commercial purpose or no significant economic dimension to it – holiday insurance for instance – damages for stress and disappointment may be recoverable.

Furthermore, if the contract is one in which the plaintiff can be said to have sought relief from a stressful situation, or contracted for a professional service aimed at ameliorating some of the unfortunate events that attend human experience, remoteness of damage principles may not be a bar to recovery.⁸⁷

(c) United Kingdom

8.72 In their 2014 Report,⁸⁸ the Law Commission of England and Wales and Scottish Law Commission concluded that the decision in *Sprung v Royal Insurance Co Ltd*⁸⁹ should no longer be applied and recommended that where an insurer has failed to pay a claim within a reasonable time it should be liable in damages for any foreseeable loss which results. This entitlement would be in addition to and distinct from: (a) any right to enforce payment of the sums due, and (b) any right to interest on those sums (whether under the contract, under another enactment, at the court's discretion or otherwise).

The Commissions recommended that the proposals should be mandatory for personal consumers, and set as a default regime for non-consumer insurance contracts, subject to contracting out.

The Law Commissions indicated that some consultees were concerned that these proposals would lead to (1) an increase in the cost of insurance; (2) uncertainty in an industry where accurate auditing and future planning are paramount, particularly in light of the 2009 EU "Solvency II" Directive⁹⁰); and (3) the opening of floodgates to speculative claims and in particular what they termed US-style "bad faith actions."⁹¹

8.73 The Commissions concluded that the number of these types of claim would be small, because of (1) the restrictions in their proposal, set out above, and (2) what they considered to be increased regulatory focus on claims handling under the Solvency II Directive. They emphasised that the proposal did not facilitate the introduction of consultees' feared "bad faith" actions. Nonetheless, while many

⁸⁷ *Hamilton Jones v David & Snape* [2004] 1 All ER 657.

⁸⁸ Law Commission of England and Wales and Scottish Law Commission Report *Insurance Contract Law: Business Disclosure; Warranties; Insurers' Remedies For Fraudulent Claims; and Late Payment* (Law Com No.353/Scot Law Com No.238, 2014) paragraphs 26.30-26.53. See Hertzell and Burgoyne "The Law Commissions and insurance contract law reform: an update" (2013) 19 JIML 105, 117 for an overview of the Law Commissions' proposals following the conclusion of the second and third joint consultations. See also Goodliffe "Late payment of insurance claims: a legal or a regulatory issue?" 123 BILA 23; Mendelowitz and Goodliffe "Damages For Late Payment and the Insurer's Duty Of Good Faith: BILA Views" 19.

⁸⁹ [1999] 1 Lloyd's Rep 111.

⁹⁰ As noted in Appendix C, below, the principal focus of the 2009 "Solvency II" Framework Directive, 2009/138/EC (which consolidates with amendments 13 Life and Non-Life Directives), is on general regulatory issues such as the right of establishment and solvency requirements for insurance undertakings. The 2009 Directive comprises 312 Articles, of which only Articles 183 to 186 impose contract-related provisions under the Heading "Information for Policyholders" in respect of life and non-life insurance.

⁹¹ Law Commission of England and Wales and Scottish Law Commission *Insurance Contract Law: Business Disclosure; Warranties; Insurers' Remedies For Fraudulent Claims; and Late Payment* (Law Com No.353/Scot Law Com No.238, 2014) paragraphs 26.43-26.45.

recommendations in the 2014 Report were implemented in the UK *Insurance Act 2015*, the recommendation on damages for late payments was not.

(d) Principles of European Insurance Contract Law (PEICL)

8.74 The authors of the PEICL drafted a clause that would govern late or delayed or withheld payment of a claim. Article 6:105(1) describes the consequences of late payment or late performance as follows:

“If insurance money is not paid in accordance with Article 6:104, the claimant shall be entitled to interest on that sum from the time when payment was due to the time of payment and at the rate applied by the European Central Bank to its most recent main refinancing operation carried out before the first calendar day of the half-year in question, plus seven percentage points.”

Article 6:105(1) provides for interest. In the comments that accompany the clause the authors of PEICL note that it was inspired by article 4(6) of Directive 2000/26/EC, the Fourth Motor Insurance Directive, which was implemented in Ireland by Regulation 4(8) of the *European Communities (Fourth Motor Insurance Directive) Regulations 2003*.⁹²

Article 4(6) provides that Member States are obliged to require insurers “to make a reasoned offer of compensation in cases where liability has not been contested and the damages have been quantified” within three months of the date when the injured party presented his claim for compensation. If this requirement is not complied with, insurers must pay the claimant interest.

Alternatively an insurer must “provide a reasoned reply to the points made in the claim in any case where liability is denied, or has not been clearly determined, or the damages have not been fully quantified”.

8.75 Regulation 9 of the 2003 Regulations provides that an insurance undertaking or claims representative that fails to comply with Regulation 4(8) commits an offence under Regulation 59 of the *European Communities (Non-Life Insurance) Framework Regulations 1994*.⁹³

Regulation 10 of the 2003 Regulations provides that the interest rate specified for the time being under section 26 of the *Debtors (Ireland) Act 1840*, as varied from time to time pursuant to section 20 of the *Courts Act 1981*, is payable by an insurance undertaking on any sum awarded to an injured party from the day on which the breach occurred.

8.76 The authors of the PEICL concluded that the interest rate should be calculated by reference to the European Central Bank (ECB) main financing rate, which is also the rate prescribed by Directive 2011/7/EC, the Directive on Late Payment in Commercial Transactions. The 2011 Directive was implemented by the *European Communities (Late Payment in Commercial Transactions) Regulations 2012*,⁹⁴ which provide that, unless otherwise specified in a contract, the interest rate payable for late payments is 8% above the ECB rate.

8.77 Article 6:105(2) of PEICL then provides:

“The claimant shall be entitled to recover damages for any additional loss caused by late payment of the insurance money.”

This Article was inserted to acknowledge that “statutory” interest alone may not be sufficient to indemnify claimants against the consequences of late payment of insurance money due. For example:

“[w]hen motor insurers or fire insurers delay payment, and a claimant urgently needs the money to buy another van for the business to replace the one stolen or to repair the fire

⁹² SI No.651 of 2003.

⁹³ SI No.359 of 1994 as amended.

⁹⁴ SI No.580 of 2012. The 2012 Regulations revoked and replaced the *European Communities (Late Payment in Commercial Transactions) Regulations 2002* (SI No.388 of 2002), which had implemented the previous Directive on Late Payments, Directive 2000/35/EC, and which was repealed and replaced by Directive 2011/7/EC.

damage to the factory, subject to the normal legal limits, the insurer in question should be liable for the consequences. The same is true when an insurer has exercised a policy option not to pay insurance money as such but to have property, which is the subject of the insurance, reinstated or otherwise to provide services”.⁹⁵

The argument advanced by the authors of PEICL was that “[i]f insurers fail to do what they have promised to do without undue delay, commercially and legally their liability is the same as that of any other contract breakers: dealers that have failed to supply a van or contractors who have failed to repair a factory roof”.⁹⁶

The authors of PEICL decided that the liability described in Article 6:105(2) was not a liability particular to insurance contract law but one that was in accordance with the liability attributed in general contract law.

That liability was also set out in Article 9:508 of the PEICL, which states that the claimant is entitled to interest where there is a delay in the payment of money, and the aggrieved party may in addition recover damages for any further loss so far as these are recoverable under PEICL.

Article 9:502 of PEICL states that the general measure of damages is “such sum as will put the aggrieved party as nearly as possible into the position in which it would have been if the contract had been duly performed” and is intended to cover the loss which the aggrieved party has suffered and the gain of which it has been deprived.

Article 9:503 of PEICL, which deals with foreseeability of the breach, states that the non-performing party is liable only “for loss which it foresaw or could reasonably have foreseen at the time of conclusion of the contract as a likely result of its non-performance, unless the non-performance was intentional or grossly negligent.” These provisions are broadly comparable to the common law approach in Ireland to damages for breach of contract.

(e) Conclusion and Recommendation

8.78 Lord Mance commented in 2011 that both parties to an insurance case would reasonably see the real obligation of an insurer as the paying of a valid claim after a reasonable period for investigation.⁹⁷

The current law, which prevents a consumer from making a claim for general or consequential non-pecuniary damages against an insurer who unreasonably withholds payment or unreasonably declines payment, would therefore appear to defeat the reasonable expectations of the parties to an insurance contract.

This is reinforced by the fact that this approach is in conflict with general contract law rules for recovery of damages, and is based on the legal fiction (which has been abandoned in many other jurisdictions) that an insurer’s primary obligation is no more than to “hold the insured harmless” against the insured peril.

The Commission has therefore concluded that this bar to recovery of damages should be replaced by a rule that is consistent with general contract law rules, which already set out well-understood boundaries as to what is recoverable by way of general damages and for other consequential non-pecuniary loss including, where relevant, damages for stress. This rule is in addition to any entitlement under existing law to interest for late payment of sums due, as set out in the *European Communities (Fourth Motor Insurance Directive) Regulations 2003*⁹⁸ and the *European Communities (Late Payment in Commercial Transactions) Regulations 2012*.⁹⁹

⁹⁵ Basedow et al (eds), *Principles of European Insurance Contract Law* (Sellier, 2009) at 220 paragraph C2.

⁹⁶ *Ibid.*

⁹⁷ Mance “The 1906 Act, Common Law and Contract Clauses - All in Harmony?” (2011) 3 LMCLQ 349.

⁹⁸ SI No. 651 of 2003: see paragraph 8.74, above.

⁹⁹ SI No.580 of 2012: see paragraph 8.76, above.

8.79 The Commission recommends that where an insurer unreasonably withholds payment of a valid claim or unreasonably delays in making a payment under a valid claim, the consumer may, in addition to the right to enforce payment of the sums due and any right to interest on those sums, seek damages in accordance with the general law of contract for any consequential loss suffered, including non-pecuniary loss such as stress.

(4) Fraudulent Claims

8.80 In the discussion of pre-contractual misrepresentation in Chapter 3, the Commission has acknowledged the importance of ensuring that strong measures are in place to discourage fraud. This applies equally at the post-contractual stage where there is a clear risk that fraudulent claims may be made. As in the pre-contractual context the test for post-contractual fraudulent claims is the test identified by the House of Lords in *Derry v Peek*,¹⁰⁰ and it has been applied in a number of Irish cases.¹⁰¹ The consequence of making a fraudulent claim is avoidance and the consumer also forfeits the claim under the insurance contract.¹⁰²

8.81 In *Superwood Holdings Plc v Sun Alliance and London Insurance Plc*¹⁰³ the Supreme Court affirmed the long-established approach that, bearing in mind the opprobrium that attaches to a finding of fraud, the onus of proving fraud rests on the insurer; and that where proof of fraud is largely a matter of inference, this must not be drawn lightly or without due regard to all the circumstances, including the consequences of a finding of fraud.

In *Michovsky v Allianz Ireland Plc*,¹⁰⁴ in which the plaintiffs claimed under a fire policy for the complete destruction of a house, the defendant insurer repudiated liability on the ground that the fire had been started deliberately by the plaintiffs. This was vigorously denied by the plaintiffs. The High Court (Kearns J) applied the test set out in the *Superwood Holdings* case and, having regard to detailed forensic evidence indicating that a boiler had been tampered with, and that a ladder had been placed against the window of the plaintiffs' bedroom on the night before the fire, the Court concluded that it could infer from the evidence that the claim was fraudulent.

While the onus of proof thus rests on insurers, Corrigan comments that Irish courts have been "quite supportive of insurers adopting firm stances in specific situations, this being particularly so in the area of fraud" and that "[i]nsurers in Ireland have a very good success rate in defeating fraudulent claims presented by policyholders".¹⁰⁵

8.82 A more difficult problem arises where the courts deal with fraud in connection with grossly exaggerated claims. Some such claims clearly fall within the category of fraud. For example, in *Fagan v General Accident Fire and Life Assurance Corp Plc*¹⁰⁶ the plaintiff had claimed for losses sustained under a fire policy. The Supreme Court agreed with the view of the High Court (Murphy J) that the evidence established that plaintiff had deliberately over-stated losses for a number of items and that the defendant was therefore entitled to repudiate liability.

¹⁰⁰ (1889) 14 App Cas 337.

¹⁰¹ For example, by the Supreme Court in *Superwood Holdings Plc v Sun Alliance & London Insurance Plc* [1995] 3 IR 303 and in *Fagan v General Accident Fire and Life Assurance Corp Plc* [1998] IESC 27; and by the High Court in *Michovsky v Allianz Ireland Plc* [2010] IEHC 43 (discussed below) and in *McAleenan v AIG (Europe) Ltd* [2010] IEHC 128 (discussed in Chapter 3, above).

¹⁰² Pre-contractual fraudulent misrepresentation renders an insurance contract void *ab initio*: see Chapter 2, above.

¹⁰³ [1995] 3 IR 303, which approved the views of Finlay CJ in *Banco Ambrosiano SpA v Ansbacher & Co* [1987] IRLM 669.

¹⁰⁴ [2010] IEHC 43.

¹⁰⁵ Corrigan "Developments in Irish Insurance Law: 'The Last 25 Years – A General Overview'" in *Landmarks in Insurance 1985-2010* (Insurance Institute of Ireland, 2010) Chapter 9, at 56.

¹⁰⁶ [1998] IESC 27.

Nonetheless, as Blayney J pointed out in the Supreme Court in the *Superwood Holdings* case, exaggeration is “not conclusive evidence of fraud.”

(a) Conclusions and Recommendations

(i) Defining Fraud

8.83 In Chapter 3, the Commission recommended that, in the pre-contractual setting, fraud should be defined as involving a misrepresentation which is false or misleading in any material respect and which the consumer either (a) knows to be false or misleading or (b) consciously disregards whether it is false or misleading. This definition excludes inadvertent misrepresentations that currently fall within the definition of fraud in *Derry v Peek* but which the Commission considers are more accurately categorised as involving negligence.

The Commission considers that, in the post-contractual setting, this proposed definition is equally appropriate because, first, it captures the type of fraud that may, as is required in most cases, be inferred from the circumstances of a claim. Second, it allows the courts to ensure that exaggeration that falls short of fraud can be correctly categorised as, at worst, negligence, thus giving rise to a suitable proportionate remedy rather than a complete dismissal of a claim; and, more often, as a bargaining position that falls well outside any attempt to defraud.

8.84 In this context, the Commission considers that section 26 of the *Civil Liability and Courts Act 2004*, discussed in Chapter 3 above, also provides a useful statutory analogy. Section 26 provides that where a plaintiff has deliberately given false or misleading evidence, in any material respect, the court must dismiss the case unless a dismissal would cause an injustice. In *Carmello v Casey*¹⁰⁷ the High Court (Peart J) commented that:

“Section 26 was introduced by the Oireachtas for the very clear purpose of avoiding injustice to, *inter alios*, defendants against whom false or exaggerated claims are mounted in the hope of recovering damages to which such plaintiffs are not entitled. Such actions are also an abuse of the process of the court. It has always been a very serious criminal offence to knowingly give false evidence under oath. The proof of such an offence is required to be beyond a reasonable doubt. This court is not so constrained and makes its finding on the balance of probability. The section is certainly of a draconian nature, but it is deliberately so in the public interest, and is mandatory in its terms, once the court is so satisfied on the balance of probability, unless to dismiss the action would result in injustice being done.”¹⁰⁸

In *Dunleavy v Swan Park Ltd*¹⁰⁹ the High Court (O’Neill J), faced with a number of particular anomalies in the plaintiff’s claim, sought from and subsequently accepted the plaintiff’s explanation at face value. The Court noted that section 26 of the 2004 Act:

“is there to deter and disallow fraudulent claims. It is not and should not be seen as an opportunity to seize upon anomalies, inconsistencies and unexplained circumstances to avoid a just liability. Great care should be taken to ensure in a discriminating way that clear evidence of fraudulent conduct in a case exists before a formal defence is launched which could unjustly do grave damage to the good name and reputation of a worthy plaintiff.”

8.85 The Commission has therefore concluded that, as in the pre-contractual context, fraud should be defined at the post-contractual stage to refer to intentional or consciously reckless claims, with the consequence that the insurer can fully repudiate the claim. Consequently, negligent or careless claims should be dealt with under the proportionate remedies discussed below.

¹⁰⁷ [2007] IEHC 362; [2008] 3 IR 524, 539-540.

¹⁰⁸ See also *Farrell v Dublin Bus* [2010] IEHC 327 at 15, where Quirke J commented that section 26 had been enacted “in order to discourage false and exaggerated claims, and to express the community’s disapproval of such dishonest behaviour.”

¹⁰⁹ [2011] IEHC 232.

8.86 The Commission recommends that where a claim made by a consumer under a contract of insurance contains information that is false or misleading in any material respect and which the consumer either (a) knows to be false or misleading or (b) consciously disregards whether it is false or misleading, the insurer should be entitled to refuse to pay the claim and should be entitled to terminate the contract.

8.87 This general recommendation on the scope of post-contractual fraud leads to the following specific points.

(ii) Whether a later fraudulent claim should affect previous genuine claims made under the same policy.

8.88 Forfeiture of a claim (rather than avoidance of the contract) does not allow a valid claim made under a valid policy to be undermined by subsequent events.

The common law, as codified in section 17 of the *Marine Insurance Act 1906*, gives an insurer the right to avoid the contract in the event of a breach of the duty of good faith. This possibly entitles an insurer to refuse to honour the claim but also to recover from the policyholder any sums paid out on a previous genuine claim.

8.89 It is undesirable to allow an insurer to avoid a policy from its inception based on events that have occurred sometime after inception and to require the policyholder to account for any valid claims made prior to a fraudulent claim.

The Law Commission of England and Wales and Scottish Law Commission concluded that “[a]voidance of past claims is unprincipled and impractical, and appears unnecessarily harsh. Instead, valid past claims should be unaffected by a subsequent fraud. This reflects the approach already taken by the courts and by good market practice.”¹¹⁰

8.90 Following the Law Commissions’ analysis, section 12(1)(a) and (b) of the UK *Insurance Act 2015* provide that if the insured makes a fraudulent claim under a contract of insurance, then: (a) the insurer is not liable to pay the claim and (b) the insurer may recover from the insured any sums paid by the insurer to the insured in respect of the claim.

The UK 2015 Act thus provides that where a policyholder makes a fraudulent claim under a contract of insurance, the insurer does not have to honour the claim and the insurer may recover from the policyholder any sums paid by the insurer to them in respect of that particular claim. There is no facility to claw back previous genuine claims. However, as the Law Commissions explained, this does not preclude insurers from investigating past claims on the basis that they may have been fraudulent but the fraud had gone undetected.¹¹¹

The Commission considers that this matter should be clarified to preclude subsequent fraud affecting previous valid claims.

8.91 The Commission recommends that a valid claim made under an insurance contract should not be affected where, under the same contract, the consumer makes a subsequent fraudulent claim or where fraudulent evidence or information is submitted or adduced in support of the subsequent claim.

¹¹⁰ Law Commission of England and Wales and Scottish Law Commission Consultation Paper *Insurance Contract Law: Post Contract Duties and Other Issues* (Law Com No. 201/Scot Law Com No. 152, 2011) paragraph 7.16.

¹¹¹ *Ibid* paragraphs 7.10-7.12. This approach was confirmed in their 2014 Report *Insurance Contract Law: Business Disclosure; Warranties; Insurers’ Remedies For Fraudulent Claims; and Late Payment* (Law Com No.353/Scot Law Com No.238, 2014).

(iii) Whether a fraudulent claim renders the contract void from the date a fraudulent claim is made, and therefore invalidates any subsequent claim under the contract

8.92 The Law Commission of England and Wales and Scottish Law Commission explored the correlative issue as to whether a fraudulent claim renders the contract void from the date a fraudulent claim is made, and therefore invalidates any subsequent claim under the contract. In their Issues Paper 7 they provisionally proposed that valid claims arising between the date of fraud and the termination should be paid, in accordance with normal contract principles whereby termination brings a contract to an end.

Following substantial criticism the Commissions were persuaded in their subsequent Consultation Paper that the common market practice is to deny subsequent claims, and that insurers frequently included express policy terms to this effect which have been upheld by the courts.¹¹²

They proposed that “a fraudster should not only forfeit the claim to which the fraud relates but also all subsequent claims,”¹¹³ but qualified this by stating that where an insurer “had knowledge of fraud but took no action, this constitute a waiver of the right to refuse subsequent claims”.¹¹⁴

This analysis is also now reflected in section 12 of the UK *Insurance Act 2015* and it is convenient for this purpose to set out in full section 12 which provides:

“(1) If the insured makes a fraudulent claim under a contract of insurance—

- (a) the insurer is not liable to pay the claim,
- (b) the insurer may recover from the insured any sums paid by the insurer to the insured in respect of the claim, and
- (c) in addition, the insurer may by notice to the insured treat the contract as having been terminated with effect from the time of the fraudulent act.

(2) If the insurer does treat the contract as having been terminated—

- (a) it may refuse all liability to the insured under the contract in respect of a relevant event occurring after the time of the fraudulent act, and
- (b) it need not return any of the premiums paid under the contract.

(3) Treating a contract as having been terminated under this section does not affect the rights and obligations of the parties to the contract with respect to a relevant event occurring before the time of the fraudulent act.

(4) In subsections (2)(a) and (3), “relevant event” refers to whatever gives rise to the insurer’s liability under the contract (and includes, for example, the occurrence of a loss, the making of a claim, or the notification of a potential claim, depending on how the contract is written).”

8.93 The Explanatory Notes accompanying the 2015 Act, in dealing with the effect of the insurer’s notice to the policyholder under section 12(1)(c) to treat the contract as terminated with effect from the time of the “fraudulent act,” state:

“The “fraudulent claim” is to be distinguished from the “fraudulent act”. The latter is intended to be the behaviour that makes a claim fraudulent, which may be after the initial submission of the claim. The timing of the “fraudulent act” is relevant in determining when the liability of the insurer ceases for the purposes of [section 12](1)(c) [of the 2015 Act]. For example, if an

¹¹² *Joseph Fielding Properties v Aviva Insurance* [2010] EWHC 2192, [2011] Lloyd’s Rep IR 238.

¹¹³ Law Commission of England and Wales and Scottish Law Commission Consultation Paper *Insurance Contract Law: Post Contractual Duties and Other Issues* (Law Com No. 201/Scot Law Com No. 152, 2011) paragraph 7.24

¹¹⁴ *Ibid* paragraph 7.25. This approach was confirmed in their *Report on Insurance Contract Law: Business Disclosure; Warranties; Insurers’ Remedies For Fraudulent Claims; and Late Payment* (Law Com No.353/Scot Law Com No.238, 2014).

insured submits a genuine claim in January and adds a fraudulent element in March (for example, adding an additional, fabricated, head of loss), the “fraudulent act” takes place in March. This is the point at which the contract may be treated as having been terminated, and from which the insurer’s liability ceases.”¹¹⁵

Thus, section 12(1)(c) of the 2015 Act entitles the insurer to refuse all liability owed to the policyholder under the contract in respect of a “relevant event” occurring after the time of the fraudulent act, and an insurer need not return any of the premiums paid. The “relevant event”, as defined in section 12(4) of the 2015 Act, refers to any event that would trigger the insurer’s liability under the particular insurance contract. The Explanatory Notes explain that “[u]sually, this will be the occurrence of loss or damage which is insured under the contract.”¹¹⁶

8.94 Because fraud undermines the relationship of trust and confidence between contracting parties the Commission considers that there must be a consequence for fraudulent claims arising from insurance contracts.

The remedy of avoidance (treating a contract as void and of no effect) is *inter alia* intended to give effect to the historically acknowledged requirement that fraudulent conduct must be deterred.

The Commission has earlier¹¹⁷ recommended that insurers should continue to be entitled to avoid (that is, treat as *void ab initio*) an insurance contract where a consumer proposer makes a fraudulent pre-contractual misrepresentation.

The Commission considers that an insurer should be entitled to avoid (that is, treat as void and of no effect) an insurance contract with immediate effect from the commission of a fraudulent act (for example, the submission of a claim that a consumer knows or ought to know is fraudulent).

However, as provided for in section 12(3) of the UK 2015 Act, and reflected in the immediately preceding recommendation in this Report, valid claims made before the commission of the fraudulent act should be met because a valid contract then subsisted.

8.95 As soon as is reasonably practicable after the insurer has become aware of the commission of the fraudulent act (that is, the submission of the fraudulent claim) the insurer should notify the offender (that is, the insured consumer) that the contract has been avoided (rendered void) and terminated with effect from the date of the fraudulent act (that is, the date of submission of the fraudulent claim).

In consequence the contract should be deemed void with effect from the date of commission of the fraudulent act (that is, the date of the submission of the fraudulent claim). Thereafter no insurance contract should be deemed to exist between the parties so that no further claims (including valid claims) should be submitted or entertained on foot of the contract.

However, should an insurer become aware of the commission of a fraudulent act but fail to notify the insured consumer of the avoidance and termination of the contract as soon as is reasonably practicable, the insurer should be deemed to have waived its right of avoidance and should not be entitled to avoid the contract (but would be entitled to any other available lawful remedies).

¹¹⁵ Explanatory Notes to the Insurance Bill as introduced in the House of Commons on 15 January 2015, paragraph 103. The House of Commons made no amendments to the Bill as passed by the House of Lords, so that these Notes reflect the text of the *Insurance Act 2015* as enacted.

¹¹⁶ Explanatory Notes to the Insurance Bill as introduced in the House of Commons on 15 January 2015, paragraph 105. The House of Commons made no amendments to the Bill, so these notes reflect the text of the 2015 Act as enacted.

¹¹⁷ See paragraph 3.131, above.

8.96 The Commission recommends that where an insurer becomes aware that a consumer has made a fraudulent claim it may, as soon as is practicable after becoming aware of that fact, notify the consumer in writing that it is avoiding the insurance contract; and if the insurer so notifies the consumer, the insurance contract will be treated as having been terminated with effect from the date of the submission of the fraudulent claim (referred to as “the date of the fraudulent act”), whereupon (a) the insurer may refuse all liability to the consumer under the insurance contract in respect of any claim made after the date of the fraudulent act, and (b) the insurer need not return any of the premiums paid under the insurance contract.

(iv) Whether the insurer can sue the consumer for damages to recover the cost of investigating a fraudulent claim.

8.97 The High Court decision in *Car and General Insurance Corp Ltd v Munden*¹¹⁸ provides some authority for the view that an admission of liability given by a policyholder, to the prejudice of the insurer, can give rise to liability in damages. However, alleged breaches by a policyholder of good faith obligations have not resulted in any damages awards in the English or Irish courts.

The Law Commission of England and Wales and Scottish Law Commission have commented that “the legal position appears to be that an insurer cannot claim damages for the reasonable and foreseeable costs of investigating a fraudulent claim. However, the possibility of damages for deceit remains.”¹¹⁹ They queried whether damages should be available to insurers to cover the reasonable costs of investigating a fraudulent claim. It was considered that this approach would convey an effective anti-fraud message as well as compensating insurers for expensive investigations.

8.98 In their 2014 Report, which contained their final analysis of the issue, they concluded that such a requirement would have little effect.¹²⁰ In particular it was argued that it would be difficult to assess the costs of the investigations where they were carried out internally. Insurers could, in a bid to ensure the court would side with them, outsource the investigation to third parties so that they could produce a detailed transparent breakdown of the costs. This approach would add to the expense of the investigation and in turn this expense would be passed on to policyholders by way of increased premiums.

These types of costs are an “inherent cost” of an insurer’s business and in any event in many cases policyholders will not be in a position to pay these costs. They also considered it significant that there had been “no major attempts by insurers to bring claims in deceit, nor any industry moves to include express terms in contracts to the effect that costs are recoverable in the case of a fraud investigation. Both of these options are already available to insurers.”¹²¹

The Commission agrees with these conclusions.

8.99 The Commission recommends that an insurer should not be empowered to claim against the consumer to recover the cost of investigating a fraudulent claim.

(5) Innocent co-insureds

8.100 Policyholders who intentionally damage or destroy their insured risk are not entitled to recover under their insurance contracts. However, where two or more policyholders are insured under the same policy and only one of them acts fraudulently, the question of whether the innocent co-insured policyholder can claim under the policy depends on the nature of both parties’ interests.

¹¹⁸ [1936] IR 584.

¹¹⁹ See Law Commission of England and Wales and Scottish Law Commission Consultation Paper *Insurance Contract Law: Post Contract Duties and Other Issues* (Law Com No. 201/Scot Law Com No. 152, 2011) paragraph 6.58.

¹²⁰ Law Commission of England and Wales and Scottish Law Commission Report *Insurance Contract Law: Business Disclosure; Warranties; Insurers’ Remedies For Fraudulent Claims; and Late Payment* (Law Com No.353/Scot Law Com No.238, 2014) paragraphs 22.28 to 22.31.

¹²¹ *Ibid* at paragraph 22.30.

The type of interest held determines whether the actions of one policyholder can be attributed to the co-insureds, thereby tainting the entire claim under the policy.¹²²

Where the interests are jointly held a wrongful or fraudulent act committed by one policyholder entitles the insurer to avoid the policy against all of the parties to the policy. Where the interests are separately held, that is, a “composite” policy, each policyholder has a right to enforce the policy in his or her own name and any claim made will generally not be affected by any fraud perpetrated by the (fraudulent) policyholder. Whether a policy is joint or composite is a matter of interpretation.¹²³

The distinction is particularly important for spouses who by the nature of their relationship usually hold a joint interest in their dwelling. This has proved particularly difficult where one spouse has intentionally destroyed property without the knowledge of the other.

(a) The “traditional” or “old” rule

8.101 Essentially what is known as the “traditional” or “old” rule focuses on the nature of the property ownership as a means for determining whether the interests are joint or composite. Where property ownership was regarded as joint, the contract was presupposed to be joint and the property interests were rendered indivisible. The general idea was that a wrongdoer should not benefit from their wrong.

8.102 In *Direct Line Insurance Plc v Khan*,¹²⁴ a husband and wife were joint policy holders under a home and contents insurance policy. Following a fire the husband filed an exaggerated claim, in particular for the expense of staying in rental accommodation when in fact he owned the rental property. Mrs Khan was not a party to her husband’s fraud. The English Court of Appeal held that her claim was not severable from her husband’s fraud, and that her husband acted as her agent and she was his principal.¹²⁵

The consequence of this approach is that the wrongdoer’s fraud is imputed to their innocent co-insured. This is not consistent with general principles of law which provide that a partner’s criminal conduct is not attributable to their innocent partner solely by virtue of the nature of their relationship, nor is such conduct by a joint owner attributable to a co-owner. If criminal liability is several and separate, then why should the civil aspect be considered joint?¹²⁶

¹²² Swaby “Blurring distinctions: Should innocent insureds be tarred with the same brush as their fraudulent agents?” (2013) 24 Insurance Law Journal; Tetley “Personal Responsibility for Intentional Conduct: Protecting the Interests of innocent Co-Insureds Under Insurance Contracts” (2013) 50 Alberta Law Review 615.

¹²³ *McAleenan v AIG (Europe) Ltd* [2010] IEHC 128 provides a detailed examination of the methodology involved in determining whether a policy is joint or composite. See also Buckley *Insurance Law* 3rd ed (Thomson Round Hall 2012) paragraph 6-73, who comments that the effect of the breach of the duty of good faith by one policyholder on a co-insured depends on the type of interest held.

¹²⁴ [2001] EWCA Civ 546, [2001] EWCA Civ 1794, [2001] All ER (D) 476.

¹²⁵ See also *Parker v National Farmers Union Mutual Insurance Society Limited* [2012] EWHC 2156 (Comm), [2013] Lloyd’s Rep IR 253 where the English High Court held that the husband’s and wife’s interests in a property were not joint, and therefore Mrs Parker’s insurance claim was not tainted by Mr Parker’s fraud or arson. However her claim was rejected on other grounds.

¹²⁶ Article 11:103 of the PEICL provides: “Breach of duty by one insured shall not adversely affect the rights of other persons insured under the same insurance contract, unless the risk is jointly insured.” The accompanying commentary, Basedow et al (eds), *Principles of European Insurance Contract Law* (Sellier, 2009) at 271 paragraph C12, states that the exception covers the situation where the interest insured is vested in more than one insured person, for example, a husband and wife. It was submitted that in “such situations the limitation of the effects of a breach by one insured to this person cannot be put into effect because the legal rules applicable to the legal relation between that insured and the other insureds do not admit any separate affection.” This appears to offer no relief for the innocent co-insured who is party to a joint policy.

(b) The “modern approach”

8.103 Case law from a number of jurisdictions, including Australia, Canada and New Zealand, demonstrates a move away from the old rule described above.¹²⁷ This responds to a growing recognition that the absolute bar to recovery dictated by the old rule produced harsh and inequitable results. The modern approach, as it has since been described, directs the court’s attention to the language of the insurance contract rather than to concepts of property law.

8.104 In the Canadian case, *Higgins v Orion Insurance Co Ltd*,¹²⁸ the Ontario Court of Appeal held that the starting position is that the policy is composite and if parties intend the policy to be joint they must use plain unambiguous language.¹²⁹

It follows that where there is no ambiguity in the contract the courts are unable to ascribe a meaning other than that which was clearly expressed by the terms. This was demonstrated to devastating effect by the majority decision of the Supreme Court of Canada in *Scott v Wawanesa Mutual Insurance Co*,¹³⁰ where the parents of a teenage son who deliberately burned down the family home were unable to claim under their policy as it clearly held them to be “co-insureds,” along with their son, and therefore it was unnecessary for the Court to discuss the issue of the modern approach.

8.105 Nonetheless, it is worth setting out the analysis of La Forest J in his minority dissenting opinion, in which he considered the parents had not taken out fire insurance to insure their son’s possessions but to protect their house. He considered it to be both unrealistic and unreasonable to assume that the named insured would view the indemnification obligation of the insurer as joint because their son’s possessions were included. He added:

“reasonable persons, unversed in the niceties of insurance law, would, in purchasing fire insurance, expect that a policy naming them as an insured without qualification would insure them to the extent of their interest. Moreover, reasonable persons would expect that they would lose the right to recover for their own wilful destruction. But the same persons would find it an anomalous result if informed that they stood to lose all if their spouse burned down their house. The following responses would be forthcoming: ‘I had nothing to do with that act of arson so why am I being punished for it? My 50 per cent interest in the house belongs to me. I could have taken out my own insurance policy on my interest; in that case if my spouse burnt down the house I was protected. Why should my getting paid depend on whether there is one policy or two? If it had been made clear to me, why would I have ever agreed to take out a ‘joint’ policy? I only stood to lose.’ ”

8.106 The Law Commission of England and Wales and Scottish Law Commission criticised the modern approach for being result-oriented rather than proceeding on the basis of what the contract actually means. They considered that it works backwards in that the courts decide what result they wish to reach in the circumstances and characterise the policy as joint or composite accordingly.¹³¹ They

¹²⁷ See Law Commission of England and Wales and Scottish Law Commission *Issues Paper 7 on The Insured’s Post-contract Duty of Good Faith* (July 2010) at paragraphs 5.26 to 5.34; and Swaby “Blurring distinctions: Should innocent insureds be tarred with the same brush as their fraudulent agents?”(2013) 24 Insurance Law Journal 60 at 75-78.

¹²⁸ (1985) 17 DLR (4th) 90.

¹²⁹ The insured parties were partners in a business where they jointly insured the premises and contents. Unknown to one party, the other fraudulently conspired to commit arson against the premises and its contents. The court held that partner liable, but with a caveat that, while the courts should do justice to the innocent, there was a need to guard against the fraudster receiving an indirect benefit.

¹³⁰ [1989] 1 SCR 1445.

¹³¹ Law Commission of England and Wales and Scottish Law Commission *Issues Paper 7 on The Insured’s Post-contract Duty of Good Faith* (July 2010) at paragraph 5.46.

considered that whether a policy is joint or composite depends on its construction, judged in the light of circumstances at the time the contract is formed, and is not affected by later events.¹³²

(c) A rebuttable presumption

8.107 The Law Commission of England and Wales and Scottish Law Commission initially proposed that a rebuttable presumption should apply to joint policies so that any fraud committed by one co-insured should be presumed to be committed by all parties. The innocent policyholders would then have to demonstrate that they were not party to the fraud in order to recover their loss.¹³³ However this was qualified to the effect that the court must take care to prevent the guilty party from reaping a financial reward from their misconduct.¹³⁴

8.108 In the Consultation Paper that followed, the Commissions referred to consultees who had queried whether the courts would be able to distinguish between cases where co-insureds acted together and cases where their interests were no longer aligned. While the Commissions' initial proposal had recommended that the recovery should be limited to the innocent insured's own interest, consultees argued that it would be difficult to value the innocent party's share, particularly where the co-insureds were married.

Another objection outlined that these claims are not actually fraudulent. The innocent co-insured is not responsible for the destruction of the property, so the exclusion of their claim would likely be policy-based with a clause to the effect that "the insurer is not liable to pay if one of the insured parties, or a friend or family member, brings about the loss or damage intentionally."

The Commissions concluded that "[d]isapplying the statutory remedies for fraud would therefore make no difference because it is a coverage issue"¹³⁵ and that legislative reform was inappropriate in circumstances where there had received almost no evidence from consultees that these cases are a problem.

(d) Proportionate Interest

8.109 In Canadian British Columbia the *Insurance Amendment Act* 2009 set out the following protections for innocent co-insureds:

"(1) if a contract contains a term or condition excluding coverage for loss or damage to property caused by a criminal or intentional act or omission of an insured or any other person, the exclusion applies only to the claim of a person

(a) whose act or omission caused the loss or damage,

(b) who abetted or colluded in the act or omission,

(c) who

(i) consented to the act or omission, and

(ii) knew or ought to have known that the act or omission would cause the loss or damage, or

(d) who is in a class prescribed by regulation.

(2) Nothing in subsection (1) allows a person whose property is insured under the contract to recover more than their proportionate interest in the lost or damaged property.

¹³² *Ibid.*

¹³³ *Ibid* at paragraphs 5.49 and 7.46.

¹³⁴ This followed the decision in *Higgins v Orion Insurance Co Ltd* (1985) 17 DLR (4th) 90.

¹³⁵ Law Commission of England and Wales and Scottish Law Commission *Insurance Contract Law: Business Disclosure; Warranties; Insurers' Remedies For Fraudulent Claims; and Late Payment* (Law Com No 353/Scot Law Com No. 238, 2014) paragraph 22.36, and in general see paragraphs 22.32 - 22.43.

(3) A person whose coverage under a contract would be excluded but for subsection (1) must comply with any requirements prescribed by regulation.”

The 2009 Act facilitates recovery under the policy by an innocent co-insured provided that the relevant person has co-operated with the loss investigation, submitted to examinations under oath and produced requested documents.¹³⁶

(e) Conclusion and recommendation

8.110 In the Consultation Paper the Commission provisionally recommended that while fraud defeats a claim, an innocent co-insured or beneficiary may recover on a proportionate basis, provided that the fraudulent policyholder cannot benefit from the policy.

Submissions received opposed reform of this area of law for a number of reasons. First, where a policy is specifically written on a joint basis, as opposed to a composite basis, this is an inherent rating criteria for pricing the risk.

Second, if a fraud is identified and proven and one of the insured parties accepts complete responsibility, an insurer would be obliged to make a proportionate settlement to the other joint insured which could ultimately be to the benefit of the fraudulent joint insured (for example a colluding husband and wife).

Third, the potential for a dishonest policyholder to engage in fraud in the knowledge that an “innocent” associate could benefit from such activity is contrary to public policy.

Fourth, if implemented, this proposal would significantly weaken an insurer’s ability to combat fraud and is likely to result in a significant increase in insurance costs for the consumer.

8.111 An innocent co-insured should not be penalised because of the nature and extent of a relationship and/or the wording of their policy. Such an outcome would be inconsistent with the reasonable expectations of a reasonable policyholder, as described by La Forest J in *Scott v Wawanesa Mutual Insurance Co*¹³⁷ and the Commission therefore rejects the traditional or old approach discussed above.

The Commission agrees with the view that allowing severance to occur while providing that the fraudulent policyholder cannot benefit from the policy is “prejudicially restrictive to the innocent insured’s recovery.”¹³⁸

The Commission believes that there is a need for greater flexibility when an insurer considers the claim of an innocent co-insured. This finds support in other jurisdictions, some of which have adopted or exceeded the limits of the modern approach when seeking to facilitate relief for innocent co-insured policyholders. The Commission favours that direction as the modern approach is limited in effect.

The Commission believes that the enactment of legislation along the lined enacted in British Columbia in 2009 would be appropriate for this jurisdiction. This would provide for severance while imposing on the innocent insured a duty to cooperate with the insurer. Although it has been suggested that this could be seen to facilitate the commission of crime, it is clear that if a fraudulent act has a darker purpose, such as an attempt to murder a spouse by setting fire to a family home, this extreme situation is already catered for by public policy principles such as *ex turpi causa non oritur actio*, which would debar a person from benefitting from his or her crime.¹³⁹

¹³⁶ Tetley “Personal Responsibility for Intentional Conduct: Protecting the Interests of Innocent Co-Insureds Under Insurance Contracts” (2013) 50 ALR 615.

¹³⁷ [1989] 1 SCR 1445: see paragraph 8.106, above.

¹³⁸ Swaby “Blurring distinctions: Should innocent insureds be tarred with the same brush as their fraudulent agents?”(2013) 24 Insurance Law Journal 60 at 83.

¹³⁹ On the application of this principle in section 120 of the *Succession Act 1965* see the Commission’s *Issues Paper on Section 120 of the Succession Act 1965* (LRC IP 7-2014).

8.112 The Commission recommends that where a consumer makes a fraudulent claim or where fraudulent evidence or information is submitted or adduced in its support or where a contract contains a term or condition excluding coverage for loss or damage to property caused by a criminal or intentional act or omission of an insured or any other person, the exclusion applies only to the claim of a person: (i) whose act or omission caused the loss or damage, (ii) who abetted or colluded in the act or omission, or (iii) who consented to the act or omission and knew or ought to have known that the act or omission would cause the loss or damage. Nothing in this recommendation should be interpreted to allow a person whose property is insured under the contract to recover more than their proportionate interest in the lost or damaged property and an innocent co-insured must cooperate fully with the relevant insurer during the course of the relevant investigation in order to be entitled to their portion of the claim.

A Case law and legislation on unfair and otherwise onerous terms

9.01 It is a general requirement of contract law in Ireland (and the United Kingdom) that a party who seeks to rely on an unfair term¹ must, in order to incorporate the term into the contract, take reasonable steps to bring such a term to the attention of the other party; and that even if this is done the other party will only be bound by such a term if it meets a test of reasonableness in all the circumstances.²

The common law principles developed by the courts on unfair and onerous terms must be considered in the light of generally applicable contract law legislation in Ireland (and the United Kingdom). For the purposes of this Report, the most significant in Ireland are the *Sale of Goods and Supply of Services Act 1980*, the *European Communities (Unfair Terms in Consumer Contracts) Regulations 1995*³ and the *Consumer Protection Act 2007*. This legislation forms part of the “general good requirements” with which insurers must comply.⁴

(1) Case law in Ireland and the United Kingdom on unfair terms

9.02 In *Carroll v An Post National Lottery Company*,⁵ the High Court (Costello P) applied common law principles on unfair and onerous terms. The defendant company ran and operated the National Lottery. The plaintiff filled out four lottery playslips in a National Lottery retail outlet and handed them over to be entered in the lottery draw. The retailer processed three of them, one twice, but failed to process the fourth playslip, and the plaintiff had not noticed this at the time of the purchase.

The plaintiff claimed that the fourth playslip contained the winning Lotto numbers and brought an action claiming that the defendant company was in breach of contract in allowing the retail outlet to negligently fail to process all four playslips. The claim was therefore based on negligence and breach of contract. In terms of breach of contract, the defendant company relied on an exclusion clause. The question then arose as to whether it had been incorporated into the contract.

¹ Cases have often involved exclusion clauses as well as other unfair or onerous terms.

² See Law Reform Commission *Consultation Paper on Insurance Contracts* (LRC CP 65–2011) paragraphs 6.02-6.05; and Clark *Contract Law in Ireland* 6th ed (Dublin: Thomson Round Hall, 2008), at 186-196.

³ SI No.27 of 1995, as amended. The 1995 Regulations implemented Directive 93/13/EEC, the 1993 EU Directive on Unfair Terms in Consumer Contracts. In May 2015, the Department of Jobs, Enterprise and Innovation published the *Scheme of a Consumer Rights Bill* (following the Department’s 2014 *Consultation Paper on Reform of the Law on Consumer Contract Rights*, both available at djei.ie), which if enacted would revoke and replace the 1995 Regulations and also repeal, with significant reforms, the *Sale of Goods Act 1893* and the *Sale of Goods and Supply of Services Act 1980* insofar as those Acts deal with consumer contracts. If enacted, the *Scheme of a Consumer Rights Bill* would also implement the key recommendations in the 2011 *Report of the Sales Law Review Group*, available at djei.ie.

⁴ The EU-derived law that regulates insurance undertakings, discussed in Appendix C, below, imposes on insurers “general good requirements” which require them to comply with the general principles and rules of contract law, notably the statutory rules concerning supply of services, unfair terms and unfair commercial practices discussed below. See Article 24 of the *European Communities (Non-Life Insurance) Framework Regulations 1994* (SI No.359 of 1994) and Article 43 of the *European Communities (Life Assurance) Framework Regulations 1994* (SI No.360 of 1994).

⁵ [1996] IEHC 50, [1996] 1 IR 443.

On the front of the playslip, at the bottom and printed in red in block capitals, was the direction to the player: "SEE INSTRUCTIONS ON REVERSE SIDE." On the reverse side, the "Rules and Regulations" contained the following:

"The National Lottery, its agents or contractors, shall not be responsible for lost or stolen tickets. Players acknowledge that Lotto agents are acting on their behalf in entering plays into the National Lottery computer system... **By playing the game, a player agrees to be bound by the National Lottery Rules and Regulations in effect at the time the play is made. A summary of these rules is available for inspection at your local Lotto Agent.**" (emphasis in original)

Among the full Rules and Regulations, authorised by the Minister for Finance under section 28 of the *National Lottery Act 1986*, was Rule 4(3)(f) which provided:

"The National Lottery shall not in any circumstances be liable to a player for any acts or omissions by the Lotto agents."

The plaintiff acknowledged that he had not read the terms and conditions on the back of the playslip. In determining whether the terms and conditions formed part of the contract between the plaintiff and the defendant company, Costello P summarised the general test as follows:

"If the document being tendered contains conditions of an unusual or particularly onerous nature the party tendering it must take reasonable steps to draw attention to such conditions in order to establish that the other party has agreed to it. The refusal to enforce the conditions is also justified if it can be shown that in all the circumstances of the case it would not be fair or reasonable to hold the other party bound by it."⁶

9.03 The test involves two parts, whether attention was drawn to the term and, if it was, whether it would be fair and reasonable to hold the other party to it.

Costello P also quoted with approval case law from the United Kingdom, including the observations of Bingham LJ in the English Court of Appeal in *Interfoto Picture Library Ltd v Stiletto Visual Programmes Ltd*:⁷

"The tendency... has... been to look at the nature of the transaction in question and the character of the parties to it; to consider what notice the party alleged to be bound was given of the particular condition said to bind him; or to resolve whether in all the circumstances it is fair to hold him bound by the condition in question. *This may yield a result not very different from the civil law principle of good faith, at any rate so far as the formation of the contract is concerned.*"⁸ (emphasis added)

In the *Carroll* case Costello P held that the defendant company had taken "reasonable steps" to bring the terms in question to the plaintiff's attention by referring on the front of the playslip to the instructions and by printing the term in a way that was "readily accessible to, and understandable by, readers."

Thus the terms had been incorporated into the contract and the plaintiff was, subject to applying the "fair and reasonable test," bound by the two most significant provisions, namely that the Lotto agents were acting on a player's behalf in entering plays into the National Lottery computer system and that the National Lottery would "not in any circumstances be liable to a player for any acts or omissions by the Lotto agents."

As to the second element of the test, whether this was "fair and reasonable", Costello P held that the provision stating that Lotto agents acted on behalf of players merely stated the position under the statutory Rules made under section 28 of the *National Lottery Act 1986*.

⁶ [1996] IEHC 50, [1996] 1 IR 443 at 463-4.

⁷ [1989] QB 433.

⁸ *Ibid* at 445, cited in *Carroll v An Post National Lottery Company* [1996] IEHC 50; [1996] 1 IR 443 at 464. The approach in *Interfoto* has also been approved in *Finnegan v JE Davy* [2007] IEHC 18 and *Ryanair Ltd v Billigfluege de GmbH* [2010] IEHC 47.

He held that Rule 4(3)(f), which excluded liability for the acts or omissions of Lotto agents, was reasonable because it was merely a statement of the existing law of negligence under which the company would not be vicariously liable for the acts of Lotto agents.

9.04 In applying this two part test, Costello P in the *Carroll* case also approved the view of Bingham LJ in *Interfoto* that this result is comparable to applying the principle of good faith which arises in the general contract law of many (though not all) civil law jurisdictions.

As already noted,⁹ this more general “good faith” requirement is to be distinguished from the related, but distinct, duty of utmost good faith in insurance contract law.

It is important to acknowledge this distinction, and that the more general concept of “good faith”, which as Bingham LJ noted is a feature of many civil law jurisdictions, now forms part of Irish law in both the *European Communities (Unfair Terms in Consumer Contracts) Regulations 1995*¹⁰ (the Unfair Contract Terms Regulations 1995) and the *Consumer Protection Act 2007*,¹¹ both of which involved, in large part,¹² the implementation of EU Directives.

Therefore, regardless of the reforms proposed in this Report concerning “utmost good faith” as it applies in insurance contract law, the separate “good faith” principle that now forms part of general contract law, and in particular the statutory consumer protection regime, will continue to apply to insurance contracts.

9.05 The fair and reasonable test applied by Bingham LJ in *Interfoto* has been applied by English courts to insurance contracts, both in consumer and business to business contracts.

In *US Trading Ltd v AXA Insurance Co Ltd*,¹³ a clause in the defendant’s fire insurance policy required the plaintiff company, a food processing company, to clean its cooker extraction system every three months. Following a fire at its premises the plaintiff made a claim under the policy, but the defendant insurer repudiated the claim on the basis that the clause was a core term with which the plaintiff had not complied.

The English High Court accepted that when a proposer enters into a contract of insurance the insurer’s normal terms will be incorporated into the contract. The court held, however, that the requirement to clean the extraction system every three months was not shown to have been a normal term, that it had not been individually negotiated, and that it was particularly onerous. On this basis the court concluded that as it had not been fairly and reasonably brought to the attention of the proposer it had not been incorporated into the policy.

The *US Trading* case is an illustration of a particularly onerous or unfair term in an insurance policy. While there is no universal agreement on a comprehensive list of such terms, the *Principles of European Insurance Contract Law* (PEICL)¹⁴ set out an indicative list which mirrors the general indicative list of unfair terms in Directive 93/13/EEC, the 1993 EU Directive on Unfair Contract Terms, as implemented in Ireland by the Unfair Contract Terms Regulations 1995. The Commission discusses that indicative list below.

⁹ See paragraph 2.04, above.

¹⁰ SI No.27 of 1995. The 1995 Regulations implemented Directive 93/13/EEC, the 1993 EU Directive on Unfair Terms in Consumer Contracts.

¹¹ The 2007 Act implemented Directive 2005/29/EC, the 2005 EU Directive on Unfair Commercial Practices.

¹² The 2007 Act also involved the consolidation and reform of other elements of consumer protection law not related to EU obligations.

¹³ [2010] Lloyd’s Rep IR 505.

¹⁴ Basedow et al (eds), *Principles of European Insurance Contract Law* (PEICL) (Sellier, 2009).

(2) Sale of Goods and Supply of Services Act 1980

(a) Sale of goods: exclusions void in consumer contracts and subject to “fair and reasonable” test in non-consumer contracts

9.06 Section 55 of the *Sale of Goods Act 1893*, as amended by the *Sale of Goods and Supply of Services Act 1980*, prohibits (“shall be void”) any attempt to exclude the operation of section 12 of the 1893 Act (which implies a condition into the contract that the seller has title to sell goods). Section 55(4) also prohibits any attempt to exclude the following from consumer sale of goods contracts: section 13 of the 1893 Act, as amended (which implies a condition into the contract that the goods will correspond to the description given); section 14 (which implies a condition into the contract that goods are of good quality and durability); and section 15 (which implies a condition into the contract that goods will correspond to any sample supplied).

In business-to-business sale of goods contracts, section 55 of the 1893 Act, as amended by the 1980 Act, provides that any attempt to exclude sections 13, 14 or 15 of the 1893 Act is only enforceable where this is “fair and reasonable,” having regard to all the circumstances of the contract and to the five factors which are referred to in the Schedule to the 1980 Act, discussed below.¹⁵

(b) Supply of services: exclusions subject to “fair and reasonable” test in consumer contracts, no statutory restrictions in non-consumer contracts

9.07 The *Sale of Goods and Supply of Services Act 1980* also introduced¹⁶ statutory implied terms into supply of services contracts by a business, including insurance contracts.¹⁷ Section 39 of the 1980 Act provides that where the supplier is “acting in the course of a business” the implied terms are:

that the supplier has the necessary skill to render the service;

that it will supply the service with due skill, care and diligence;

that where materials are used they will be sound and reasonably fit for the purpose for which they are required; and

that where goods are supplied under the contract they will be of merchantable quality within the meaning of section 14(3) of the *Sale of Goods Act 1893*, as amended by the 1980 Act.

The 1980 Act also differentiates between consumer and non-consumer contracts but, in respect of consumer supply of services contracts, section 40 of the 1980 Act provides that the implied terms may be excluded provided such exclusion is “fair and reasonable” having regard to all the circumstances and the five factors listed in the Schedule to the Act, discussed below, and that the exclusion has been specifically brought to the attention of the consumer.

(c) “Fair and reasonable” test in the Sale of Goods and Supply of Services Act 1980

9.08 The Schedule to the 1980 Act provides that:

“1. In determining... if a term is fair and reasonable the test is that it shall be a fair and reasonable one to be included having regard to the circumstances which were, or ought reasonably to have been, known to or in contemplation of the parties when the contract was made.

¹⁵ In May 2015, the Department of Jobs, Enterprise and Innovation published the *Scheme of a Consumer Rights Bill*, available at djei.ie, which if enacted would replace, with reforms, the 1893 and 1980 Acts to the extent that they apply to sale of goods and supply of services contracts involving individual consumers.

¹⁶ The 1980 Act implemented the recommendations in the 1974 *Report of the National Consumer Advisory Council*, available at oireachtas.ie (in the digital archive of Documents Laid before the Houses of the Oireachtas).

¹⁷ The 1980 Act excludes from the definition of “service” aviation services, meteorological services, the universal postal service, contracts of employment, contracts for the supply of electricity and for the carriage of passengers or goods by land, sea or air. The *Scheme of a Consumer Rights Bill* published in May 2015 would if enacted include such services within the proposed Bill.

2. Regard is to be had in particular to any of the following which appear to be relevant:

(a) the strength of the bargaining positions of the parties relative to each other, taking into account (among other things) alternative means by which the customer's requirements could have been met;

(b) whether the customer received an inducement to agree to the term, or in accepting it had an opportunity of entering into a similar contract with other persons, but without having to accept a similar term;

(c) whether the customer knew or ought reasonably to have known of the existence and extent of the term (having regard, among other things, to any custom of the trade and any previous course of dealing between the parties);

(d) where the term excludes or restricts any relevant liability if some condition is not complied with, whether it was reasonable at the time of the contract to expect that compliance with that condition would be practicable;

(e) whether any goods involved were manufactured, processed or adapted to the special order of the customer."

9.09 These factors are identical to those in the UK's *Sale of Goods Act 1979* and *Supply of Goods and Services Act 1982* which implemented the recommendations of the Law Commission of England and Wales and Scottish Law Commission in their 1969 Joint Report *Exemption Clauses in Contracts*¹⁸ that such a "fair and reasonable" test should be introduced.

(d) Application of "fair and reasonable" test in 1980 Act is similar to common law "fair and reasonable" test

9.10 The "fair and reasonable" test in the UK's *Sale of Goods Act 1979* was applied by the UK House of Lords in *Geo Mitchell Ltd v Finney Lock Seeds Ltd*.¹⁹ In that case, the plaintiff, a company comprising market garden farmers, ordered a specific type of late cabbage seeds from the defendant seed merchants.

The defendant company delivered some seed but after it had been planted, it produced commercially useless cabbages and had to be ploughed in. The plaintiff claimed damages for loss of the crop; the defendant sought to rely on a limitation clause which limited its liability to the price of the seed.

9.11 Both the *Sale of Goods and Supply of Services Act 1980* and the UK *Sale of Goods Act 1979* provide: (a) that it is a condition of a sale of goods contract that the goods be of merchantable quality; (b) that any attempt to circumvent this by an exclusion clause in a consumer contract is void; but (c) that in a non-consumer sale of goods contract, it is permissible unless it is not "fair and reasonable" which is to be determined by the court having regard to all the circumstances of the case and the five specific factors listed in the Schedule to the 1980 Act which are identical to those in the 1979 Act.

9.12 Applying the statutory test in the UK 1979 Act in the *Mitchell* case, the House of Lords noted that factors (a), (b) and (c) were relevant to the case. Of these, factor (c) leaned towards the defendant seed company, but factors (a) and (b) leaned in favour of the plaintiff company.

In particular, the defendant seed company had, in the past, settled what were regarded as "genuine" claims for compensation for faulty seed crop failure for sums well above the price of the seed.

In addition, although the limitation clause had been inserted to keep seed prices low, it was held in the *Mitchell* case that it would not have seriously affected prices for Finneys to have insured itself against the kind of loss to its customers that had arisen in the case itself.

On this basis, the House of Lords concluded that the limitation clause was not "fair and reasonable" and so the plaintiff company was entitled to rely on the implied term of merchantable quality.

¹⁸ Law Commission of England and Wales and Scottish Law Commission *Exemption Clauses in Contracts First Report: Amendments to the Sale of Goods Act 1893* (Law Com. No.24/Scot Law Com. No.12,1969).

¹⁹ [1983] 2 AC 803.

9.13 The “fair and reasonable” test is of course a case-by-case test so that, in a different case, if the insurance costs would have involved a greater burden on a seller of goods, a similar exclusion or limitation might be regarded as “fair and reasonable.” In that respect, the “fair and reasonable” test is much more fluid than the outright ban on an identical exclusion clause in a consumer sale of goods contract.

9.14 The statutory “fair and reasonable” test in section 39 of the *Sale of Goods and Supply of Services Act 1980*, which applies to consumer supply of services contracts, was considered by the High Court (Carroll J) in *McCarthy v Joe Walsh Tours Ltd.*²⁰

In that case the plaintiffs had booked a holiday through the defendant company, in relation to which they alleged breach of contract because the quality of the holiday was below what they could reasonably have expected. The booking form, which the first plaintiff signed, contained a box beside the place for the signature in which the customer acknowledged that all terms included in the booking form had been brought to the customer’s attention and that these had been accepted. The terms in the booking form included a provision that all claims must be dealt with by the arbitration scheme operated by the defendant company, which included a ceiling of £5,000 for any single claim and also excluded any liability for personal injuries. The plaintiff stated that he was unaware that there was an arbitration clause in the booking conditions and that this had not been brought to his attention at the time of signing the contract.

Carroll J, applying common law principles, held that an arbitration clause should be regarded as a “usual” contract term, not an “unusual or onerous” term, and that it would have been unreasonable for the plaintiff to assume that the contract was purely oral and that he was adding nothing by signing the booking form. She therefore concluded that, on the basis of common law rules, the arbitration clause formed part of the contract between the parties.

Carroll J then considered the effect of sections 39 and 40 of the *Sale of Goods and Supply of Services Act 1980*. As already noted, section 39 of the 1980 Act provides that it is an implied term that a service will be supplied with due skill, care and diligence; and that while this may be varied by agreement where the recipient of the service is a consumer, as in the *McCarthy* case, such a variation must be fair and reasonable and have been specifically brought to the recipient’s attention.

Carroll J held that, as the arbitration scheme contained a ceiling of £5,000 for any single claim and also purported to exclude any liability for personal injuries, this clearly constituted an attempt to limit the terms implied under section 39 of the 1980 Act and that, to be effective, the defendant was required to draw specific attention to these limits. Since the arbitration clause had not been specifically drawn to the plaintiff’s attention, Carroll J held that the variation which it effected was not “fair and reasonable” under section 40 of the 1980 Act. On that basis the plaintiff was entitled to rely on the implied term in section 39 of the 1980 Act that the defendant would supply the holiday with due care, skill and diligence.

The application of the statutory “fair and reasonable” test by Carroll J in the *McCarthy* case and by the UK House of Lords in the *Mitchell* case is remarkably similar to the application by Costello J of the common law “fair and reasonable” test in *Carroll v An Post National Lottery Company*.²¹

(3) European Communities (Unfair Terms in Consumer Contracts) Regulations 1995

9.15 The *European Communities (Unfair Terms in Consumer Contracts) Regulations 1995* implemented Directive 93/13/EEC on unfair terms in consumer contracts and are comparable to the UK *Unfair Terms in Consumer Contracts Regulations 1999*. The 1995 Regulations, like the *Sale of Goods and Supply of Services Act 1980*, apply to sale of goods and supply of services contracts, which means that they apply to insurance contracts.

Unlike the 1980 Act, which applies to business-to-business contracts and to business-to-consumer contracts (though, as discussed above, in a differentiated manner), the 1995 Regulations are limited to consumer contracts meaning natural persons acting for purposes outside their business.

²⁰ [1991] ILRM 813.

²¹ [1996] IEHC 50, [1996] 1 IR 443: see discussion above.

9.16 Regulation 3 of the 1995 Regulations provides that they apply to contracts that have not been individually negotiated. Regulation 3(4) provides that this refers to contracts which have been drafted in advance and the consumer has therefore not been able to influence its substance, in particular “a pre-formulated standard contract.”²²

Regulation 6(1) of the 1995 Regulations provides that “an unfair term in a contract concluded with a consumer by a seller or supplier shall not be binding on the consumer.”

(a) Examples of “unfair terms” in contracts generally

9.17 Schedule 3 to the 1995 Regulations, which replicates Annex 3 of the 1993 Directive, sets out “[a]n indicative and non-exhaustive list of the terms which may be regarded as unfair” under the 1995 Regulations. Head 77 of the *Scheme of a Consumer Rights Bill* published by the Department of Jobs, Enterprise and Innovation in 2015²³ would, if enacted, provide that the list of unfair terms in the Scheme of the Bill (which broadly correspond to those in the 1995 Regulations) would be “presumed” to be unfair, this being a rebuttable presumption.²⁴

Schedule 3 contains 17 such terms and although it is not a complete list of “unfair terms” it provides a useful point of reference. The following six examples provide an indication of the range of terms listed:²⁵

1. Making an agreement binding on the consumer but where the provision of services by the supplier is subject to a condition whose realisation depends on its own will alone. For example, a term which requires the consumer to pay without, in effect, any indication that the supplier of a service intends to carry out any part of its promises.
2. Permitting the supplier to retain sums paid by the consumer where the supplier decides not to conclude or perform the contract, without providing for the consumer to receive compensation of an equivalent amount from the seller or supplier where the supplier is the party cancelling the contract.
3. Requiring any consumer who fails to fulfil his obligation to pay a disproportionately high sum in compensation. This reflects common law rules which prohibit disproportionate penalty clauses.
4. Authorising the supplier to dissolve the contract on a discretionary basis where the same facility is not granted to the consumer, or permitting the supplier to retain the sums paid for services not yet supplied where the supplier dissolves the contract.
5. Irrevocably binding the consumer to terms with which the consumer had no real opportunity of becoming acquainted before the conclusion of the contract. This is similar to the common law notification requirement, as discussed in *Carroll v An Post National Lottery Company*²⁶ above.
6. Enabling the supplier to alter the terms of the contract unilaterally without a valid reason which is specified in the contract.

²² The *Scheme of a Consumer Rights Bill* published in 2015 by the Department of Jobs, Enterprise and Innovation (see fn 3, above) proposes that the Bill would apply to both pre-formulated standard contracts and also to contracts in which a consumer has participated in drafting.

²³ See fn3, above.

²⁴ See the Explanatory Note to Head 77 of the *Scheme of a Consumer Rights Bill* (Department of Jobs, Enterprise and Innovation, May 2015), available at djei.ie.

²⁵ The six discussed in this Report are lettered (c), (d), (e), (f), (i) and (j) in Schedule 3 to the 1995 Regulations, in turn derived from the list in the Annex to the 1993 Directive.

²⁶ [1996] IEHC 50, [1996] 1 IR 443.

(b) Examples of “unfair terms” in insurance contracts from PEICL

9.18 The authors of the PEICL²⁷ helpfully include the following indicative list of onerous or unfair insurance contract terms by way of mirroring the general indicative list of unfair terms in Schedule 3 of the 1993 Directive:

1. *Hidden Terms*. These include terms that are not fully disclosed or intelligible to the consumer; terms which cross refer to legal provisions not disclosed in the contract; “small print” provisions; and “entire agreement” clauses.
2. *Exculpatory Provisions*. These include terms excluding or limiting liability for non-performance or defective performance, or one sided performance obligations.
3. *Terms imposing Barriers to Redress*. These include evidentiary obstacles, onerous rules on maintaining and proving a claim, arbitration clauses, or clauses that otherwise enable slow payment of a claim.
4. *Cancellation Clauses*. These include unilateral rights by the insurer to cancel, particularly when this can be done without the insured being able to arrange cover or recover the premium.
5. *Unilateral Variation of Cover*. These include clauses where an insurer, without good cause, can unilaterally vary either the cover or the premium, or assign the policy.
6. *Penalty provisions*. This includes a term that imposes a disproportionate penalty for breach by the consumer.

9.19 In some instances, these examples directly match those listed in the 1993 Directive and the 1995 Regulations, while others are examples tailored to insurance contracts. It is also notable that they mirror the kind of exclusion or onerous clauses that have been litigated, such as the onerous clause discussed by the English High Court in *US Trading Ltd v AXA Insurance Co Ltd*.²⁸

(c) Terms to be drafted in plain, intelligible language and interpreted favourably to consumer: similar to common law rules

9.20 Regulation 5(1) of the 1995 Regulations provides that in the case of contracts where all or certain terms offered to the consumer are in writing, the seller or supplier must ensure that terms are drafted in “plain, intelligible language.” This appears to be similar to the first element of the common law “fair and reasonable” rule that onerous terms must be brought to the attention of the other party.

Regulation 5(2) provides that, where there is a doubt about the meaning of a term, the interpretation most favourable to the consumer shall prevail. This is similar to the common law *contra proferentem* rule for the interpretation of contract terms that have been drafted by one party and not individually negotiated.

(d) “Good faith” test is similar to “fair and reasonable” test in 1980 Act

9.21 Regulation 3(2) of the 1995 Regulations provides that a contract term is unfair if:

“*contrary to the requirement of good faith*, it causes a significant imbalance in the parties’ rights and obligations under the contract to the detriment of the consumer, taking into account the nature of the goods or services for which the contract was concluded and all circumstances attending the conclusion of the contract and all other terms of the contract or of another contract on which it is dependent.” (emphasis added)

The “fair and reasonable” test applied by Costello P in *Carroll v An Post National Lottery Company*²⁹ leads to results that are comparable to applying the principle of good faith which has long formed a part of the general contract law of many (though not all) civil law jurisdictions.

²⁷ Basedow et al (eds), *Principles of European Insurance Contract Law (PEICL)* (Sellier, 2009) at 119-122.

²⁸ [2010] Lloyd’s Rep IR 505, discussed above.

²⁹ [1996] IEHC 50; [1996] 1 IR 443.

It is not surprising therefore that, as the overwhelming majority of EU Member States are civil law jurisdictions, a “good faith” test was included in the 1993 Directive on Unfair Contract Terms, which the 1995 Regulations implemented; but it is worth noting that the comparable concept of “fair and reasonable” terms was applied by Costello P in the *Carroll* case as part of generally applicable contract law derived from common law (that is, judge-made law).

As Bingham LJ noted in the English *Interfoto* case (cited with approval by Costello in the *Carroll* case) for these purposes the common law “fair and reasonable test” concept and the civil law “good faith” concept are virtually identical in practical terms.

9.22 This view is reinforced by Regulation 3(3) of the 1995 Regulations which provides that, in determining whether a term satisfies the requirement of good faith, regard must be had to the four matters listed in Schedule 2 to the 1995 Regulations, which replicates precisely a recital to the 1993 Directive.³⁰

Schedule 2 provides:

“In making an assessment of good faith, particular regard shall be had to:

- the strength of the bargaining positions of the parties,
- whether the consumer had an inducement to agree to the term,
- whether the goods or services were sold or supplied to the special order of the consumer, and
- the extent to which the seller or supplier has dealt fairly and equitably with the consumer whose legitimate interests he has to take into account.”

The first three factors in this list are virtually identical to the first, second and fifth factors listed in the Schedule to the *Sale of Goods and Supply of Services Act 1980*, referred to above, and which are used in determining whether an exclusion clause is “fair and reasonable” for the purposes of the 1980 Act.

The fourth factor in Schedule 2 to the 1995 Regulations, which uses the phrase “dealt fairly and equitably with the consumer,” is almost indistinguishable from the phrase “fair and reasonable.”

While the 1993 EU Directive and thus the 1995 Regulations use the term “good faith” it is clear that the factors by which that is to be assessed are virtually the same as those used to assess what is “fair and reasonable” under the 1980 Act.

When it is borne in mind that the factors listed in the 1980 Act owe their origins to the recommendations of the Law Commission of England and Wales and Scottish Law Commission in their 1969 Joint Report *Exemption Clauses in Contracts*,³¹ it can be said that the content of the “good faith” test has as much a common law origin as a civil law origin.

Bingham LJ’s comments in the English *Interfoto* case, cited by Costello P in *Carroll v An Post National Lottery Company*, could be mirrored and refashioned to say that the civil law concept of “good faith” (at least to the extent that this is reflected in the 1993 EU Directive on Unfair Contract Terms) leads to the same results as the “fair and reasonable” test in common law jurisdictions, whether in its non-statutory form (as applied in *Carroll*) or statutory form (as enacted in the 1980 Act).

³⁰ Two of the recitals to the 1993 Directive read as follows: “Whereas it is necessary to fix in a general way *the criteria for assessing the unfair character of contract terms*; Whereas the assessment, according to the general criteria chosen, of the unfair character of terms, in particular in sale or supply activities of a public nature providing collective services which take account of solidarity among users, must be supplemented by a means of making an overall evaluation of the different interests involved; *whereas this constitutes the requirement of good faith*; *whereas in making an assessment of good faith*, particular regard shall be had to the strength of the bargaining positions of the parties, whether the consumer had an inducement to agree to the term and whether the goods or services were sold or supplied to the special order of the consumer; *whereas the requirement of good faith may be satisfied by the seller or supplier where he deals fairly and equitably with the other party whose legitimate interests he has to take into account.*” (emphasis added).

³¹ Law Commission of England and Wales and Scottish Law Commission *Exemption Clauses in Contracts First Report: Amendments to the Sale of Goods Act 1893* (Law Com. No.24, Scot Law Com. No.12, 1969).

(e) Good faith test in Court of Justice of EU

9.23 The Commission is not aware of any judgment of the superior courts in which the “good faith” test in the 1995 Regulations has been considered. Neither is there evidence in the Case Studies published by the Financial Services Ombudsman (FSO) that the 1995 Regulations have been explicitly relied on in the context of insurance contract practices.³²

The Case Studies published by the non-statutory Insurance Ombudsman of Ireland, whose functions were taken over by the FSO, reported a limited number of cases where the 1995 Regulations were considered.³³

9.24 The Court of Justice of the EU (CJEU) has provided some helpful guidance on the 1993 Directive.³⁴ For example, in *Aziz v Catalunyaacaixa*³⁵ the plaintiff had taken out a loan, secured by a mortgage on his family home, with the defendant, a Spanish bank. The plaintiff began to default on his monthly loan payments and the defendant bank initiated enforcement proceedings against him. The bank also sought to invoke the loan agreement’s “acceleration clause” which allowed it to terminate the contract immediately and to claim back the total of the original loan amount. The loan agreement also imposed a fixed annual default interest rate of 18.75% for sums not paid when due, and did not require any additional obligation on the bank to notify the plaintiff that it would apply this interest rate.

9.25 The plaintiff did not defend the enforcement proceedings and the court ordered execution of the loan. An auction of the plaintiff’s family home was arranged, but no bid was made, with the result that, in accordance with Spanish legislation, ownership of the property was vested in the bank at 50% of its value and the plaintiff was evicted from his home. Shortly before this, he had applied for a declaration seeking annulment of a term of the mortgage loan agreement on the ground that it was unfair under the 1993 Directive and, accordingly, annulment of the mortgage enforcement proceedings.

It was noted that the relevant Spanish legislation sets out limited grounds upon which a debtor may challenge mortgage enforcement proceedings; these do not include the existence of an unfair term in the mortgage loan agreement.

In deciding whether the terms in the loan agreement in the case were unfair under the 1993 Directive, the CJEU pointed out that this was a matter for the national courts to determine, and that the CJEU itself could provide general guidance only in this respect.

Nonetheless, the CJEU held that in applying the “good faith” test in the 1993 Directive and in evaluating whether a “significant imbalance” to the detriment of the consumer exists, a court should contrast the actual contract terms with rules that would otherwise apply in the absence of the terms in question and whether the seller or supplier could reasonably assume that the consumer would, in individual contract negotiations, have agreed to the term in question.

³² The FSO has not specifically referred to the 1995 Regulations in any of the Case Studies released on its website. However, general standards of “fairness,” “reasonableness” and a desire to avoid inequitable results permeate the decisions (See Case Studies from 2009 at financialombudsman.ie). Similarly, several of the early adjudications by the non-statutory Insurance Ombudsman, described in its publication *Digest of Cases of the Insurance Ombudsman 1992-1998*, reflect an approach using a “fair and reasonable” test (Case Studies 84 and 119). Ambiguous terms (Case Studies 3, 83 and 131, for example) or reliance upon an unreasonable interpretation of a term, expression, or an exclusion (Case Studies 24, 94, 128 and 134, for example) were also successfully contested before the non-statutory Insurance Ombudsman.

³³ Case Study 95 of the Insurance Ombudsman of Ireland suggested that travel insurance which included an exclusion clause that specifically excluded cover for medical expenses incurred in Ireland was arguably covered by the exclusion in Recital 19 of the 1993 Directive.

³⁴ Cases C-240/98-C244/98 *Oceano Grupo Editorial SA v Rocio Murciano Qintero* [2000] ECR I-4941; Case C-168/05 *Mostazo Claro v Centro Móvil Milenium* [2006] ECR I-1042; Case C-40/08 *Asturcom Telecomunicaciones SL v Maria Cristina Rodríguez Nogueira* [2009] ECR I- 9579; and Case C-415/11 *Aziz v Catalunyaacaixa* (judgment of 14 March 2013).

³⁵ Case C-415/11 *Aziz v Catalunyaacaixa* (judgment of 14 March 2013).

9.26 The CJEU went on to note that, whereas the agreement provided for annual default interest of 18.75%, the statutory interest rate in Spain at the time stood at 7%. The Court stated that the question for the national court to determine was whether this differential was appropriate for securing the attainment of the objectives pursued in Spain and did not go beyond what was necessary to achieve them.

As to the acceleration clause, which allowed the bank to call in the total loan after a single failure to meet a due payment of principal or interest, the CJEU stated that the national court must in particular assess whether that right is conditional upon the non-compliance by the consumer with an essential obligation of the contract and whether such non-compliance is sufficiently serious in the light of the term and amount of the loan.

9.27 The Law Commission of England and Wales and Scottish Law Commission have also commented on the relative absence of case law in the United Kingdom on the 1993 Directive, and have recommended that any new legislation governing unfair terms should reflect the important guidance from the CJEU “so that the courts are aware of their duty.”³⁶ The Commission considers that such an approach would benefit reform of insurance contract law in Ireland.

(4) Consumer Protection Act 2007

9.28 The *Consumer Protection Act 2007* has three main elements: (a) the consolidation and reform of much pre-2007 legislation in the area of consumer protection;³⁷ (b) the establishment of the National Consumer Agency,³⁸ and (c) implementation of Directive 2005/29/EC, the 2005 EU Directive on Unfair Commercial Practices.

The 2007 Act, like the *European Communities (Unfair Terms in Consumer Contracts) Regulations 1995* and the *Sale of Goods and Supply of Services Act 1980*, applies to sale of goods and supply of services contracts, so that it applies to insurance contracts.³⁹

Like the 1995 Regulations (but unlike the 1980 Act, which applies to business-to-business contracts and to business-to-consumer contracts, though, as discussed above, in a differentiated manner) the 2007 Act is limited to consumer contracts (defined as a natural person who is acting wholly or mainly for purposes unrelated to the person’s trade, business or profession⁴⁰).

(a) 2007 Act prohibits unfair commercial practices, based in part on “good faith” test

9.29 Section 41 of the 2007 Act, which contains a general prohibition on unfair commercial practices, prohibits a trader from engaging in an unfair commercial practice, that is, a practice which is: (a) contrary to the requirements of professional diligence, which in turn can result either from breaching the “good faith” principle or the “skill and care” standard; and which (b) materially distorts or is likely to distort the economic behaviour with regard to the product of the “average consumer”⁴¹ whom it reaches or to whom it is directed.

³⁶ Law Commission of England and Wales and Scottish Law Commission, *Unfair Terms in Consumer Contracts: Advice to the Department for Business, Innovation and Skills* (March 2013), at paragraph S.41 (p xiii).

³⁷ The 2007 Act repealed in full the following Acts: the *Merchandise Marks Act 1887*, the *Merchandise Marks Act 1891*, the *Merchandise Marks Act 1911*, the *Merchandise Marks Act 1931*, the *Prices Act 1958*, the *Prices (Amendment) Act 1972*, the *Consumer Information Act 1978* and the *Pyramid Selling Act 1980*. The provisions in these Acts were replaced by consolidated and reformed provisions in the 2007 Act.

³⁸ In accordance with the *Competition and Consumer Protection Act 2014*, the National Consumer Agency and the Competition Authority amalgamated to form the Competition and Consumer Protection Commission: see ccpc.ie.

³⁹ The 2007 Act deals with the supply of a “product” which section 2(1) of the 2007 Act defines as “goods or services.”

⁴⁰ Section 2(1) of the *Consumer Protection Act 2007* as amended by section 75(b) of the *Competition and Consumer Protection Act 2014*.

⁴¹ The concept of the “average consumer” is discussed further, below.

The 2007 Act uses the “good faith” principle as a key element of the prohibition on unfair commercial practices, just as the 1995 Regulations do in connection with unfair terms in consumer contracts. This can be traced to the EU origins (in part) of the 2007 Act, but the “good faith” principle is similar to the common law “fair and reasonable” test and the statutory “fair and reasonable” test in the *Sale of Goods and Supply of Services Act 1980*.

As previously noted,⁴² this more general “good faith” requirement is to be distinguished from the related, but distinct, duty of utmost good faith in insurance contract law. Thus, regardless of the reforms proposed in this Report concerning “utmost good faith” as it applies in insurance contract law, the separate “good faith” principle that now forms part of general contract law, including the statutory consumer protection regime in the 2007 Act (and the Unfair Contract Terms Regulations 1995 discussed above), will continue to apply to insurance contracts.

(b) *Misleading, aggressive and prohibited commercial practices in the 2007 Act and their relevance to insurance contracts*

9.30 The 2007 Act specifies three types of “unfair commercial practices”: misleading commercial practices,⁴³ aggressive commercial practices⁴⁴ and prohibited commercial practices.⁴⁵

9.31 Section 43(1) provides that a commercial practice is “misleading” if it includes the provision of false information, in relation to any matter set out in section 43(3), that would be likely to cause the average consumer to make a transactional decision that the average consumer would not otherwise make. Among the specific matters listed in section 43(3) of the 2007 Act are:

- the benefits or fitness for purpose of the product;
- the price of the product, the manner in which that price is calculated or the existence or nature of a specific price advantage;
- the after-supply customer assistance available to consumers in relation to the product;
- the handling of consumer complaints in relation to the product; and
- the legal rights of a consumer (whether contractual or otherwise) or matters respecting when, how or in what circumstances those rights may be exercised.

9.32 Section 53(1) provides that a commercial practice is aggressive if “by harassment, coercion or undue influence⁴⁶ it would be likely to (a) cause significant impairment of the average consumer’s freedom of choice or conduct in relation to the product concerned, and (b) cause the average consumer to make a transactional decision that the average consumer would not otherwise make.”

9.33 Section 55 of the 2007 Act provides that a trader shall not engage in a specific list of 31 “prohibited commercial practices” which are sometimes referred to as the “Black List.”⁴⁷ Some of these 31 prohibited commercial practices are clearly referable to sale of goods contracts while others are explicitly referable to supply of services contracts, and in both respects they overlap to some extent with, for example, the *Sale of Goods and Supply of Services Act 1980*.

In terms of sale of goods, section 55(1)(m) of the 2007 Act prohibits what it describes as “bait and switch,” that is:

⁴² See paragraph 2.04, above.

⁴³ Section 42 of the 2007 Act.

⁴⁴ Section 52 of the 2007 Act.

⁴⁵ Section 55 of the 2007 Act.

⁴⁶ Section 52(4) defines “undue influence” as: “exploiting a position of power in relation to a consumer so as to apply pressure (without necessarily using or threatening to use physical force) in a way that significantly limits the consumer’s ability to make an informed choice in relation to the trader’s product.”

⁴⁷ See, for example, the National Consumer Agency’s *Guide to the Consumer Protection Act 2007* at 7, available at http://corporate.nca.ie/eng/Business_Zone/Guides/Consumer_Protection_Act_guide.pdf

“making an invitation to purchase a product, then:

- (i) demonstrating a defective sample of the product, or
 - (ii) refusing to—
 - (I) show or display the product to the consumer,
 - (II) take an order from the consumer for the product, or
 - (III) deliver the product to the consumer within a reasonable period of time,
- with the intention of promoting a different product (bait and switch).”

This overlaps with the implied terms in sections 12 to 15 of the *Sale of Goods Act 1893*, as amended by the *Sale of Goods and Supply of Services Act 1980*.

Section 55(1)(y) of the 2007 Act prohibits the following in contracts for the supply of services:

“making a representation or creating an impression that after-supply service in relation to a product is available in a relevant State other than the one in which the product is supplied, when it is not so available.”

This overlaps with the provisions on after-sales service in the *Sale of Goods and Supply of Services Act 1980*.

9.34 Of particular relevance to contracts of insurance, section 55(3)(d) of the 2007 Act prohibits:

“in relation to a consumer’s claim on an insurance policy, doing either or both of the following:

- (i) requiring the consumer to produce documents irrelevant to the validity of the claim;
- (ii) persistently failing to respond to the consumer’s correspondence on the matter, in order to dissuade the consumer from exercising contractual rights in respect of that claim.”⁴⁸

9.35 Unlike the position with misleading and aggressive commercial practices, each of the “prohibited commercial practices” in section 55 of the 2007 Act is regarded as an “unfair commercial practice” in all circumstances, and it need not be established, for example, that it causes the “average consumer” to make a transactional decision that he or she would not otherwise have taken.

9.36 Some of the misleading commercial practices listed in section 42 of the 2007 Act are of specific relevance to insurance contracts, such as the provision of misleading information as to the “benefits... of the product,” the “after-supply customer assistance available to consumers in relation to the product” and the “handling of consumer complaints in relation to the product.”

Similarly, section 52 of the 2007 Act (particularly as it includes “undue influence” as an instance of an aggressive commercial practice) may be relevant.

In addition, section 55 of the 2007 Act contains a number of prohibited practices concerning supply of services contracts generally, as well as two specific matters concerning claims handling in insurance contracts. In respect of the handling of insurance claims, section 55 prohibits a commercial practice that would require the consumer to produce documents irrelevant to the validity of the claim, and persistent failure to respond to the consumer’s correspondence on the matter in order to dissuade the consumer from exercising contractual rights in respect of that claim.

9.37 Section 74 of the 2007 Act provides that a consumer who is aggrieved by an unfair commercial practice has a right of action for relief by way of damages, including exemplary damages, against the following: (a) any trader who commits or engages in the prohibited act or practice; or (b) if such trader is a body corporate, any director, manager, secretary or other officer of the trader, or a person who purported to act in any such capacity, who authorised or consented to the doing of the act or engaging in the practice.

⁴⁸ This is discussed in Chapter 8, above, on post-contractual duties.

9.38 Both in terms of the generality of the scope of the 2007 Act and since it makes specific references to insurance contracts, it is evident that the 2007 Act imposes an important layer of contractual obligations on insurers.

(c) The “average consumer” and the “reasonable consumer” in the 2007 Act

As noted above, the 2007 Act applies the “average consumer” test in determining whether a consumer has been subjected to an unfair commercial practice. Section 2(2) of the 2007 Act provides that “the average consumer” has the meaning assigned to it by the 2005 EU Directive on Unfair Commercial Practices, and that:

“when applied in relation to a particular commercial practice or product of a trader:

(a) if the commercial practice or product is directed at a particular group of consumers, the expression shall be read as “the average member of that group”, and

(b) if the commercial practice or the product is a practice or product that would be likely to materially distort the economic behaviour only of a clearly identifiable group of consumers whom the trader could reasonably be expected to foresee as being particularly vulnerable because of their mental or physical infirmity, age or credulity, the expression shall be read as “the average member of that vulnerable group”.

9.39 Recital 18 of the 2005 Directive notes that the Court of Justice of the EU has described the “average consumer” as being reasonably well informed and reasonably observant and circumspect, taking into account social, cultural and linguistic factors, and the Directive also contains provisions aimed at preventing the exploitation of consumers whose characteristics make them particularly vulnerable to unfair commercial practices.⁴⁹

9.40 The “average consumer” is therefore also the “reasonable consumer” and insurance contract case law (including the judgment of McCarthy J in *Aro Road*⁵⁰) suggests movement towards the reasonable policyholder in the context of the duty of disclosure.

9.41 The “average” consumer is generally objective in nature but since some consumers may be more vulnerable from a negotiating perspective than others, Recital 19 of the 2005 Directive provides that where:

“certain characteristics such as age, physical or mental infirmity or credulity make consumers particularly susceptible to a commercial practice or to the underlying product and the economic behaviour only of such consumers is likely to be distorted by the practice in a way that the trader can reasonably foresee, it is appropriate to ensure that they are adequately protected by assessing the practice from the perspective of the average member of that group.”

9.42 While the term “average consumer” is predominantly an objective concept it also includes a subjective element that takes into account the specific characteristics of the consumer in question. This in turn has an objective element because it is related to “the perspective of the average member of that group.”

⁴⁹ The concept of the “average consumer” was developed in the case law of the Court of Justice of the EU concerning Directive 84/450/EEC, the 1984 Directive on misleading advertising, which was implemented by the *European Communities (Misleading Advertising) Regulations 1988* (SI No.134 of 1988). See, for example, Case C-210/96 *Gut Springenheide and Tusky v Oberkreisdirektor Steinfurt* [1998] ECR I-4657 at paragraph 31 (“reasonably well informed and reasonably observant and circumspect”) and Case C-220/98 *Estée Lauder Cosmetics GmbH & Co OHG v Lancaster Group GmbH* [2000] ECR I-00117 at paragraph 29 (“taking into account social, cultural and linguistic factors”). Directive 84/450/EEC was repealed and replaced by Directive 2006/114/EC, the 2006 Directive on Misleading and Comparative Marketing Communications. The 2006 Directive was implemented by the *European Communities (Misleading and Comparative Marketing Communications) Regulations 2007* (SI No.774 of 2007).

⁵⁰ [1986] IR 403, at 414: see the discussion in Chapter 2, above.

9.43 The *National Consumer Agency's Guide to the 2007 Act*⁵¹ refers indirectly to Recitals 18 and 19 of the 2005 Directive as follows:

"The European Court of Justice interprets the 'average consumer' as 'reasonably well informed and reasonably observant and circumspect, taking into account social cultural and linguistic factors.' Where a commercial practice is likely to distort the economic behaviour of a clearly identifiable group who are particularly vulnerable because of their mental or physical infirmity, age or credulity in a way which the trader could reasonably be expected to foresee, the average member of that group would be regarded as the 'average consumer.'"

9.44 A similar movement towards combining objective and subjective elements to take account of the characteristics of particular consumers is also evident in the changes made when the 2006 *Consumer Protection Code* was replaced by the *Consumer Protection Code 2012*.⁵²

(5) Conclusions and recommendations

9.45 In the Consultation Paper, the Commission provisionally recommended that there should be a statutory duty on an insurer to draw attention to unusual or onerous terms.⁵³ Submissions received by the Commission suggested: (i) that existing legislation, such as the 1995 Regulations, adequately deals with this matter, and (ii) that any proposal should be sufficiently precise to produce results that are satisfactory in practice and avoid unnecessary disputes.

However, as to (i), the Commission considers that the effect of the 1995 Regulations on insurance contract law has not yet become sufficiently appreciated or understood; and, as to (ii), the Commission accepts that the phrase "unusual terms" may not be sufficiently precise or well-accepted in contract law to have a settled meaning.

In this respect, the phrase "onerous term or unfair term" is likely to be well-understood as it features both in the case law, such as the *Carroll* and *Interfoto* cases discussed above, and also in legislation such as the Unfair Contract Terms Regulations 1995 and the *Consumer Protection Act 2007*.

9.46 The Commission considers that an insurer who seeks to rely on an unfair or otherwise onerous term must, in order to incorporate the term into the contract, take reasonable steps to bring such a term to the attention of the consumer.

It would also be appropriate to provide that, in determining whether a term is to be deemed unfair or otherwise onerous, regard should be had to whether it was one which in all the circumstances was, or ought reasonably to have been, known to or in the contemplation of the insurer and the consumer both at the pre-contractual stage and when the contract of insurance was entered into. This is consistent with long-established case law, and with domestically-inspired statutory provisions (such as the "fair and reasonable" test in the *Sale of Goods and Supply of Services Act 1980*) as well as EU-derived legislation (such as the "good faith" test in the 1995 Regulations and the 2007 Act).

In determining whether a term meets this test, regard is to be had in particular to any of the following which appear to be relevant: (a) the strength of the bargaining positions of the insurer and the consumer relative to each other; (b) whether the consumer had an inducement to agree to the term; (c) whether the contract of insurance was supplied to the special order of the consumer; and (d) the extent to which the insurer has dealt fairly and equitably with the consumer whose legitimate interests the insurer has to take

⁵¹ National Consumer Agency *Guide to the Consumer Protection Act 2007* at iv.

⁵² The Central Bank's *Guide for Regulated Entities to the Consumer Protection Code 2012*, at paragraph 4.2, sets out three categories of vulnerable consumers. Category 1 concerns those that were capable of making decisions but their particular life stage or circumstances should be taken into account when assessing suitability. Examples were age, poor credit history, low income, serious illness, bereavement etc. Category 2 concerns those that were capable of making decisions but required reasonable accommodation in doing so. Examples included hearing impairment, vision impairment, not having English as a first language, and poor literacy. Category 3 concerns those with limited capacity to make decisions, either temporary or permanent. Examples included mental illness or an intellectual disability.

⁵³ Law Reform Commission *Consultation Paper on Insurance Contracts* (LRC CP 65 – 2011) paragraph 6.10.

into account. These factors are derived from those set out in Schedule 2 to the *European Communities (Unfair Terms in Consumer Contracts) Regulations 1995*.

A non-exhaustive list of types of terms that may be regarded as unfair or otherwise onerous in insurance contracts should also be set out. As noted above, the authors of the PEICL have developed such a list (derived from the general list in Annex 3 of the 1993 Directive on Unfair Terms in Consumer Contracts) as follows:

- terms that are not fully disclosed or intelligible to the consumer, terms which cross refer to legal provisions not disclosed in the contract, and provisions that use small print;
- terms that exclude or limit liability for non-performance or defective performance, and one-sided performance obligations;
- terms that include evidentiary obstacles, onerous rules on maintaining and proving a claim, arbitration or mediation clauses, and clauses that otherwise enable slow payment of a claim;
- terms which confer on the insurer unilateral rights to cancel, particularly when this can be done without the consumer being able to arrange cover or recover the premium;
- terms under which the insurer, without good cause, may unilaterally vary either the cover or the premium, or assign the policy; and
- terms that impose a disproportionate penalty for breach by the consumer.

Such terms may be, though are not necessarily, unfair or onerous, but reflecting the proposal in Head 77 of the *Scheme of a Consumer Rights Bill* published by the Department of Jobs, Enterprise and Innovation in 2015,⁵⁴ they should be “presumed” to be unfair, this presumption being of course rebuttable.

9.47 The Commission also recommends that, to ensure consistency with existing law and practice, the concept of a consumer in the statutory framework being proposed in this Report should refer to the term “average consumer” as defined in the *Consumer Protection Act 2007* and in the Central Bank’s *Consumer Protection Code 2012*.

9.48 The Commission recommends that an insurer who seeks to rely on an unfair or otherwise onerous term should, in order to incorporate the term into the contract, take reasonable steps to bring such a term to the attention of the consumer.

9.49 The Commission recommends that the definition of “consumer” in the statutory framework proposed in this Report should include reference to an “average consumer,” that is, a consumer who is reasonably well-informed and reasonably observant and circumspect, taking into account social, cultural and linguistic factors. If a contract of insurance is directed at a particular group of consumers, “average consumer” shall be read as “the average member of that group” and if the contract of insurance would be likely materially to distort the economic behaviour only of a clearly identifiable group of consumers who are natural persons, and whom the insurer could reasonably be expected to foresee as being particularly vulnerable because of their mental or physical infirmity, age or credulity, “average consumer” shall be read as “the average member of that vulnerable group.”

9.50 The Commission recommends that, in determining whether a term is an unfair or otherwise onerous term, regard should be had to whether it was one which in all the circumstances was, or ought reasonably to have been, known to or in the contemplation of the insurer and the consumer both at the pre-contractual stage and when the contract of insurance was entered into.

9.51 The Commission recommends that, in determining whether a term is an unfair or otherwise onerous term, regard should also be had to any of the following which appear to be relevant: (a) the strength of the bargaining positions of the insurer and the consumer relative to each other, (b) whether the consumer had an inducement to agree to the term, (c) whether the contract of insurance was supplied to the special order of the consumer, and (d) the extent to

⁵⁴ See paragraph 9.17, above.

which the insurer has dealt fairly and equitably with the consumer whose legitimate interests the insurer has to take into account.

9.52 The Commission recommends that the following non-exhaustive types of terms may be presumed (the presumption being rebuttable) to be unfair or otherwise onerous terms: (a) terms that are not fully intelligible to the consumer, terms which cross refer to legal provisions not disclosed in the contract, and provisions that use small print, (b) terms that exclude or limit liability for non-performance or defective performance, and one-sided performance obligations, (c) terms that include evidentiary obstacles, onerous rules on maintaining and proving a claim, arbitration or mediation clauses, and clauses that otherwise enable slow payment of a claim, (d) terms that confer on the insurers unilateral rights to cancel, particularly when this can be done without the consumer being able to arrange cover or recover the premium, (e) terms under which the insurer, without good cause, may unilaterally vary either the cover or the premium, or assign the policy, and (f) terms that impose a disproportionate penalty for breach by the consumer.

(6) Clarifying the scope of the “main subject matter” of insurance contracts

9.53 Regulation 4 of the European Communities (Unfair Terms in Consumer Contracts) Regulations 1995 provides that:

“A term shall not of itself be considered to be unfair by relation to the definition of the main subject matter of the contract or to the adequacy of the price and remuneration, as against the goods and services supplied, in so far as these terms are in plain, intelligible language.”

There is some uncertainty as to the exact scope of the “main subject matter” of the contract. This has also been discussed in terms of the boundary between core and non-core terms. In this context the Law Commission of England and Wales and Scottish Law Commission endorsed the view of the English Office of Fair Trading (OFT) that for core terms to be exempt they must have formed “part of the way consumers perceived the bargain.”⁵⁵

In other words, inserting terms or disclaimers into contracts in places where a consumer is unlikely to see them, or providing terms or disclaimers after the contract has been agreed, is unlikely to meet the consumer’s reasonable expectations.⁵⁶

9.54 This general approach was endorsed by the UK House of Lords in *Director General of Fair Trading v First National Bank*⁵⁷ on the basis that the purpose of the 1993 Directive would plainly be frustrated if the exemption for core terms were to be so broadly interpreted as to cover any terms “other than those falling squarely within it.”

9.55 Nonetheless, the subsequent decision of the UK Supreme Court in *Office of Fair Trading v Abbey National plc*⁵⁸ indicates difficulty in determining the precise boundary between core and non-core terms.

In this case, the Office of Fair Trading (OFT) sought a declaration that certain charges imposed where a bank account holder went into unauthorised overdraft were “unfair” under the UK’s *Unfair Terms in Consumer Contracts Regulations 1999*, which had implemented the 1993 Directive.

The agreed facts were that when a bank customer used an unauthorised overdraft and then made a payment request (whether by standing order, direct debit or using an ATM or debit card), UK financial institutions generally made the payment as requested, and then charged fees (which might include “paid

⁵⁵ Law Commission of England and Wales and Scottish Law Commission Consultation Paper on *Insurance Contract Law: Misrepresentation, Non-Disclosure and Breach of Warranty by the Insured* (Law Com No. 182/Scottish Law Com No. 134), paragraph 2.87.

⁵⁶ *Ibid* at paragraph 2.94. The European Commission regards it as desirable that a narrow view of the exemption given to core terms should be adopted.

⁵⁷ [2001] UKHL 52; [2002]1 AC 481 at 491.

⁵⁸ [2009] UKSC 6, [2010] AC 696.

item” charges and unauthorised overdraft fees) which accrued on a daily basis while the unauthorised overdraft continued.

The OFT argued that such fees were unfair under the UK 1999 Regulations because they were not a fair reflection of the actual costs incurred by financial institutions but rather constituted a penalty on the consumer.

The English High Court and Court of Appeal held that, although the charges were not penal, they could be assessed for fairness under the 1993 Directive and the UK 1999 Regulations.

On further appeal, the UK Supreme Court unanimously held that the charges could not be assessed for fairness because overdraft fees related to a bank’s remuneration and they therefore formed part of the “core terms,” that is, the “main subject matter” of the contract.

Nonetheless, Baroness Hale stated that while the Court had no option other than to conclude as it did, Parliament could have chosen to implement the 1993 Directive in a different manner because it permitted discretion as to the precise manner in which “subject matter of the contract” is to be defined.

9.56 The distinction between core and non-core terms in relation to insurance contracts is further complicated by the English language version of Recital 19 of the 1993 Directive which provides:

“in insurance contracts, the terms which clearly define or circumscribe the insured risk and the insurer’s liability shall not be subject to [the Directive]... since these restrictions are taken into account in calculating the premium paid by the consumer.”

9.57 This text appears to suggest that terms relating to the premium to be charged, that is, the price, are exempt from scrutiny on the basis that such terms relate to the definition of the main subject matter of the contract.⁵⁹

The net effect is that the English language text gives the impression that every term that deals with the insured risk and the insurer’s liability is taken into account in calculating the premium and is therefore exempt from scrutiny for fairness under the 1993 Directive.

9.58 The Law Commission of England and Wales and Scottish Law Commission provide an example where the same insurance product might fall on either side of the core and non-core term boundary, depending on context:⁶⁰

“Take a case where a policy was sold as ‘insurance for winter sports adventure holidays,’ but a sub-paragraph of one of the lengthy policy terms excluded off-piste skiing, and no particular attempt was made to bring this to the proposer’s attention. The exclusion of off-piste skiing would not be a core term. However, if the policy were sold explicitly as ‘suitable for skiing on piste,’ the same term might be exempt from review, provided it was presented in a plain intelligible way.”

9.59 However, as highlighted by a number of writers⁶¹ including the authors of the PEICL, Recital 19 is phrased differently in other official language versions of the 1993 Directive.

⁵⁹ Bird, Owen and Legh-Jones (eds), *MacGillivray on Insurance* 11th ed (Sweet & Maxwell, 2008), at paragraphs 10-020 and 11-036, suggests that the following would be exempt from the unfairness test in the 1993 Directive: exclusion clauses, warranties, provisions which define and circumscribe a risk, and those which play an important part in determining the premium. The Law Commission of England and Wales and Scottish Law Commission did not dissent from the view that Recital 19 and article 4(2) of the 1993 Directive had this result, pointing to both the opinion of textbooks and the decision in *Bankers Insurance Company v South* [2003] EWHC 380; [2004] Lloyd’s Rep IR 1. It is important to note that the Commission has recommended the abolition of the current concept of warranties in insurance contracts: see Chapter 4, above.

⁶⁰ Law Commission of England and Wales and Scottish Law Commission Consultation Paper on *Insurance Contract Law: Misrepresentation, Non-Disclosure and Breach of Warranty by the Insured* (Law Com No. 182/Scottish Law Com. 134, 2007) at paragraph 2.90.

⁶¹ See for example, Ruhl “Precautionary Obligations in European Insurance Contract Law” in Basedow, Hopt and Zimmermann (eds), *Max Planck Encyclopedia of European Private Law* (Oxford UP, 2012).

In the German language version, Recital 19 provides that the exemption only applies if the term in question has “actually” been considered in the calculation of the price. One commentator concluded that “the relevance of such contractual terms for the calculation of the premium is the reason why these terms are excluded from review in the English version, whilst it is a condition for the exclusion in other versions.”⁶² The authors of the PEICL suggested in 2009 that the UK and Ireland may be isolated in giving the core provision exemption such wide scope.⁶³

9.60 In the Consultation Paper, the Commission provisionally recommended that Regulation 4 of the 1995 Regulations should be clarified in the context of insurance contracts so that it is provided, to avoid any doubt, that: (a) a term in an insurance contract shall not in itself be regarded as unfair where the subject matter of the term has actually been considered by the insurer in the calculation of the premium; (b) that this has been drawn to the attention of the proposer; and (c) that this clarification to Regulation 4 should apply to consumers as defined for the purposes of the jurisdiction of the FSO, namely, natural persons and businesses with an annual turnover not exceeding €3 million.⁶⁴

That provisional recommendation was largely modelled on Article 2:304 of the PEICL, which in turn is a modified version of Articles 3, 4 and 6 of the 1993 Directive, tailored to the specific circumstances of insurance contracts.

9.61 Mirroring the 1993 Directive, Article 2:304(1) of the PEICL provides that a term, not individually negotiated, shall not be binding if, contrary to the requirements of good faith and fair dealing, it causes a significant imbalance in the rights and obligations of the consumer arising under the contract to his or her detriment. In evaluating the unfair nature of the term Article 2:304(1) provides that account must be taken of “the nature of the insurance contract, all the other terms of the contract and the circumstances at the time the contract was concluded.”⁶⁵

Article 2:304(2) of the PEICL provides that the “contract shall continue to bind the parties if it is capable of continuing in existence without the unfair term. If not, the unfair term shall be substituted by a term which reasonable parties would have agreed upon had they known the unfairness of the term.”

Article 2:304(3) provides that it applies to terms that restrict or modify cover but applies neither to (a) the adequacy in value of the cover and the premium, nor to (b) terms that state the essential description of the cover granted or the premium agreed, provided the terms are in plain and intelligible language.

9.62 The Commission endorses the view that an insurance risk covers several circumstances: (1) the factual risk (for example, property insurance against a certain type of damage); (2) the legal risk (for example, the provisions of law concerning damage caused by the policyholder through gross negligence); (3) the cost risk (administration costs, unwarranted claims and high legal costs); and (4) the financial risk (economic circumstances, for example, high interest rates).

All of these factors must be taken into consideration to varying degrees when deciding on the premium and the terms of the policy. However, to provide effective protection of the insured’s rights, the number of clauses exempted from the fairness test must be restricted.

9.63 The authors of the PEICL contend that the relevant terms are those that give a “crucial definition of the type and subject of insurance, the insured risk, the insurer’s liability, the insurance benefit, the sum insured, the insured interest or the insurable value.”

Therefore terms that restrict, change, elaborate or modify the insurer’s obligation to perform are not core terms and therefore subject to review under the 1993 Directive, and Article 2:304.

The authors of the PEICL provide the following by way of illustration:

⁶² *Ibid.*

⁶³ See Basedow et al (eds), *Principles of European Insurance Contract Law* (Sellier, 2009) at 116-117.

⁶⁴ Law Reform Commission *Consultation Paper on Insurance Contracts* (LRC CP 65 – 2011) at paragraph 6.46.

⁶⁵ The rules defining when a term is not individually negotiated, or the implications of when some terms have been individually negotiated as well as the burden of proof regarding a claim that a term has been individually negotiated are identical to those under the 1993 Directive.

“If, for example, a policyholder takes out professional indemnity insurance, this would imply the exclusion of a general liability as part of the crucial definition of the “type and subject of insurance”. This implicit exclusion would therefore not be subject to review. However, if a term of the policy excludes liability for pure economic loss, such a term would be subject to review.”⁶⁶

9.64 Submissions received by the Commission in response to the provisional recommendation suggested that the calculation of premium is based on underwriting criteria and the risk that is presented rather than the terms of the policy, and that this should, therefore, be excluded from the general test of fairness in the 1993 Directive. It was also suggested that the subject matter of the term itself could influence the underwriter’s judgement in relation to acceptance of the business.

9.65 The Commission accepts that an underwriter’s judgement and expertise in determining the premium to be charged is an important element in any insurance contract. This is consistent with the provisional recommendation in the Consultation Paper, which the Commission confirms in this Report, that where the subject matter of the term has actually been considered by an insurer it should remain exempt from the test of unfairness in the 1993 Directive, as implemented in Regulation 4 of the Unfair Contract Terms Regulations 1995.

9.66 The Commission considers that this has the advantage of providing clarity in an area where, as the decision of the United Kingdom’s Supreme Court in *Office of Fair Trading v Abbey National plc* demonstrates, the boundary between core and non-core terms is difficult to find.

This is also consistent with the approach of the Department of Jobs, Enterprise and Innovation which, in its 2014 Consultation Paper on the Reform of Consumer Contract Rights,⁶⁷ concluded that the *Abbey National* case gives rise to justifiable concerns because it interpreted “core terms” in a manner that does not accord with the reasonable expectations of consumers and had left the law in a state of some uncertainty.⁶⁸ The Department proposed that the exemption may therefore need to be clarified in general terms and sought the views of consultees on this.

In the wake of the Department’s consultation, Head 74(2) of the *Scheme of a Consumer Rights Bill*,⁶⁹ which it published in May 2015, would if enacted narrow the exemption by proposing that “price” would not be regarded as a “core term” or part of the “main subject matter” of the contract where it is “incidental or ancillary to the main subject matter of the contract.” The Department explained that this proposal was also consistent with case law of the CJEU on the main subject matter of the contract in the 1993 Directive.⁷⁰

9.67 In this context, the Department cited the decision of the CJEU in *Van Hove v CNP Assurances SA*,⁷¹ in which the Court addressed the application of the exemption in an insurance contract setting.

In this case, the plaintiff had entered into two loan contracts with a bank and, at the same time, he also signed a group insurance contract with the defendant insurance company to cover all the loan repayments in the event of his death, or 75% of the repayments in the event of “total incapacity for work.” Following a workplace accident, the plaintiff was adjudged to have become 72% permanently incapacitated. The insurance company’s doctor concluded that the plaintiff’s health allowed him to work

⁶⁶ Basedow et al (eds), *Principles of European Insurance Contract Law* (Sellier, 2009) at 117 paragraph C4.

⁶⁷ Department of Jobs, Enterprise and Innovation *Consultation Paper on Reform of the Law on Consumer Contract Rights* (2014): see fn3, above.

⁶⁸ Department of Jobs, Enterprise and Innovation *Consultation Paper on Reform of the Law on Consumer Contract Rights* (2014) paragraph 149.

⁶⁹ See fn3, above.

⁷⁰ Department of Jobs, Enterprise and Innovation *Scheme of Consumer Rights Bill* (May 2015), Explanatory Note to Head 74(2), citing Case C-143/13, *Matei v Volksbank Romania SA* (CJEU, 26 February 2015) and Case C-96/14, *Van Hove v CNP Assurances SA* (CJEU, 23 April 2015).

⁷¹ Case C-96/14, *Van Hove v CNP Assurances SA* (CJEU, 23 April 2015).

part-time. On this basis, the insurance company refused to continue to cover the loan repayments in respect of the plaintiff's 72% incapacity.

The plaintiff issued proceedings in France claiming that the contract term relating to the definition of "total incapacity for work" and the conditions under which repayments were covered was unfair under the 1993 Directive. He argued, in particular, that the definition was unintelligible to a lay consumer, and that the term was worded in such a way as to cause a significant imbalance to the detriment of the consumer. The insurance company argued that the term was covered by the exemption from being considered as unfair under Article 4(2) of the 1993 Directive because it concerned the subject-matter of the contract.

On a reference from the French court, the CJEU held that it could not be ruled out that the contract term concerned the subject-matter of the contract, because it appeared to circumscribe the insured risk and the insurer's liability under the insurance contract. The CJEU left it to the national court to determine this point, however.

The CJEU added that in making this decision the national court would have to consider whether the term was grammatically intelligible to the consumer and have regard to the specific context of the insurance contract. Thus, in the present case, the Court considered that because the insurance in this case was connected to a loan agreement the consumer might not be expected to have exercised the same vigilance regarding the extent of the risks covered if the insurance had been taken out separately.

9.68 The decision of the CJEU in *Van Hove v CNP Assurances SA*⁷² emphasises the importance of assessing whether a term forms the "main subject matter of the contract" against the background of the specific contractual setting in which the question is considered. This reinforces the Commission's general recommendations on unfair and onerous terms already made above in this Chapter, especially those which require that attention be drawn to such terms and that they be drafted in clear and intelligible language.

It also supports the Commission's conclusion that only issues and risks that have actually been considered by an insurer, as opposed to issues and risks that might have been considered by a hypothetical "prudent" insurer, should be taken into account in determining whether a term forms the "main subject matter of the contract."

The Commission therefore sees no reason to depart from the view expressed in the Consultation Paper that Article 2:304 of the PEICL, which contains a version of the relevant provisions of the 1993 Directive tailored specifically to insurance and which refers to an insurer actually considering the subject matter of a term in determining the premium, is a suitable model on which to provide clarification of Regulation 4 of the 1995 Regulations as it applies to insurance contracts.

9.69 The Commission recommends that, without prejudice to Regulation 4 of the *European Communities (Unfair Terms in Consumer Contracts) Regulations 1995*, a term in a consumer contract of insurance shall not in itself be regarded as unfair where the subject matter of the term has actually been considered by the insurer in the calculation of the premium and where the term has been drawn to the attention of the proposer in writing.

⁷² Case C-96/14, *Van Hove v CNP Assurances SA* (CJEU, 23 April 2015).

CHAPTER 10 FORM OF THE CONTRACT

A Current Law on the Form of a Contract of Insurance

(a) Case law on form of contract

10.01 There is no general common law obligation on insurers to record negotiations or to reduce insurance contracts to documentary form, although there are good commercial and ethical reasons why insurers should adopt sound recording and documentary practices. As McGillivray points out:¹

“There is nothing to prevent a valid contract of fire, accident or burglary insurance being constituted by informal writing or correspondence or even by mere oral communications. In practice, however, it is difficult to satisfy a court that there is an oral contract when one party disputes its existence, and attempts to set up such an agreement are not to be undertaken lightly. The small trouble involved in recording contracts in writing is amply justified to avoid later evidentiary difficulties. When an informal contract is recorded in writing, the written terms are not necessarily a conclusive statement of the contract in law, because oral evidence is admissible to prove other terms of the contract, if it is established that the document was not intended to be a complete record of it.”

10.02 In addition to these practical reasons for having written documentation, the courts have held that, in individual circumstances, a failure to request information, or to provide and record information adequately, may affect insurers’ customary rights under insurance contract law.² Subject to these specific instances, however, judicial protection of proposers/policyholders and insurers has been available only on an *ad hoc* basis.

(b) Legislation on form of contract

10.03 The existing legislation on insurance, which consists of a series of Acts and ministerial Regulations, focuses predominantly on regulating insurance undertakings (such as prudential and solvency matters) rather than regulating the form of insurance contracts.³ Nonetheless, a number of legislative provisions have imposed, to a greater or lesser degree, mandatory requirements concerning the form and content of insurance contracts.

¹ Legh-Jones, Birds and Owen (eds) *MacGillivray on Insurance Law* 11th ed (Sweet & Maxwell 2008) at paragraph 3-002 (footnotes omitted).

² In *Aro Road and Land Vehicles Ltd v Insurance Corporation of Ireland plc* [1986] IR 403, at 414, the Supreme Court (McCarthy J, with whom Walsh and Hederman JJ agreed) held that where an insurer does not make use of a “proposal form with its presumably relevant questions” the common law duty of disclosure may be abridged or waived. Similarly, in *Manor Park Homebuilders Ltd v AIG Europe (Ireland) Ltd* [2008] IEHC 174; [2009] 1 ILRM 190, at 216, the High Court (McMahon J) emphasised that an insurer’s right to reject a claim under an insurance policy for misrepresentation or non-disclosure can be lost because of careless information-gathering practices. The Court held that, by failing to make reasonable inquiries and to issue appropriate documentation at the pre-contract stage, or to provide a policy within a reasonable period after agreeing insurance cover, the insurer had fallen short of the good faith obligations resting on the reasonably prudent insurer and was, therefore, in breach of its duty “to adequately inform itself of the facts and... to deal fairly with the insured or consider his interests.”

³ See Appendix C, below, for a discussion of the regulatory development of insurance in Ireland.

The *Life Assurance Act 1774* requires that a policy of life insurance must be in writing and must include on it the name of the beneficiary.⁴

Similarly, section 22 of the *Marine Insurance Act 1906* provides that “a contract of marine insurance is inadmissible in evidence unless it is embodied in a marine policy in accordance with this Act.”⁵

To the same effect, section 66 of the *Road Traffic Act 1961* requires insurers who issue approved policies of motor insurance to issue a prescribed form certificate of insurance to the policyholder.

Some important statutory requirements also apply to health insurance,⁶ and although section 13 of the *Health Insurance Act 1994*⁷ provides for Regulations prescribing certain information that should accompany health insurance contracts and health insurance advertisements, no Regulations have been made to date (2015) under this power.

10.04 It has been recognised for many decades that these long-established, but relatively limited, requirements should be replaced or at least supplemented by more complete documentary requirements that would apply to insurance contracts more generally.

The 1976 *Report of the Committee of Inquiry into the Insurance Industry*⁸ (the O’Donoghue Report) recommended the enactment of legislation that would require life insurance undertakings to provide to a proposer a statement of rights under the contract in an approved form at the time of entering into the contract.⁹

Section 5 of the *Insurance Act 1989* contains a standard Regulation-making power that could have implemented this recommendation, but for many years this power remained unused because, instead, Government accepted that the non-statutory codes of practice developed by Insurance Ireland, discussed in previous Chapters, were sufficient.

⁴ See Chapter 2, above.

⁵ As discussed in Chapter 1, marine insurance is outside the scope of this Report.

⁶ See the *Health Insurance Act 1994*, as amended by the *Health Insurance (Amendment) Act 2012*, which includes requirements concerning lifetime community rating, namely that, subject to certain conditions such as that a person takes out health insurance before the age of 35, every person is charged the same premium for the same service. The 1994 Act, as amended by the 2012 Act also put in place a long-term system of risk equalisation, a system of cost subsidy between health insurance providers intended to ensure that providers with a higher proportion of older subscribers, who are more likely to avail of health insurance cover, are not at a competitive disadvantage by comparison with providers who have a higher proportion of younger subscribers. The long-term regime in the 2012 Act replaced temporary schemes in place since the original risk equalisation scheme in the 1994 Act had been declared invalid by the Supreme Court in *Bupa Ireland Ltd v Health Insurance Authority* [2008] IESC 42; [2009] 1 ILRM 81.

⁷ Section 13 of the 1994 Act, as inserted by section 11 of the *Health Insurance (Miscellaneous Provisions) Act 2009*. Section 13 of the 1994, as originally enacted, had provided for a Regulation-making power limited to dealing with misleading, inaccurate or exaggerated advertisements and claims. Section 13(1) of the 1994 Act, as inserted by section 11 of the 2009 Act, provides for much more wide-ranging Regulations, which could include: (a) specifying the type of health insurance contract and the information that should accompany the contract, (b) requiring health insurance undertakings which supply the contract to ensure that the information accompanies the contract in the manner and form specified in the Regulations, (c) regulating or prohibiting the supply by registered undertakings of the contract if any Regulations made under paragraph (b) are not complied with in so far as the Regulation applies to the contract, and (d) without prejudice to the generality of paragraph (a), requiring registered undertakings to include a statement in their offers to renew health insurance contracts, or a class of such offers, as to the rights (including open enrolment rights), or a class of such rights, of the policy holders concerned in respect of the contracts.

⁸ *Report of the Committee of Inquiry into the Insurance Industry* (Prl. 5530, 1976)(the O’Donoghue Report). The Report, discussed further in Appendix C, is available at oireachtas.ie (in the digital archive of documents laid before the Houses of the Oireachtas).

⁹ *Ibid* at paragraph 11.5.2.

10.05 Some elements of these Insurance Ireland codes have since been superseded by mandatory statutory requirements many of which involve the implementation of EU law. Thus, section 43B of the *Insurance Act 1989*, inserted into the 1989 Act by the *Insurance Act 2000*,¹⁰ imposes specific pre-contractual and post-contractual written information requirements for life insurance policies, and implemented the relevant obligations in Article 13 of Directive 92/96/EEC, the 1992 Third Life Assurance Framework Directive.¹¹

10.06 The O'Donoghue Report had also recommended that legislation, envisaged at that time to protect consumers from misleading advertisements and statutory duties concerning the supply of services, should include insurance undertakings.¹² This was enacted as the *Consumer Information Act 1978* (since incorporated into the *Consumer Protection Act 2007*) and the *Sale of Goods and Supply of Services Act 1980*.¹³

10.07 In addition to the mandatory requirements in section 43B of the 1989 Act,¹⁴ sections 43B and 43D also provide for the making of Regulations which could prescribe further requirements, and this Regulation-making power was used for the first time in the *Life Assurance (Provision of Information) Regulations 2001*.¹⁵ These supplement the requirements in section 43B of the 1989 Act by prescribing a mandatory list of pre-contractual information to be provided to the proposer together with a "template" of life insurance policy terms which must be provided after the contract has been concluded.

While the general requirements in section 43B of the 1989 Act involved the direct implementation of the relevant requirements of Directive 92/96/EEC (the 1992 Third Life Assurance Framework Directive), the detail contained in the 2001 Regulations goes far beyond the requirements of the 1992 Directive.

10.08 Further reform of the insurance industry, and of insurance contract law, has also derived from other initiatives that have a predominantly local, rather than EU, influence.¹⁶

¹⁰ Part IIIA of the *Insurance Act 1989*, comprising sections 43A to 43G of the 1989 Act, together with the associated Third Schedule to the 1989 Act, were inserted into the 1989 Act by sections 7 and 12 of the *Insurance Act 2000*.

¹¹ Section 43B of the 1989 Act might also be seen as a belated implementation, in 2000, of the recommendation to the same general effect in the 1976 Report.

¹² *Ibid*, at paragraph 16.4.1.

¹³ The 1976 Report declined to make more wide-ranging recommendations for the statutory regulation of insurance contracts because the Committee was conscious that "discussions are at present taking place on... the Draft Directive relating to the Harmonisation of Insurance Contract Law which will have the effect of harmonising the provisions of insurance contracts throughout the EEC." (*Report of the Committee of Inquiry into the Insurance Industry* (Pr. 5530, 1976), at paragraph 16.5.2.) This was a reference to proposals that led to the publication in 1979 by the EU Commission of a draft 1979 Directive on Insurance Contracts, but this was ultimately withdrawn by the EU Commission because of objections raised by a number of EU member States: see Appendix C, below. Instead, (subject to the limited number of areas, such as those provided for in section 43B of the *Insurance Act 1989*, on which harmonised rules have been agreed) at the time of writing the EU appears to be focused on preparing an "Optional Instrument" Regulation on insurance contracts, derived from the *Principles of European Insurance Contract Law* (PEICL), so that reform of insurance contract law continues to be primarily a matter for each EU Member State.

¹⁴ Part IIIA of the *Insurance Act 1989*, comprising sections 43A to 43G of the 1989 Act, together with the associated Third Schedule to the 1989 Act, were inserted into the 1989 Act by sections 7 and 12 of the *Insurance Act 2000*.

¹⁵ SI No.15 of 2001, as amended by the *Life Assurance (Provision of Information) (Amendment) Regulations 2002* (SI No.161 of 2002).

¹⁶ The 2002 *Report of the Motor Insurance Advisory (Board Report of the Motor Insurance Advisory Board* (2002), available at djei.ie, discussed in Appendix C, below, made 67 recommendations for reform which were intended to improve the competitiveness of the insurance industry, and thereby reduce the costs of insurance to policyholders. While much of the focus of the 2002 MIAB Report was on motor insurance, a number of the

Thus, the *Non-Life Insurance (Provision of Information) (Renewal of Policy Insurance) Regulations 2007*,¹⁷ which apply to 8 specified classes of non-life insurance,¹⁸ require insurers to issue to their clients in writing, not less than 15 working days prior to the date of expiry of any such policy of insurance (a) where the insurer wishes to invite a renewal, a notification of renewal of the policy of insurance, or (b) a notification that it does not wish to invite a renewal, unless in this second case the insurer has reason to believe that the client would not wish to renew the policy.¹⁹

10.09 These Acts and Regulations form part of the dispersed statutory framework on insurance contracts that also includes a series of Regulations derived from the extensive EU-derived law in this area. This framework includes in particular:

- the *European Communities (Non-Life Insurance) Framework Regulations 1994*,²⁰ which implemented a series of EU Directives on Non-Life Insurance,²¹ and which apply to 18 classes of non-life insurance;²² and

72 recommendations ranged beyond this class of non-life insurance. It recommended that Regulations should be introduced requiring motor insurers to provide policyholders with a “minimum period of notice, of not less than 15 working days” of the terms on which renewal is offered, and the notice would include “no claims bonus” documents to enable clients to “shop around” for comparative quotes. This was implemented in the *Motor Insurance (Provision of Information) (Renewal of Policy of Insurance) Regulations 2002*. (SI No.389 of 2002). The 2004 *Final Report of the Motor Insurance Advisory Board (Final Report of the Motor Insurance Advisory Board (2004))*, available at djei.ie, noted that the 2002 Regulations had “greatly assisted private policyholders in securing cheaper quotations... as could similar arrangements for commercial policyholders.” (p.4 of Introduction (letter to Tánaiste and Minister for Enterprise, Trade and Employment from Chairperson). The Competition Authority, in its 2005 *Final Report on Competition Issues in the Non-Life Insurance Market, (Competition Issues in the Non-Life Insurance Market: Final Report and Recommendations* (in two volumes), Vol.1, at paragraphs 7.31-7.59, available at www.tca.ie.) recommended that this approach should also be applied to a much wider range of non-life insurance renewal and this, in turn, was implemented in the *Non-Life Insurance (Provision of Information) (Renewal of Policy Insurance) Regulations 2007* (SI No.74 of 2007).

¹⁷ SI No.74 of 2007. The 2007 Regulations also revoked the *Motor Insurance (Provision of Information) (Renewal of Policy of Insurance) Regulations 2002* (SI No.389 of 2002).

¹⁸ The 2007 Regulations apply to the following 8 classes out of the 18 classes of non-life insurance listed in Annex I of the *European Communities (Non-Life Insurance) Framework Regulations 1994* (SI No.359 of 1994). Class 1: Accident (including fixed pecuniary benefits or benefits in the nature of indemnity). Class 2: Sickness (including fixed pecuniary benefits or benefits in the nature of indemnity). Class 3: Land Vehicles, other than railway rolling stock (all damage to or loss of such vehicles). Class 7: Goods in transit (all damage or loss to merchandise, baggage, and all other goods). Class 8: Fire and natural forces (all damage to or loss of property, other than property in classes 3, 4, 5, 6 and 7, due to: fire, explosion, storm, natural forces other than storm, nuclear energy or land subsidence). Class 9: Other damage to property (all damage to or loss of property, other than property included in classes 3, 4, 5, 6 and 7, due to hail or frost, and any event such as theft, other than those mentioned under class 8). Class 10: Motor vehicle liability (all liability arising out of the use of motor vehicles operating on the land, including carrier’s liability). Class 13: General liability (all liability other than those forms mentioned under classes 10, 11 and 12). For a full list of the 18 classes to which the Non-Life Regulations 1994 apply, and the corresponding categories in the *Insurance Act 1936*, see Appendix C, fn3, below.

¹⁹ The 2007 Regulations also reiterated the requirement in the 2002 Regulations that, in the case of motor insurance, the notice must also include the policyholder’s “no claims discount.”

²⁰ SI No.359 of 1994. The 1994 Regulations have been amended a number of times including by the *Central Bank and Financial Services Authority of Ireland Act 2003* and the *Central Bank Reform Act 2010*. These amendments provided for the transfer of the regulation of insurance undertakings to the Central Bank (between 2003 and 2010, IFSRA).

²¹ Directive 73/239/EEC (First Council Directive: taking-up and pursuit of the business), Directive 88/357/EEC (Second Council Directive amending 73/239/EEC: provisions to facilitate effective exercise of freedom to

- the *European Communities (Life Assurance) Framework Regulations 1994*,²³ which implemented a series of EU Directives on Life Insurance.²⁴

These Regulations, and the EU Directives they implement, focus primarily on general regulatory issues such as the right of establishment and solvency requirements for insurance undertakings. Nonetheless, they also contain some specific provisions concerning the form of insurance contracts.

10.10 By way of example of the complexity of following this patch-work of requirements, the Commission notes that Article 45(1) and (2) of, and Annex III to, the *European Communities (Life Assurance) Framework Regulations 1994* originally imposed the relevant requirements concerning pre-contractual and post-contractual documents in life insurance contracts.

Article 45(1) and (2) of, and Annex III to, the 1994 Regulations were revoked by section 14(1) of the *Insurance Act 2000*. They were replaced by Part IIIA of the 1989 Act (comprising sections 43A to 43G of the 1989 Act²⁵) and Schedule 3 to the 1989 Act.²⁶

The other elements of Article 45 of the 1994 Regulations remain in place. These include important provisions as to whether some or all of these requirements apply to consumers only or to businesses. Thus, while in general the 1994 Regulations apply to both, Article 45(4)(b) of the 1994 Regulations provides that the “cooling-off” period for life insurance does not apply in “contracts of insurance where none of the proposers or policyholders is an individual.”

This important limitation on the scope of the information requirements (which the Commission considers could be more clearly worded) would only be apparent to a person tracing the relevant requirements through a series of poorly linked statutory provisions comprising a combination of primary and secondary legislation.

10.11 It has been recognised that the complexity of the legislative framework at EU level has also become unwieldy. Directive 2009/138/EC, usually known as the 2009 “Solvency II” Framework Directive, brings together in a single text 13 EU Insurance Directives,²⁷ including the Life Assurance and Non-Life Insurance Directives which have been implemented in the *European Communities (Non-Life Insurance) Framework Regulations 1994*²⁸ and the *European Communities (Life Assurance) Framework Regulations 1994*.²⁹

provide services), Directive No. 90/618/EEC (amending 73/239/EEC and 88/357/EEC: motor vehicle liability insurance), and Directive 92/49/EEC (Third Council Directive amending 73/239/EEC and 88/357/EEC).

²² Annex I of the 1994 Regulations lists the 18 classes of non-life insurance risk to which they apply: see the Appendix C of the Report, fn3 for the list.

²³ SI No.360 of 1994. The 1994 Regulations have been amended a number of times including by the *Central Bank and Financial Services Authority of Ireland Act 2003*. These amendments provided for the transfer of the regulation of insurance undertakings to the Central Bank (between 2003 and 2010, IFSRA).

²⁴ Directive 79/267/EEC (First Council Directive on Life Assurance); Directive 90/619/EEC (Second Council Directive on Life Assurance); and Directive 92/96/EEC (Third Council Directive on Life Assurance).

²⁵ Inserted into the 1989 Act by section 7 of the 2000 Act.

²⁶ Inserted into the 1989 Act by section 12 and Schedule 2 of the 2000 Act.

²⁷ As discussed in Appendix C, below, the principal focus of the 13 Directives which the 2009 Solvency II Framework Directive consolidated is on general regulatory issues such as the right of establishment and solvency requirements for insurance undertakings. The extent of this focus can be readily seen when it is noted that it is not until Articles 183 to 186 of the 2009 Directive that the provisions headed “Information for Policyholders” in respect of non-life and life insurance are reached.

²⁸ SI No.359 of 1994.

²⁹ SI No.360 of 1994.

At the time of writing (June 2015), the 2009 Solvency II Framework Directive is scheduled to be implemented in 2016.³⁰

10.12 Some information requirements that apply to insurance contracts are contained in Acts or Regulations that do not have in their title either “Assurance” or “Insurance.” The *Sale of Goods and Supply of Services Act 1980*, the *European Communities (Unfair Terms in Consumer Contracts) Regulations 1995*,³¹ and the *Consumer Protection Act 2007*, discussed in Chapter 9, impose requirements that apply to contracts in general, including insurance contracts, and also impose some specific requirements that apply to insurance contracts only.

Among those are a requirement that the supplier of a service (this includes an insurer) must provide its service with due skill, care and diligence (under the 1980 Act). Among the specific requirements are that: the main subject matter of a contract is in general excluded from the test as to whether such a term is an “unfair term” (under the 1995 Regulations) and that insurers must not engage in post-contractual practices that would impose disproportionate obstacles on a policyholder making a claim under the policy (under the 2007 Act).

10.13 In the context of online service providers (including insurers), a range of statutory obligations arise, many again derived from EU Directives. Thus, the *European Communities (Directive 2000/31/EC) Regulations 2003*,³² which implemented Directive 2000/31/EC, the 2000 Directive on Electronic Commerce, impose generally applicable transparency and information requirements for online service providers.

More particularly, the *European Communities (Distance Marketing of Consumer Financial Services) Regulations 2004*³³ impose a set of information disclosure requirements and confer a cancellation right on consumers (defined as natural persons acting outside their trade or profession) in respect of financial services, which includes insurance.

Schedules 1 and 2 to the 2004 Regulations contain a comprehensive list of the information and notices which must be given to a consumer before the conclusion of a distance contract for the supply of a financial service.

(c) Consumer Protection Code 2012

10.14 To some extent, the complexity of the legislative framework in this area has been tempered by the content of the *Consumer Protection Code 2012*, which was made by the Central Bank of Ireland under, among other statutory provisions, section 61 of the *Insurance Act 1989*.

The *Consumer Protection Code 2012* identifies a significant range of the statutory pre-contractual and post-contractual provisions with which a regulated entity, such as an insurer, must comply when dealing with a policyholder.

These include general principles governing the insurer’s behaviour, the provision of information, knowing the customer and their suitability to the insurance product in question, and post-contractual information requirements.

While breaches of the Code are subject to the significant regulatory powers of the Central Bank of Ireland, they do not, at present, constitute a basis on which the individual policyholder may claim a breach of insurance contract law.

³⁰ The date for implementation of the 2009 Directive was postponed from 2012 to 2016 until full agreement was reached on some of the solvency criteria in it. See generally the guidance material published by the Central Bank of Ireland, available at centralbank.ie.

³¹ SI No.27 of 1995, as amended.

³² SI No.68 of 2003.

³³ SI No.853 of 2004, which implemented Directive 2002/65/EC, the 2002 Directive on Distance Marketing of Consumer Financial Services.

(d) Insurance Ireland Codes

10.15 The Insurance Ireland voluntary codes of practice recognise the importance of good information gathering practices and the use of documents to improve communication with proposers (pre-contractually) and policyholders (post-contractually).

They also identify requirements to advise proposers of the consequences of failure to disclose all material circumstances and a suggestion that proposers should complete a written declaration that they have been so advised.

The Codes do not however require the mandatory maintenance of records or provision of any particular documents by insurers to proposers³⁴ and decisions such as *Manor Park Homebuilders Ltd v AIG Europe (Irl) Ltd*³⁵ indicate that, notwithstanding the existence of these Codes since the early 1990s, poor documentary practices continue to give rise to difficulties for insurers and policyholders alike.

(e) Financial Services Ombudsman

10.16 The establishment in 2004 of the statutory Financial Services Ombudsman (FSO) has provided a significant additional level of protection for insurance consumers. While the FSO has an important level of discretion in arriving at decisions involving disputes between insurers and their policyholders, it is also limited to making decisions that reflect the general framework concerning insurance contract law and is not free to make decisions inconsistent with that framework.

(f) Conclusions and recommendation

10.17 The Commission has concluded that there is a strong case for the relevant provisions to be consolidated in a single general legislative framework. This would facilitate transparency and bring greater clarity and certainty to the area.

This would also be consistent with the consolidation of relevant EU law, as the 2009 “Solvency II” Framework Directive brings together in a single text 13 EU Insurance Directives, including the Life Assurance and Non-Life Insurance Directives which have been implemented by the *European Communities (Non-Life Insurance) Framework Regulations 1994*,³⁶ the *European Communities (Life Assurance) Framework Regulations 1994*³⁷ and a number of dispersed elements of various *Insurance Acts*, notably Part IIIA of the *Insurance Act 1989* (as inserted by the *Insurance Act 2000*).

Bearing in mind that the Commission has also recommended in this Report a wide-ranging number of reforms for consumer insurance contracts, it considers that the insurance sector should be given a reasonable period of time to put in place suitable arrangements to implement in practice those reforms. It would also allow relevant consumer bodies (notably the Competition and Consumer Protection Commission) as well as the media to communicate their effects to the public. The Commission notes in this respect that, in connection with the comparable reforms enacted in the UK under the *Consumer Insurance (Disclosure and Representations) Act 2012* and the *Insurance Act 2015* a period of up to 18 months after enactment was provided for before those reforms were to come into force. The Commission considers that such a time frame would be a suitable precedent for this jurisdiction.

10.18 The Commission recommends that the essential requirements concerning the form of insurance contracts should be consolidated in a single general legislative framework. The Commission also recommends that, having regard to the wide-ranging nature of the reforms recommended in this Report, a period of 18 months should be allowed after the enactment of the relevant legislation before the reforms would come into force.

³⁴ See, for example the *Code of Practice on Life Assurance—Duty of Disclosure* and the *Code of Practice on Non Life Insurance*. The requirements of the Codes must also be seen against the background of the statutory requirements now imposed under, for example, the Acts and Regulations discussed above.

³⁵ [2008] IEHC 174; [2009] 1 ILRM 190: see Chapter 8, above.

³⁶ SI No.359 of 1994.

³⁷ SI No.360 of 1994.

B Specific Matters Concerning Form of the Contract

(1) Provision of Pre-Contractual and Post-Contractual Information

10.19 Pre-contractual documents help to ensure transparency and allow proposers to review contracts in order to make informed decisions before entering into a contract. Post-contractual information assists the policyholder to understand the scope of the policy.

Such information allows the benefits of a life policy to be clearly understood and, in a claim under a non-life policy, the policyholder is made aware of additional matters like policy excesses (which are common in motor and health policies).

(a) Life Policies

10.20 For life policies section 43B of and the Third Schedule to the *Insurance Act 1989*³⁸ impose mandatory pre-contractual and post-contractual information requirements which “must be provided in a clear and accurate manner, in writing.”

Section 43B implemented the requirements of Article 31 of Directive 92/96/EEC (the 1992 Third Life Assurance Framework Directive)³⁹ and provides that, before concluding a life insurance contract, information must be provided to the proposer under the following 13 headings which directly concern the terms of the proposed insurance contract:⁴⁰

- definition of each benefit and each option,
- length of term of the contract,
- means of terminating the contract,
- means of payment of premiums and duration of payments,
- means of calculation and distribution of bonuses,
- indication of surrender and paid-up values and the extent to which they are guaranteed,
- information on the premiums for each benefit, both main benefits and supplementary benefits, where appropriate,
- for unit-linked policies, definition of the units to which the benefits are linked,
- indication of the nature of the underlying assets for unit-linked policies,
- arrangements for application of the cooling-off period,
- general information on the tax arrangements applicable to the type of policy,

³⁸ Inserted into the 1989 Act by the *Insurance Act 2000*.

³⁹ These elements of Article 31 of the 1992 Directive had already been implemented by Article 45(1) and 45(2) and Annex III of the *European Communities (Life Assurance) Framework Regulations 1994* (SI No.360 of 1994). Section 14 of the *Insurance Act 2000* revoked Article 45(1) and (2) and Annex III of the 1994 Regulations. Article 31 of the 1992 Directive is now set out in Article 185 of Directive 2009/138/EC, the 2009 Solvency II Framework Directive, which brings together in a single text 13 EU Insurance Directives, including the 1992 Directive.

⁴⁰ In addition, section 43B of the 1989 Act, as inserted into the 1989 Act by sections 7 and 12 of the 2000 Act, imposes the following information requirements related to the assurance undertaking (as opposed to the terms of the contract, with which this Report is primarily concerned) before concluding the life assurance contract: (i) the name of the undertaking and its legal form; (ii) the name of the EU Member State in which the head office and, where appropriate, the agency or branch concluding the contract is situated; and (iii) the address of the head office and, where appropriate, of the agency or branch concluding the contract. Section 43B of the 1989 Act also requires any changes in this information to be notified during the term of the life insurance contract. As is clear from item (iii) in this list, these obligations arise directly from the EU Life Assurance Directives the other provisions of which have been implemented in the *European Communities (Life Assurance) Framework Regulations 1994* (SI No.360 of 1994).

the arrangements for handling complaints concerning contracts by policyholders, lives assured or beneficiaries under contracts including, where appropriate, the existence of a complaints body, without prejudice to the right to take legal proceedings, and

the law applicable to the contract where the parties do not have a free choice or, where the parties are free to choose the law applicable, the law the assurer proposes to choose.

Section 43B of and the Third Schedule to the 1989 Act also provide that throughout the term of the life assurance contract the policyholder must receive (in addition to the policy conditions, both general and special) the following post-contractual information:

- all the information listed in points 1 to 9, above, in the event of a change in the policy conditions or amendment of the law applicable to the contract, and
- every year, information on the state of bonuses.

10.21 The *Life Assurance (Provision of Information) Regulations 2001*⁴¹ supplemented the requirements in section 43B of the 1989 Act by prescribing, in detail, the specific form of the pre-contractual information to be provided to proposers together with some of the detailed elements of the life insurance policy which must be provided after the contract has been concluded.⁴²

⁴¹ SI No.15 of 2001, as amended by the *Life Assurance (Provision of Information) (Amendment) Regulations 2002* (SI No.161 of 2002).

⁴² In 2008 the Financial Regulator (now the Central Bank of Ireland) published a Consultation Paper on the 2001 Regulations, *Review of the Life Assurance (Provision of Information) Regulations 2001* (CP34, September 2008), available at www.centralbank.ie. The 2008 Consultation Paper sought views on how the presentation of information required by the 2001 Regulations could be improved. This consultation process did not progress any further in light of proposals being developed since 2008 by the EU Commission on Packaged Retail Investment Products (PRIPs). The work on PRIPs arose directly from the global financial crisis that emerged in 2008 when retail investors lost money in investments that carried risks that were not transparent or understood by those investors. The general purpose of the proposals to emerge from PRIPs is to restore consumer confidence in financial investment products by ensuring greater transparency in the information provided to retail investors. In 2012 the EU Commission published a draft Regulation on Key Information Documents for Investment Products (COM(2012) 352 final), which requires financial investment products to provide Key Information Documents (KIDs) to retail investors. This draft Regulation would exclude from its scope insurance products that only offer insurance benefits, such as “pure protection” life insurance products, or non-life insurance products, which provide no surrender value that is exposed to fluctuations in the performance of one or more underlying assets or reference values. It would therefore appear that this draft 2012 Regulation would not affect the type of life insurance product covered by the 2001 Regulations. The concept of KIIDs in the draft 2012 Regulation is based on the Key Investor Information Documents (KIID) that must be provided by collective investment schemes (such as investment fund managers) under Directive 2009/65/EC, the 2009 Directive on Undertakings for Collective Investment in Transferable Securities (“UCITS IV”), which was implemented in the *European Communities (Undertakings for Collective Investment in Transferable Securities) Regulations 2011* (SI No.352 of 2011) (the requirements of the KIID are in Regulations 98 to 102 of the 2011 Regulations). The Central Bank has published relevant material on the preparation of a KIID: see Guidance Note 1/11 *Undertakings for Collective Investment in Transferable Securities (UCITS)–Publication of a Key Investor Information Document* (July 2011), available at centralbank.ie. It is notable that Regulation 99(1) of the 2011 Regulations provides that KIIDs “constitute pre-contractual information” and Regulation 99(2) provides: “A person shall not incur civil liability solely on the basis of the key investor information, including any translation of such information, unless it is misleading, inaccurate or inconsistent with the relevant parts of the prospectus. Key investor information shall contain a clear warning in this respect.”

The 2001 Regulations require, for example, that the pre-contractual information must contain specific information using the following headings (which must be in capital letters):

- “(1) MAKE SURE THE POLICY MEETS YOUR NEEDS!
- (2) WHAT HAPPENS IF YOU WANT TO CASH IN THE POLICY EARLY OR STOP PAYING PREMIUMS?
- (3) WHAT ARE THE PROJECTED BENEFITS UNDER THE POLICY?
- (4) WHAT INTERMEDIARY REMUNERATION OR SALES REMUNERATION IS PAYABLE?
- (5) ARE RETURNS GUARANTEED AND CAN THE PREMIUM BE REVIEWED?
- (6) CAN THE POLICY BE CANCELLED OR AMENDED BY THE INSURER?
- (7) INFORMATION ON TAXATION ISSUES.”

The detailed and prescriptive nature of the 2001 Regulations is illustrated by the requirement that the following warning must be included (in bold) in the information provided under item (1), above (“make sure the policy meets your needs”):

“WARNING

If you propose to take out this policy in complete or partial replacement of an existing policy, please take special care to satisfy yourself that this policy meets your needs. In particular, please make sure that you are aware of the financial consequences of replacing your existing policy. If you are in doubt about this, please contact your insurer or insurance intermediary.”

Similarly, the 2001 Regulations require that the following must be included (in bold) in the information provided under item (3) (“what are the projected benefits under the policy?”):

“IMPORTANT

THESE ILLUSTRATIONS ASSUME A RETURN OF (RATE)% PER ANNUM. THIS RATE IS FOR ILLUSTRATION PURPOSES ONLY AND IS NOT GUARANTEED.

ACTUAL INVESTMENT GROWTH WILL DEPEND ON THE PERFORMANCE OF THE UNDERLYING INVESTMENTS AND MAY BE MORE OR LESS THAN ILLUSTRATED.”

Thus, while section 43B of the 1989 Act involved the implementation of the requirements of Article 31 of Directive 92/96/EEC, (the 1992 Third Life Assurance Framework Directive),⁴³ the detail contained in the 2001 Regulations is much more prescriptive than required by the 1992 Directive. Such additional requirements in national law are perfectly permissible because EU Member States agreed in the 1992 Directive that its provisions could be supplemented by more extensive requirements to ensure that there is a proper understanding of the commitments involved.⁴⁴

(b) Non-Life Policies

10.22 Article 27 of the *European Communities (Non-Life Insurance) Framework Regulations 1994*⁴⁵ prescribes a much less extensive list of pre-contractual information to be provided to proposers in

⁴³ Article 31 of the 1992 Directive is now set out in Article 185 of Directive 2009/138/EC, the 2009 Solvency II Framework Directive, which brings together in a single text 13 EU Insurance Directives, including the 1992 Directive.

⁴⁴ Article 31(3) of the 1992 Directive provides that Member States “may require... undertakings to furnish information in addition to that listed in [the Directive]... only if it is necessary for a proper understanding by the policyholder of the essential elements of the commitment.” This is repeated in Article 185(7) of Directive 2009/138/EC, the 2009 Solvency II Framework Directive, which consolidates, among other Directives, the 1992 Directive. Thus, neither the 1992 or 2009 Directive involve “maximum harmonisation” measures (such a Directive would preclude Member States from legislating for additional requirements).

⁴⁵ SI No.359 of 1994.

advance of concluding a non-life policy. The information is primarily limited to stating the law applicable to the contract (that is, item 13 from the list of matters that must be notified for life insurance).

This limited amount of pre-contractual information reflects precisely the matters required under the EU Directives on Non-Life Insurance which the 1994 Regulations implemented.⁴⁶

Unlike life insurance, no comparable pre-contractual or post-contractual requirements have been added by means of ministerial Regulations made under section 43B or 43D of the *Insurance Act 1989*, although there is no impediment to doing this for non-life insurance, and clearly this was done, (albeit limited to documentary renewal requirements), in the *Non-Life Insurance (Provision of Information) (Renewal of Policy Insurance) Regulations 2007*.⁴⁷

(c) Distance Marketing of Consumer Financial Services Regulations 2004

10.23 The *European Communities (Distance Marketing of Consumer Financial Services) Regulations 2004*⁴⁸ require insurers who conduct their business through “distance marketing” methods⁴⁹ to provide consumers⁵⁰ with prescribed pre-contractual information and with all the terms of the contract after it has been concluded.

Regulation 6(1) of the 2004 Regulations provides:

“Within a reasonable time *before* a consumer is bound by a distance contract for the supply of a financial service, the supplier shall give the consumer the information specified in Schedule 1.” (emphasis added)

Schedule 1 to the 2004 Regulations lists the following mandatory pre-contractual information:⁵¹

- the identity and geographical address of the main business of the supplier;
- where the consumer resides in another Member State and the supplier has a representative in that State, the identity of that representative and the geographical address relevant;
- where the consumer’s dealings are with a person (other than the supplier) who is acting as an advisor or agent, (i) the person’s identity, capacity, address, and electronic mailing address;
- particulars of the supplier’s registered company or equivalent, if relevant;
- the particulars of the relevant supervisory authority;
- the particulars of the supplier’s profession as regulated by law, if relevant;
- the registration number assigned for value-added tax purposes;

⁴⁶ Directive 73/239/EEC (First Council Directive: taking-up and pursuit of the business); Directive 88/357/EEC (Second Council Directive amending 73/239/EEC: provisions to facilitate effective exercise of freedom to provide services); Directive No. 90/618/EEC (amending 73/239/EEC and 88/357/EEC: motor vehicle liability insurance); and Directive 92/49/EEC (Third Council Directive amending 73/239/EEC and 88/357/EEC).

⁴⁷ SI No.74 of 2007.

⁴⁸ SI No.853 of 2004, which implemented Directive 2002/65/EC, the 2002 Directive on Distance Marketing of Consumer Financial Services.

⁴⁹ Including online, telephone or email communications. These methods are increasingly replacing the traditional setting of a physical high street insurance office: see Appendix C, below.

⁵⁰ Limited to a natural person who is acting otherwise than in the course of a business.

⁵¹ In addition, as with section 43B of the *Insurance Act 1989*, Schedule 1 to the 2004 Regulations also requires the supplier to supply information related to the financial service supplier, notably: the identity, main business and address of the supplier; if the consumer resides in another EU Member State, the name and address of the supplier’s representative in that State; name and address(es) of the advisor or agent with whom the consumer may be dealing and a statement of capacity; the supplier’s registered company details, if applicable; details of any relevant supervisory authority under any applicable authorisation scheme; details of any membership of a professional body regulated by law; VAT registration details.

- a description of the main characteristics of the financial service;
- total price payable including fees;
- a relevant notice about risks and performance fluctuations;
- possible additional taxes and costs;
- limitations on the accuracy of information provided;
- arrangements for payment and performance;
- additional charges for use of a means of distance communication;
- availability of cancellation rights and details relating to this;
- minimum length of the service where it is of a recurring nature;
- early or unilateral termination details and charges;
- instructions on exercise of the right to cancel the contract;
- details of the applicable law selected by the supplier on the issue of establishing relations with the consumer;
- any term in the contract on applicable law or jurisdiction;
- language(s) in which contract details will be given;
- language(s) in which the supplier will communicate with the consumer during the currency of the contract;
- availability of access to out-of-court redress mechanisms for the consumer;
- details on guarantee funds or other compensation agreements.

This list is comparable to the 13 items listed in section 43B of and the Third Schedule to the *Insurance Act 1989*⁵² that apply to life insurance policies, though clearly the 24 items in the 2004 Regulations take into account that they apply to life and non-life insurance (and other financial products such as bank loans).

10.24 Regulation 6(2) of the 2004 Regulations provides that:

“The supplier shall—

- (a) make known to the consumer the commercial purpose of the contract, and
- (b) give that information in a way that is clear and comprehensible, taking into account the means of communication used, and
- (c) in giving that information, comply with all enactments and rules of law that—
 - (i) require good faith in commercial transactions, or
 - (ii) provide protection to those who are unable to give their consent, such as minors.”

Regulation 6(2)(c)(i) explicitly requires the insurer to comply with “enactments and rules of law” that require “good faith in commercial transactions.” This is drafted in a manner sufficiently wide to include the common law and statutory rules of contract law discussed in Chapter 9, which refer to a “fair and reasonable” test, which has the same effect in terms of outcome as a “good faith” test.⁵³

⁵² Inserted into the 1989 Act by the *Insurance Act 2000*.

⁵³ The connection with the statutory rules discussed in Chapter 9 is reinforced by Regulation 9(6) of the 2004 Regulations.

(d) Consumer Protection Code 2012

10.25 Chapter 4 of the *Consumer Protection Code 2012* contains general requirements that replicate the statutory requirements referred to above, notably those in section 43B of and the Third Schedule to the *Insurance Act 1989*⁵⁴ and in the Distance Marketing Regulations 2004.⁵⁵

The 2012 Code also expressly notes that detailed statutory requirements already apply to certain insurance products, such as those in the *Life Assurance (Provision of Information) Regulations 2001*⁵⁶ and the *Non-Life Insurance (Provision of Information) (Renewal of Policy Insurance) Regulations 2007*.⁵⁷

The 2012 Code contains more detailed requirements as to the contents of insurance contracts than in the current legislative framework. These include: the information that must accompany an insurance quotation, as well as particular information in respect of motor insurance policies, permanent health insurance policies, property insurance policies, and serious illness policies.

The 2012 Code also requires insurers to explain to consumers, at the proposal stage, the consequences for the consumer of failure to make full disclosure of relevant facts. It provides that an insurer:

“must issue policy documents, within five business days of all relevant information being provided by the consumer and cover being underwritten, to any consumer to whom it has sold its insurance policy directly or to any insurance intermediary that has sold its insurance policy... This provision also applies in the case where the consumer renews an existing policy.”⁵⁸

This also takes account, *inter alia*, of insurers who agree to hold a proposer on cover, pending the receipt of certain additional information or documents.

10.26 It is of great benefit to have these requirements, as well as the additional detail, brought together in the 2012 Code but, because of the patch-work nature of the legislative framework, it would be preferable if the key legislative provisions, together with the reforms recommended in this Report, were brought together under a single legislative framework.

(e) Principles of European Insurance Contract Law (PEICL)

10.27 The Commission considers that the relevant provisions of Articles 2:201 and 2:501 of the PEICL on pre-contractual and post-contractual information, set out below, contain a useful statement, at an appropriate level of generality, that could form the basis for the relevant provisions of the general legislative framework.

The text of Articles 2:201 and 2:501 reflect the existing EU *acquis* because they are largely modelled on the EU Life Insurance and Non-Life Insurance Directives (now consolidated in the 2009 “Solvency II” Directive) and on the 2002 Distance Marketing Directive, which has already been implemented in Irish law by the Distance Marketing Regulations 2004.

(i) Provision of Pre-contractual Documents

10.28 Article 2:201(1) of the PEICL provides that insurers should supply proposers with (i) a copy of the proposed contract terms as well as (ii) a document which includes the following information:

- the name and address of the contracting parties;
- the name and address of the insured and of the beneficiary;
- the name and address of the intermediary;

⁵⁴ Inserted into the 1989 Act by the *Insurance Act 2000*.

⁵⁵ SI No.853 of 2004.

⁵⁶ SI No.15 of 2001, as amended by the *Life Assurance (Provision of Information) (Amendment) Regulations 2002* (SI No.161 of 2002).

⁵⁷ SI No.74 of 2007.

⁵⁸ The 2012 Code also provides that an insurance intermediary must also, within five working days of receiving the policy documents from an insurance undertaking, provide them to the consumer.

- the subject matter of the insurance and the risks covered;
- the sum insured and any deductibles;
- the amount of the premium or the method of calculating it;
- when the premium falls due as well as the place and mode of payment;
- the contract period and the liability period;
- the right to revoke the application or avoid the contract;⁵⁹
- the law applicable to the contract or, if a choice of law is permitted, the law proposed by the insurer;
- the existence of an out-of-court complaint and redress mechanism for the applicant and the methods for having access to it;
- the existence of guarantee funds or other compensation arrangements.

Article 2:201(1) requires the provision of this information only “if relevant”, so that the information can be tailored to meet the requirements of individual contracts (for example, risks and exclusion, premiums, details of the policyholder and beneficiary), and the requirements can be met in a variety of ways, including the provision of basic information on a website followed by retrievable or printable text within SMS messages or emails.⁶⁰

10.29 Article 2:201(2) of the PEICL provides that “[i]f possible, this information shall be provided in sufficient time to enable the applicant to consider whether or not to conclude the contract”.

10.30 Article 2:201(3) of the PEICL provides that when the proposer applies for insurance on the basis of an application form and/or a questionnaire, as provided by the insurer, the insurer should supply the proposer with a copy of the completed documents.

10.31 The Commission agrees with the authors of PEICL that these documents are of “decisive evidential value” when determining the contents and requirements of the concluded contract of insurance.⁶¹ The Commission considers that relevant documentation, without undue difficulty can and should be furnished by insurers as soon as is reasonably practicable.

(ii) Contents

10.32 Article 2:501 of the PEICL provides that when concluding an insurance contract, an insurer should provide (i) an insurance policy, and (ii) the general contract terms which are not included in the policy, including the following post-contractual information, if relevant:

- the name and address of the contracting parties;
- the name and address of the insured and of the beneficiary;
- the name and address of the intermediary;
- the subject matter of the insurance and the risks covered;
- the sum insured and any deductibles;
- the amount of the premium or the method of calculating it;
- when the premium falls due as well as the place and mode of payment;
- the contract period and the liability period;

⁵⁹ In accordance with Article 2:303 of the PEICL.

⁶⁰ Article 2:201(2) of the PEICL provides that “if possible” relevant information “shall” be provided in “sufficient time” to enable the applicant to consider whether or not to conclude a contract. As to non-compliance with such a requirement, see the discussion at paragraphs 10.94ff, below.

⁶¹ Basedow et al (eds), *Principles of European Insurance Contract Law* (Sellier, 2009) at 93.

- the right to avoid the contract;⁶²
- the law applicable to the contract;
- the existence of an out-of-court complaint and redress mechanism for the applicant and the methods for having access to it;
- the existence of guarantee funds or other compensation arrangements.

This list of 12 post-contractual items is virtually identical to the list of 12 pre-contractual items in Article 2:201 of the PEICL, and it also reflects the approach in the EU Directives, discussed above.

(f) Conclusions and recommendations

(i) Type of pre-contractual information and post-contractual information to be provided

10.33 As the PEICL largely reflects existing requirements of the EU *acquis*, which have already been implemented in Irish law, the Commission considers that the provisions in Article 2:201 on pre-contractual information and Article 2:501 on post-contractual information could be applied where both life insurance and non-life insurance are supplied to consumers.

In Ireland the main effect would be that these requirements would now apply where life insurance and non-life insurance are supplied in the “traditional” office setting: they already apply, in accordance with the Distance Marketing Regulations 2004, where they are supplied through distance marketing means, such as telephone, email or the internet.

In view of the increasing percentage of insurance that is arranged by distance marketing means (see Appendix C, below) and the consequential decreasing level of insurance that is arranged in an office setting, the Commission considers that this reform has the dual advantage of providing a clearer legislative framework and one that applies in all settings whether online or off-line.

(ii) Provision of Documentation

10.34 In the Consultation Paper, the Commission provisionally concluded that the contemporaneous provision of the policy document at the conclusion of the contract (as envisaged by the PEICL) was an overly onerous obligation, particularly in the context of an insurance setting where preliminary cover is sought or documents need to be prepared or reviewed.

Accordingly, the Commission provisionally recommended that, subject to a possible “cooling-off period”, insurers should transmit the policy documents to consumers within 15 working days of the contract being agreed. However, since publication of the Consultation Paper, the Central Bank’s *Consumer Protection Code 2012* now offers good, non-prescriptive guidance on this matter, and in light of the extensive consultation process involved in the production of the 2012 Code, the Commission no longer considers it necessary to recommend a prescriptive timeframe.

10.35 Nonetheless (consistent with the Commission’s recommended reformulation in Chapter 3 of the pre-contractual duty of disclosure), the provision of pre-contractual information, whether contained in a form of a proposal or set of questions, is especially important when it comes to determining the contents of the concluded contract of insurance or a possible breach of the duty to provide information in answer to questions posed.

The Commission therefore considers that a general requirement to provide policy documents and any other contractual details to a policyholder at, or after, the conclusion of the contract would be consistent with the general recommendation concerning the obligation on a consumer to provide pre-contractual information. The Commission also considers that post-contractual information and documentation can and should, without undue difficulty, be furnished by insurers as soon as is reasonably practicable.

⁶² In accordance with Article 2:303 of the PEICL.

(iii) Mislaid Policy Documents

10.36 During the currency of an insurance contract, especially one that is renewed, documents which may be essential to understanding the nature of the contract and its obligations and requirements can become mislaid; and policyholders must be able to obtain those documents (or copies) from insurers with relative ease.

In Canada, section 531 of Alberta's *Insurance Act 2000* provides that an insurer shall on request furnish to the policyholder a copy of (a) the policyholder's application or proposal for insurance, and (b) the policyholder's policy; and that the insurer must furnish the first copy of the policy free of charge, but may charge a reasonable fee to cover its expenses in furnishing additional copies.⁶³

Where copies of policy documents become mislaid, the Commission considers that, because of the importance of such documents to the policyholder, the approach taken in section 531 of Alberta's *Insurance Act 2008* should be adopted in Ireland.

10.37 The Commission recommends that within a reasonable time but before a consumer is bound by a contract of insurance, the insurer should provide the consumer with the following pre-contractual information: (a) the name and address of the contracting parties, (b) the name and address of the insured and of the beneficiary, (c) the name and address of the intermediary, if any, (d) the subject matter of the insurance and the risks covered, (e) the sum insured and any deductibles, (f) the amount of the premium or the method of calculating it, (g) when the premium falls due as well as the place and mode of payment, (h) the contract period and the liability period, (i) the right to avoid or terminate the contract, including in accordance with the recommendations in this Report, (j) the law applicable to the contract, (k) the existence of an out-of-court complaint and redress mechanism for the policyholder and the methods for having access to it, and (l) the existence of guarantee funds or other compensation arrangements.

10.38 The Commission recommends that within a reasonable time after concluding a contract of insurance, the insurer should provide the consumer in writing with the following contractual information where relevant to the specific contract of insurance: (a) the completed application or proposal form, if any, (b) the insurance policy and (c) the information required under the above recommendation unless that information is already included in the insurance policy.

10.39 The Commission recommends that where a consumer applies to the insurer for a second or subsequent copy of one or all of the documents referred to above, the insurer should provide the consumer with the document or documents and may charge a reasonable fee to cover its expenses for providing a second or subsequent copy.

(2) Contractual material in writing or other durable form

10.40 Existing law contains a number of information requirements affecting insurance contracts. However there is no general provision requiring that all terms of the contract must be reduced to writing or other durable form in order to be enforceable.

The general contract rules of offer and acceptance and of identifiable consideration apply to an insurance contract. In *Kennedy v London Express Newspapers*⁶⁴ an advertisement in the *Daily Express* newspaper expressly provided readers with details of the benefits of insurance cover. The High Court held that no actual registration mechanism formed a part of the means of concluding the contract, so that there was a concluded contract when the plaintiff completed a document providing the newspaper with details of registration by way of a letter posted in Dublin. Similarly, general contract law rules provide that a binding insurance contract comes into existence once the proposer has promised to pay the premium, even where this promise has been made verbally and has not yet been reduced to writing. When doubts arise

⁶³ To the same effect see section 26 of British Columbia's *Insurance Act*.

⁶⁴ [1931] IR 532.

about the terms upon which the contract has been concluded judicial relief can be, and often has been, sought.⁶⁵

10.41 This is reflected in Article 2:301 of the PEICL which provides: “An insurance contract shall not be required to be concluded or evidenced in writing nor subject to any other requirement as to form. The contract may be proved by any means, including oral testimony.”

The Commission endorses the view that the essential element of an insurance contract is whether the parties have reached agreement and on what terms. Indeed, consistently with the view in the PEICL, it is socially desirable that insurance cover can be put in place as quickly as possible once the parties have reached agreement, and a requirement that all terms be put in writing would cause unnecessary delay.

The Commission has made a number of recommendations that will impose additional written information requirements on insurers. However, as the parties to an insurance contract place weight on oral information, representations and assurances made and provided to them, these matters should not be excluded from the contract because they have not been reduced to writing. It would be inappropriate to provide for such a prescriptive requirement because of the wide variety of insurance products, both life and non-life, that are now available to consumers.

10.42 **The Commission recommends that the enforceability of a contract of insurance should not be dependent upon whether its terms have been reduced to writing and recommends also that particular terms of the contract may be proved by any means, including oral testimony.**

(3) How information is to be provided

10.43 There are no legislative provisions of general application in Ireland that expressly regulate the size of print in, or the legibility of, consumer or other contracts. In the Consultation Paper the Commission provisionally recommended that insurance contract terms should be drafted in plain, intelligible language.

Regulation 5 of the *European Communities (Unfair Terms in Consumer Contracts) Regulations 1995*⁶⁶ require consumer contracts, including insurance contracts, to be drafted in “plain, intelligible language.”

Reflecting this, provision 4.1 of the *Consumer Protection Code 2012* also provides that a regulated entity (including an insurer) “must ensure that all information it provides to a consumer is clear, accurate, up to date, and written in plain English.”

The 2012 Code includes a number of provisions relating to the presentation and legibility of material provided by insurers to consumers, which include provisions relating to matters governing font size, warning signs and footnotes.⁶⁷

10.44 The *Life Assurance (Provision of Information) Regulations 2001*⁶⁸ contain detailed pre-contractual and post-contractual information requirements to ensure that consumers receive clear information. They specifically state that the pre-contractual information must be provided in a “clear and accurate manner.”

⁶⁵ See Law Reform Commission *Consultation Paper on Insurance Contracts* (LRC CP 65 – 2011) paragraphs 7.36 to 7.38 which provide a number of examples from case law.

⁶⁶ SI No.27 of 1995, as amended, which implemented Article 5 of Directive 93/13/EEC, the Directive on Unfair Terms in Consumer Contracts. See the discussion of the 1995 Regulations in Chapter 9, above.

⁶⁷ Paragraphs 3.4-3.7, 4.10, 4.12, 4.13 and 4.14 of the Code of Practice for Premium Rate Services issued by the Commission for Communications Regulation also contains provisions dealing with the presentation and legibility of commercial promotions for such services.

⁶⁸ These Regulations were made under sections 43B and 43D of the *Insurance Act 1989* (inserted by the *Insurance Act 2000*).

The 2008 *Review of the Life Assurance (Provision of Information) Regulations 2001*⁶⁹ recommended the “avoidance of legal or financial jargon where possible”⁷⁰ and where such terms are deemed unavoidable, they should be “fully explained, perhaps in an attached glossary to the documentation.”

It also proposed that in terms of document layout “the predominantly textual information should be included at the start of the documentation with the more complex, numerical based information such as the tables of illustrative benefits and charges and information on commission, later in the documentation. This should mean that the consumer has a clear understanding of the product before being presented with the numerical information.”⁷¹

10.45 In 2013 the Department of Jobs, Enterprise and Innovation published a *Consultation on the Regulation of Small Print in Consumer Contracts*.⁷² The Paper commented on the legibility and intelligibility of terms used in contracts in general because “[b]oth aspects are clearly important if consumers are to be in a position properly to understand contract terms.”⁷³

Legibility refers to font size, layout, and the contrast between print and background. Intelligibility refers to unclear or highly legalistic language, excessively long sentences and paragraphs, and lack of differentiation between core and peripheral contract terms.

The Paper concluded that “[t]hrough courts in common law jurisdictions have sometimes criticised the use of excessively small print in contract documents, it is likely that, at least in cases not involving statutory provisions on unfair contract terms, they would be slow to absolve a contracting party from liability solely on the ground that the size of type rendered the contract terms difficult to read.”⁷⁴

The Paper outlined two main options for the future: (1) the making of an order setting a minimum font size for contracts under section 53 of the *Sale of Goods and Supply of Services Act 1980*⁷⁵ or (2) the enactment of provisions on the legibility and intelligibility of consumer contracts in a proposed Consumer Rights Bill, which will consolidate and reform consumer contracts legislation. In 2014, the Department of Jobs, Enterprise and Innovation published a *Consultation Paper on Reform of the Law on Consumer Contract Rights*,⁷⁶ which indicates that the matter will be dealt with using the second option, that is, in the proposed Consumer Rights Bill. In May 2015, the Department published the *Scheme of a Consumer Rights Bill*.⁷⁷

⁶⁹ *Review of the Life Assurance (Provision of Information) Regulations 2001* (CP 34, September 2008), available at centralbank.ie. As noted above, the consultation process initiated by the Financial Regulator (and later transferred to the Central Bank of Ireland) was not progressed to completion in light of the EU Commission’s work on the Packaged Retail Investment Products (PRIPs). Also as noted, it appears that the EU Commission’s proposals arising from its work on PRIPs will not apply to “simple” insurance products that do not contain an investment component.

⁷⁰ *Review of the Life Assurance (Provision of Information) Regulations 2001* (CP 34, September 2008) at paragraph 3.

⁷¹ *Ibid* at paragraph 4.

⁷² Department of Jobs, Enterprise and Innovation *Consultation on the Regulation of Small Print in Consumer Contracts* (Department of Jobs, Enterprise and Innovation, 2013), available at djei.ie.

⁷³ *Ibid* paragraph 19 (footnotes omitted).

⁷⁴ *Ibid*.

⁷⁵ Section 53 of the *Sale of Goods and Supply of Services Act 1980*, which applies to both business-to-consumer and business-to-business contracts, provides for the making of a statutory order to regulate the size of print but it has never been invoked.

⁷⁶ Department of Jobs, Enterprise and Innovation *Consultation Paper on Reform of the Law on Consumer Contract Rights* (Department of Jobs, Enterprise and Innovation, 2014) available at djei.ie.

⁷⁷ *Scheme of a Consumer Rights Bill* (May 2015), available at djei.ie, discussed in Chapter 9, above.

10.46 The authors of PEICL in Article 1:203(1) provide the following in respect of the language and interpretation of insurance documents:

“All documents provided by the insurer shall be plain and intelligible and in the language in which the contract is negotiated.”

Article 1:203 is modelled on Article 5 of the Unfair Terms Directive, as implemented in Ireland by Regulation 5(1) of the Unfair Terms in Consumer Contracts Regulations 1995, noted above.

10.47 The Commission favours a standardised approach to the type of language that is to be included in insurance consumer contracts and their accompanying documentation.

The Commission concludes that in the interests of transparency all language in a contract of insurance should be drafted in “plain, intelligible language”. This reflects the general provision in Regulation 5(1) of the Unfair Contract Terms Regulations 1995 and Article 1:203(1) of the PEICL. The Commission also notes that provision 4.1 of the *Consumer Protection Code 2012* requires that that all information provided to a customer must be clear, accurate, up to date, and written in plain English.

10.48 The Commission recommends that all documents provided by the insurer to the consumer should be drafted in plain and intelligible language.

(4) How information is to be interpreted

10.49 Where a contractual term is ambiguous the interpretation less favourable to the drafter is adopted (in the vast majority of cases this would be the insurer) using the *contra proferentem* rule.⁷⁸

A similar rule is reflected in Regulation 5(2) of the Unfair Contract Terms Regulations 1995, which requires that consumer contracts, including insurance contracts, are to be drafted in “plain, intelligible language” and where there is “doubt” about the meaning of a contract term the interpretation most favourable to the consumer is to prevail.

This position is also adopted by the authors of PEICL in Article 1:203(2) which provides that:

“When there is doubt about the meaning of the wording of any document or information provided by the insurer, the interpretation most favourable to the policyholder, insured or beneficiary, as appropriate, shall prevail.”⁷⁹

10.50 The *contra proferentem* rule was applied to insurance contracts by Kingsmill Moore J *In re Sweeney and Kennedy’s Arbitration*:⁸⁰

“The wording of the proposal form and the policy was chosen by the underwriters who knew, or must be deemed to have known, what matters were material to the risk and what information they desired to obtain. They were at liberty to adopt any phraseology which they desired.”

10.51 The Supreme Court in *Analog Devices BV v Zurich Insurance Company*⁸¹ referred to the rule as a “fundamental principle”,⁸² and it has been applied in many insurance cases, including *Keating v New*

⁷⁸ This derives from the legal maxim *verba chartarum fortius accipiuntur contra proferentem* (“the words of documents are construed against the grantor”): see Buckley *Insurance Law* 3rd ed (Thomson Round Hall 2012) paragraph 6-05 fn8.

⁷⁹ The Article is modelled on Article 5 of the Unfair Terms Directive, implemented in Ireland by Regulation 5 of the Unfair Terms in Consumer Contracts Regulations 1995, noted above.

⁸⁰ [1950] IR 85 at 98-99. In this case an application form asked the proposer if any of his drivers are “under 21 years of age or with less than 12 months experience.” The proposer truthfully answered in the negative but at a later date he hired a driver who failed to satisfy these conditions. The Court held that the insurer should not be allowed to avoid the policy on the basis that a promissory warranty as to the future was implicitly built into the contract. The Court considered that the insurer “could have provided clearly and expressly that no driver should be employed who was under 21 years of age or had less than 12 months’ experience, and they could have done this by means of a special condition or by an addition.”

⁸¹ [2005] IESC 12; [2005] 1 IR 274.

Ireland Insurance,⁸³ *Manor Park Homebuilders Ltd v AIG (Europe) Ltd*⁸⁴ and *McAleenan v AIG (Europe) Ltd*.⁸⁵

10.52 English case law has moved towards an approach that prevents the *contra proferentem* rule being used to give a strained interpretation of contractual terms that might not reflect a meaning that a reasonable person would deduce from the words themselves.⁸⁶ This approach is also reflected in the Supreme Court decision in *Emo Oil Ltd v Sun Alliance Insurance plc*⁸⁷ in which the Court commented:

“In the past some courts were quick to find ambiguity in policies of insurance, in order to apply the canon of construction *contra proferentem*, and that raised the suspicion that the canon was being used to create the ambiguity, which then justified the (further) use of the canon: the cart (or the canon) got before the horse in the pursuit of the insurer. Orthodoxy, however, is that *contra proferentem* ought only to be applied for the purpose of removing a doubt, not for the purpose of creating a doubt, or magnifying an ambiguity, when the circumstances of the case raise no real difficulty. The maxim should not be used to create the ambiguity it is then employed to solve. First there must be genuine ambiguity.”⁸⁸

Since at “all times the opportunity for an insurer to protect itself is fully in its own hands,”⁸⁹ the contract must be construed in the context of the policy and in the circumstances of the case and therefore cannot be found to be “ambiguous in the abstract.” The aim of contractual interpretation is to find the meaning which the document would convey to a reasonable person having all the background knowledge reasonably available to the parties, including anything which would have affected the way a reasonable person would have understood it but excluding previous negotiations or subjective intent.⁹⁰ The Commission therefore considers that it should be explicitly provided that where there is ambiguity or doubt about the meaning of the wording of any document or information provided by the insurer, the interpretation most favourable to the policyholder should prevail.

10.53 The Commission recommends that where there is ambiguity or doubt about the meaning of the wording of any document or information provided by the insurer to the consumer the interpretation most favourable to the consumer will prevail.

(5) Prescribed notices, notification and forms

10.54 Insurance contracts contain a number of notification formalities which can vary depending on the type of insurance and the particular insurer’s policy.

In the Consultation Paper, the Commission provisionally recommended that legislation should: (i) prescribe notices, notification and forms for insurance contracts comparable to those already required under existing legislation such as the Distance Marketing Regulations 2004; and (ii) impose a statutory duty on insurers to provide proposers with the prescribed notices, notification and forms.

⁸² *Ibid* at paragraph 14.

⁸³ [1990] 2 IR 383 at 395.

⁸⁴ [2008] IEHC 174; [2009] 1 ILRM 190.

⁸⁵ [2010] IEHC 128.

⁸⁶ See *Investors Compensation Scheme Ltd v West Bromwich Building Society* [1998] 1 WLR 896; *HIH Casualty and General Insurance Ltd. v Chase Manhattan Bank* [2003] UKHL 6; [2003] 1 All ER (Comm) 349 and Clark *Contract Law in Ireland* 6th ed (Round Hall 2008) at 197-198 and 357-358.

⁸⁷ [2009] IESC 2.

⁸⁸ *Ibid* quoting Clarke *The Law of Insurance Contracts*, 5th ed (London, 2006) at paragraph 15-5.

⁸⁹ Corrigan “Developments in Irish Insurance Law: ‘The Last 25 Years – A General Overview’” in *Landmarks in Insurance 1985-2010* (Insurance Institute of Ireland, 2010) Chapter 9, at 58.

⁹⁰ *O’Reilly v Irish Life Assurance Plc* [2005] IEHC 449 at paragraph 87.

The Commission invited submissions on the precise nature and content of such prescribed requirements.⁹¹

Some submissions received by the Commission suggested that such an obligation would be “too prescriptive” and that insurance policies currently contain reasonable and satisfactory timelines for claims notifications, cancellations and other similar events; that existing legal and regulatory requirements are reasonable and effective; and that change could, albeit unintentionally, cause confusion without achieving improvement.

Consultees accepted that while greater clarification of notification requirements was desirable, it was preferable that any proposed legislation should simply provide that the insurers must prescribe in policy wordings the precise notice requirements and provide standard forms of notification of claims (and/or circumstances where relevant); and that the proposed legislation should not prescribe specific notice requirements and/or the content of notification forms, particularly as these will vary depending on the type of insurance involved.

10.55 The Commission concludes that, in general, insurers are best placed to determine the notification time periods that will be required for the many and differing types of insurance contracts. However there should be a general obligation that all notifications requirements required by insurers should be brought to the attention of their policyholders and that any such notice periods should comply with general requirements concerning unfair or otherwise onerous terms, as discussed in Chapter 9.

The Commission also considers that provision should be made for Regulations to prescribe particular notice periods in specific insurance contracts, which would be without prejudice to existing statutory notice requirements.

The Commission considers that further details concerning any formalities in a consumer insurance contract (that is, in addition to those recommended in this Report), such as prescribed notices, notification and forms, should be set out either in Regulations to be made by the Minister for Finance or in a Code of Practice to be issued by the Central Bank of Ireland.

As to Regulations, this reflects the current position that a number of detailed requirements concerning the content of insurance contracts are set out in Regulations such as the *Life Assurance (Provision of Information) Regulations 2001*,⁹² the *European Communities (Distance Marketing of Consumer Financial Services) Regulations 2004*⁹³ and the *Non-Life Insurance (Provision of Information) (Renewal of Policy Insurance) Regulations 2007*.⁹⁴

Similarly, the Central Bank’s *Consumer Protection Code 2012* currently contains detailed requirements concerning certain notification periods and dispute handling related to insurance contracts.

⁹¹ Law Reform Commission *Consultation Paper Insurance Contracts* (LRC CP 65 – 2011) paragraph 7.50.

⁹² SI No.15 of 2001, as amended by the *Life Assurance (Provision of Information) (Amendment) Regulations 2002* (SI No.161 of 2002).

⁹³ SI No.853 of 2004, as amended by the *European Communities (Distance Marketing of Consumer Financial Services) (Amendment) Regulations 2005* (SI No.63 of 2005).

⁹⁴ SI No.74 of 2007. The 2007 Regulations also revoked the *Motor Insurance (Provision of Information) (Renewal of Policy of Insurance) Regulations 2002* (SI No.389 of 2002).

10.56 **The Commission recommends that any formalities in a consumer insurance contract, such as prescribed notices, notification and forms, should be brought to the attention of the consumer at the commencement of the contract and should comply with the requirements concerning unfair or otherwise onerous terms.⁹⁵**

10.57 **The Commission recommends that further details (that is, in addition to those recommended in this Report) concerning any formalities in a consumer insurance contract, such as prescribed notices, notification and forms, should be set out either in Regulations to be made by the Minister for Finance or in a Code of Practice to be issued by the Central Bank of Ireland.**

(6) *The right to cancel or the “cooling-off” period*

(a) *No general right to cancel or withdraw from the contract*

10.58 Where insurance contracts are conducted face to face there is no general right to cancel or withdraw from the contract, in other words, there is no general “cooling-off” period.

For life assurance, however, Article 45(3) of the *European Communities (Life Assurance) Framework Regulations 1994*⁹⁶ prescribes a compulsory cooling-off period of 30 days after the date on which the policy was issued.⁹⁷

Article 45 also provides that the notice of cancellation “shall” expressly indicate that the person has withdrawn from the proposed insurance contract and “shall” have the effect of releasing that person from any future obligation arising from the insurance contract.

The notice of cancellation “shall” be deemed to be served on the insurance undertaking at the time when such notice is posted to an address as specified by the insurance undertaking. Any sums paid by the person serving the notice of cancellation in connection with the insurance contract “shall” be refunded in full by the insurance undertaking.⁹⁸ However the cooling-off period “shall” not apply in the case of the following:

- contracts of insurance effected for a term of six months’ duration or less;
- contracts of insurance where none of the proposers or policyholders is an individual;
- contracts of creditor insurance effected for the purpose of insuring the repayment of a loan and where it is intended that such a contract will be assigned or deposited with the lender; and
- contracts of reinsurance.

(b) *Distance Marketing of Consumer Financial Services Regulations 2004*

10.59 The *European Communities (Distance Marketing of Consumer Financial Services) Regulations 2004*,⁹⁹ which apply to insurance consumers not acting within the course of their business or trade, currently provide for a right of withdrawal or a cooling-off period of 14 days except for life assurance

⁹⁵ The requirements concerning unfair or otherwise onerous terms are discussed in Chapter 9, above.

⁹⁶ SI No. 360 of 1994. As noted above, the 1994 Regulations implemented the following EU Directives on Life Insurance: Directive 79/267/EEC (First Council Directive on Life Assurance); Directive 90/619/EEC (Second Council Directive on Life Assurance); and Directive 92/96/EEC (Third Council Directive on Life Assurance).

⁹⁷ Article 45(3) of the Life Regulations 1994 provides that the date on which a policy is issued is the date on which the policy is delivered to the person who submitted the proposal for the insurance or, if the policy is sent directly to that person by post, the date on which the policy is posted.

⁹⁸ Article 45(11) of the Life Regulations 1994 also provides: “In the case of the serving of notice of cancellation in respect of a single premium life assurance contract, the insurance undertaking may, when the person has withdrawn from the proposed contract, refund the amount of premium paid less any losses incurred by the insurance undertaking as a result of fluctuations in the financial markets during the period of the legal validity of the insurance contract.”

⁹⁹ SI No.853 of 2004. As noted above, the 2004 Regulations implemented Directive 2002/65/EC, the 2002 Directive on Distance Marketing of Consumer Financial Services.

where the period is 30 days.¹⁰⁰ This time period does not begin to run until the pre-contract information requirements have been complied with.¹⁰¹ The Distance Marketing Regulations 2004 do not apply to:

- an insurance policy under which insurance cover is provided for less than one month;
- a travel insurance policy; or
- a baggage insurance policy.¹⁰²

(c) PEICL

10.60 Article 2:303 of the PEICL provides for a general cooling-off period for insurance contracts modelled on the EU Life Assurance Directives and the EU Distance Marketing Directive, which were implemented, respectively, in Ireland by the *European Communities (Life Assurance) Framework Regulations 1994*¹⁰³ and the *European Communities (Distance Marketing of Consumer Financial Services) Regulations 2004*.¹⁰⁴

Article 2:303(1) provides that the policyholder “shall be entitled to avoid the contract by giving written notice within two weeks after receipt of acceptance or delivery of” the post-contractual information, whichever is the later.

10.61 In line with the 2002 Distance Marketing Directive, Article 2:303 provides that the policyholder is entitled to avoid the contract *ab initio*. The consequences of avoidance are governed by Article 4:115 of the PEICL which provides that “either party may claim restitution of whatever it has supplied under the contract, provided it makes concurrent restitution of whatever it has received. In relation to insurance it means the insurer is entitled to restitution of any payment of insurance money while the policyholder is entitled to restitution of any payment of premium. The insurer is not entitled to claim reimbursement of any expenses in relation to the conclusion of the contract.”

10.62 Like the Life Assurance Consolidation Directive and the 2002 Distance Marketing Directive, the authors of the PEICL recognise that there are circumstances where the granting of a cooling-off period is not appropriate and, like those Directives, PEICL provides for exceptions to the general applicability of the cooling-off period, although its list is more expansive than in the Directives. Article 2:303(2) of the PEICL states that the policyholder shall not be entitled to avoid the contract in the following five circumstances:

- when the duration of the contract is less than one month;
- when the contract is prolonged under Article 2:602;¹⁰⁵
- in the case of preliminary insurance;
- in the case of liability insurance;
- in the case of group insurance.

¹⁰⁰ Regulations 11(4) and 11(5) of the Distance Marketing Regulations 2004.

¹⁰¹ Regulation 11(6) of the Distance Marketing Regulations 2004.

¹⁰² Regulation 12(1)(b) of the Distance Marketing Regulations 2004.

¹⁰³ SI No.360 of 1994.

¹⁰⁴ SI No.853 of 2004.

¹⁰⁵ The authors of the PEICL comment: “The prolongation is to be distinguished from renewal in the sense of a new agreement for the purposes of the applicant’s or the insurer’s information duties, of the duty to issue certain documents in relation to the conclusion of the contract, of the consequences attached to the non-payment of the first premium and of other obligations in relation to the formation phase of the contract. If, however, one of the parties gives notice... and a new contract is made between the same parties afterwards, it will depend upon the particular circumstances of the case whether the rules of law relating to the formation stage of the contract apply.” Basedow et al (eds), *Principles of European Insurance Contract Law* (Sellier 2009) at 146.

The first exception provides that where the duration of the contract is less than one month there will be no cooling-off period. The authors of the PEICL argue that in short-term insurance contracts such as these, “a right of avoidance would create a disproportionate uncertainty about the validity of the contract”, furthermore a policyholder would not be “substantially prejudiced due to the low premiums for such short term contracts.”¹⁰⁶

This exception reflects Article 6(2)(b) of the Distance Marketing Directive, which was implemented by Regulation 12(1)(b) of the Distance Marketing Regulations 2004.

The second exception concerns “prolonged contracts” which are triggered under the PEICL after a one year period unless certain obligations are met. The Commission does not make any recommendation on such contracts because most insurance contracts in Ireland run for a one year period and are then subject to renewal requirements.

The third exception specifically identifies “preliminary insurance cover”, the type of insurance that comes “with the understanding that it will end as soon as the main insurance contract takes effect after a short lapse of time.”¹⁰⁷ An example of this type of insurance given by the authors of PEICL is insurance that must be taken out as a precondition to obtain certain public licences, such as car insurance. If the policyholder were allowed to avoid the contract within a period of two weeks, the purpose of this requirement, for example the protection of third party victims of potential traffic accidents, would be undermined, because such victims would be unprotected.¹⁰⁸

This type of insurance would normally be of a short duration and so could well fall within the category of insurance cover provided for less than one month under Regulation 12(b) of the Distance Marketing Regulations 2004. However the authors of the PEICL argue that, given the potential negative impact on innocent third parties should a policyholder attempt to cancel such insurance, it should be explicitly included as an exception.

The fourth and fifth exceptions, namely liability and group insurance, are often taken out for the benefit of third parties. The authors of the PEICL state that the avoidance by the policyholder of a liability insurance contract “would essentially impair the interest of third parties who would not even be informed of such avoidance.”¹⁰⁹

Similarly the PEICL argues that the “avoidance of the contract by the policyholder would interfere with the rights and interests of those group members who are not party to the insurance contract. It follows that the exception does not apply where the group members have concluded individual insurance contracts under a general framework agreement.”¹¹⁰

(d) Conclusion and Recommendations

10.63 While there is no general right of withdrawal from an insurance contract, a policyholder is entitled to withdraw from a life insurance contract for a period of up to 30 days for both face to face and distance transactions, and for a period of up to 14 days for non-life insurance that is contracted at a distance, such as over the telephone, by email or the internet.

10.64 The Commission concludes that a general right of withdrawal is consistent with pre-existing rights and with the Commission’s recommendations regarding the pre-contractual and post-contractual information requirements in Chapters 3 and 8, above. However any such period should not be overly prescriptive and would benefit from the exceptions identified by the PEICL.

Consistent with the provisions of the Distance Marketing Regulations 2004, the period of time should be triggered after the “receipt of all material information, including the standard terms,” so that the

¹⁰⁶ Basedow et al (eds), *Principles of European Insurance Contract Law* (Sellier 2009) at 112 paragraph C8.

¹⁰⁷ *Ibid* at 112 paragraph C9.

¹⁰⁸ *Ibid* at 112 paragraph C9.

¹⁰⁹ *Ibid* at 113 paragraph C11.

¹¹⁰ *Ibid* at 113 paragraph C12.

policyholder can “appraise the contract of insurance offered” in order to “make a well-informed decision whether it meets his needs.”

10.65 The Commission recommends that a consumer should be entitled to avoid an insurance contract by giving written notice, in the case of non-life insurance within 14 working days and in the case of life assurance within 30 working days,¹¹¹ after receipt of acceptance or delivery of the post-contractual documents, whichever is the later. The notice provisions are subject to the following exceptions: (i) the duration of the contract is less than one month; (ii) an existing contract is renewed on substantially the same terms and conditions as the original agreement; and (iii) it is preliminary insurance, liability insurance or group insurance.

10.66 The Commission recommends that where the insurer gives written notice of avoidance the insurer cannot charge anything other than the premium for the period of cover.

(7) Cancelling outside the “cooling-off” period

10.67 Outside of the cooling-off period the right to cancel a contract of insurance is generally governed by the terms of the contract.¹¹²

Where these contracts can be cancelled by either party the manner in which this can be executed may not be the same for the insurer as it is for the policyholder. For example some contracts provide that where the policyholder cancels the contract during the period of insurance they will generally receive a *pro rata* refund of premiums paid, less a cancellation charge.

However this is not always the case as some policies state that this type of repayment will only occur if the insurer decides to cancel a policy, and where the policyholder cancels, the insurer will retain all the premiums already paid, or will refund a proportion smaller than if the insurer had cancelled the policy.

No general minimum notification period is prescribed and notice given is dependent on the particular insurer, the policy in place, or specific legislation. For example, the Road Traffic Acts require a minimum of 10 days’ notice¹¹³ in respect of motor policies but this can be as much as 90 days in specially negotiated commercial contracts. Other types of policies do not have a statutory notice period.

10.68 Insurers generally send written notice by registered post to a policyholder’s last known address.¹¹⁴ However not all insurers issue notice by registered post.

In a case taken to the Financial Services Ombudsman¹¹⁵ a couple’s insurance policy was cancelled after two successive payments had not been made due to insufficient funds in their bank account. The complainant was adamant that she was unaware that this had occurred and that she had never received any correspondence from the insurer warning her that the policy was due to lapse. In contrast the insurance company claimed to have sent three letters to the complainant and further letters to her building society informing it.

However like the complainant, the building society stated that it received no correspondence in relation to this matter. Although registered post was not used and there was no proof the letters had been sent, the FSO made a determination in favour of the insurer.

¹¹¹ As the Commission is simply extending the application of these time limits, it does not consider that this recommendation conflicts with the earlier recommendation not to prescribe the precise nature and content of such prescribed notices, notification and forms.

¹¹² See *Carna Foods Ltd v Eagle Star Insurance Co* [1997] 2 IR 193. Fraud, misrepresentation or non-disclosure renders a contract of insurance void *ab initio* thereby entitling the insurer to cancel a policy. Schedule 1(2) of the *Life Assurance (Provision of Information) Regulations 2001* stipulates what happens if a policyholder wants to cash in the policy early or stop paying their premiums.

¹¹³ Regulation 6 of the *Road Traffic (Compulsory Insurance) (Amendment) Regulations 1992* (SI No.346 of 1992) provides that Saturday, Sunday and any public holiday is not included in the reckoning of the ten clear days.

¹¹⁴ See Buckley *Insurance Law* 3rd ed (Thomson Round Hall 2012) paragraph 5-171.

¹¹⁵ See “Widow of man who took own life gets €500 insurance settlement” *The Irish Times*, 7 March 2014.

While the FSO correctly determined that it was the complainant's responsibility to ensure premiums were paid the Commission is less comfortable with the determination that postal correspondence was "beyond the control" of the sender.

10.69 If the standard procedure is "registered post", and the reasoning for this is obvious – to disprove any claim that such correspondence was not received (and by extension to prove that the correspondence was indeed issued), the Commission queries any justification for non-registered post particularly in light of the above outcome.

10.70 It is notable that among the non-exhaustive list of terms in Schedule 3 to the Unfair Contract Terms Regulations 1995 which may be regarded as unfair, and therefore not binding on a consumer, is the following:

"(d) permitting the seller or supplier to retain sums paid by the consumer where the latter decides not to conclude or perform the contract, without providing for the consumer to receive compensation of an equivalent amount from the seller or supplier where the latter is the party cancelling the contract."

10.71 The Commission has already recommended in Chapter 9 that an insurer who seeks to rely on an unfair or otherwise onerous term should, in order to incorporate the term into the contract, take reasonable steps to bring such a term to the attention of the consumer and that it should also comply with the requirements concerning unfair or otherwise onerous terms. In light of the serious consequences of cancelling an insurance contract the Commission considers there is need for written notice to be delivered by a method of recorded delivery such as registered post, or by email, by text or the internet (in circumstances where such means were indicated as a method of communication).

The Commission also considers that in circumstances where the insurer chooses to cancel the contract of insurance during the term of the contract, for whatever reason, they should refund the balance of the premium for the unexpired period of insurance without any further cost to the consumer. The consumer should not be subject to any additional cost associated with the cancellation of the contract as this was done at the behest of the insurer.

10.72 The Commission recommends that in circumstances where an insurer cancels an insurance contract during the term of the contract, it should communicate this to the consumer by notice in writing and by a method of recorded delivery (which may be by email, SMS text or other electronic means using the internet where the insurer can establish receipt of the notification by the consumer).

10.73 The Commission recommends that where an insurer so cancels an insurance contract it must refund the balance of the premium for the unexpired period of insurance without any further cost to the consumer.

(8) *Renewal of the insurance contract*

10.74 Section 43F(2) of the *Insurance Act 1989*¹¹⁶ defines a "renewal notice" as "a notice in writing issued by an insurer or an insurance intermediary which requests a client to renew the policy concerned in accordance with the terms and conditions of the policy, of any endorsements to the policy and of the notice".

10.75 Two issues arise on the renewal of a contract of insurance. First, what type of notification periods, if any, are required. Second, if the insurer is required to issue a renewal notification, what type of information it is required to provide.

(a) *Notification periods upon renewal*

10.76 Specific renewal notification time periods in current legislation are designed to afford the policyholder the opportunity to "shop around" for cover.

¹¹⁶ Inserted by the *Insurance Act 2000*.

Under Regulation 5 of the *Non-Life Insurance (Provision of Information) (Renewal of Policy Insurance) Regulations 2007*¹¹⁷ an insurer shall, not less than 15 working days prior to the date of expiry of a policy of insurance: (a) where the insurer wishes to invite a renewal, issue to the client in writing a notification of renewal of the policy of insurance, or (b) issue to the client in writing a notification that it does not wish to invite a renewal, unless in the case of this sub-paragraph (b) the insurer has reason to believe that the client would not wish to renew the policy.

10.77 The Commission accepts that the renewal notice period in Regulation 5 of the *Non-Life Insurance (Provision of Information) (Renewal of Policy Insurance) Regulations 2007* is an appropriate time period and sees no justification for its extension or curtailment.

(b) Provision of information upon renewal

10.78 Regulation 6 of the 2007 Regulations sets out a limited number of information requirements upon renewal of the 8 classes of non-life insurance to which they apply; and a number of specific requirements in respect of motor insurance policies, such as the provision of a no-claims bonus certificate. The explanatory note that accompanies the 2007 Regulations states that the renewal notification should be accompanied by “the terms of the renewal.”

10.79 Regulation 9 of the *Life Assurance (Provision of Information) Regulations 2001*¹¹⁸ provides that life insurers must provide policyholders with an annual written statement containing:

- the current premium payable;
- the current surrender or maturity value; and
- such further information as the assurer considers appropriate.

10.80 The Central Bank’s 2008 Review of these Regulations remarked that, for policies that do not have a surrender value, the 2001 Regulations do not require an annual statement.¹¹⁹

Therefore for policies such as mortgage protection or life assurance or other similar risk policies there is no regular communication from the insurer to the policyholder.

The Central Bank commented that “having access to an annual communication from the insurer in the form of a statement, consumers would, at a minimum, be reminded that they have such policies in place and would be encouraged to monitor their policies and to be more proactive with their finances.”¹²⁰

The Central Bank suggested that, in order to make informed decisions, a policyholder should be provided with more than just the current surrender value. It was suggested that the 2001 Regulations could be expanded to include an annual statement. The Central Bank invited views on whether the following information should be provided to policyholders on a yearly basis on the policy anniversary:

- Opening policy surrender value
- Amount paid in by policyholder in the year
- Details of charges related to risk benefits deducted in the year (if any)
- Other charges deducted in the year
- Investment Growth in the year
- Closing policy surrender value
- Details of risk benefits covered (if any).

¹¹⁷ SI No.74 of 2007.

¹¹⁸ SI No.15 of 2001, as amended by the *Life Assurance (Provision of Information) (Amendment) Regulations 2002* (SI No.161 of 2002).

¹¹⁹ *Review of the Life Assurance (Provision of Information) Regulations 2001* (CP 34, September 2008) at 17.

¹²⁰ *Ibid.*

The Central Bank commented that “[w]here a policy does not have a surrender value, the information provided can be amended accordingly to reflect the particular type of product. A product with no potential surrender value would only require to show details of any risk benefits and the amount paid in to the policy during the year”.¹²¹

The Commission endorses the views expressed in the 2008 Review of the 2001 Regulations and recommends that such information should be provided on renewal of life insurance.

10.81 The Commission recommends that in the case of renewal of non-life consumer insurance contracts the 15 day renewal notice period in Regulation 5 of the *Non-Life Insurance (Provision of Information) (Renewal of Policy Insurance) Regulations 2007* should continue to apply, and that the renewal notification from the insurer to the consumer should be accompanied by the terms of the renewal.

10.82 The Commission recommends that in the case of a life insurance policy (other than an industrial assurance policy) consumers should be provided on a yearly basis and on the policy anniversary with the following by the insurer: current premium payable; opening policy surrender value; current surrender or maturity value; amount paid in by consumer in the year; details of charges related to risk benefits deducted in the year (if any); other charges deducted in the year; investment growth in the year; closing policy surrender value; details of risk benefits covered (if any); and such further information as the insurer considers appropriate.

(9) Issuing reasons for adverse underwriting decisions

10.83 There are no statutory or common law obligations requiring an insurer to issue a statement in writing to a policyholder setting out the reasons for cancelling the contract, for not renewing the insurance cover or for offering insurance cover on less advantageous terms.

In *Carna Foods Ltd v Eagle Star Insurance Co*¹²² the Supreme Court held that a term could not be implied into an insurance contract obliging an insurer to give reasons for its decisions and that there was no implied obligation on the insurer to put the plaintiff back into the position, regarding obtaining insurance cover, that it had enjoyed before entering into the contracts of insurance with the defendant.

The Court also rejected an argument that the refusal to give reasons amounted to a concerted practice which restricted or distorted competition contrary to section 4 of the *Competition Act 1991*,¹²³ or the abuse of a dominant position contrary to section 5 of the 1991 Act.¹²⁴ The Court concluded:¹²⁵

“If the failure to give reasons for a declination or cancellation of an insurance policy were to cause undue difficulty for persons requiring such insurance in general then it may be that the appropriate Minister would take steps to deal with the problems so created for the public.”

10.84 The *Consumer Protection Code 2012* provides that where an insurer refuses to quote a consumer for motor or property insurance it is required to take the following steps within 5 business days of the refusal.¹²⁶

- In the case of motor insurance: “provide the consumer with its refusal and its reasons for refusing cover, on paper or on another durable medium and notify the consumer of their right to refer the matter to the Declined Cases committee and the method of doing so”.
- In the case of property insurance: “inform the consumer of its refusal and its reasons for refusing cover and notify the consumer that failure to have property insurance in place could lead to a

¹²¹ *Review of the Life Assurance (Provision of Information) Regulations 2001* (CP 34, September 2008) at 18.

¹²² [1995] 1 IR 526 (HC); [1997] 2 IR 193 (SC).

¹²³ Since replaced by comparable provisions in the *Competition Act 2002*.

¹²⁴ Also since replaced by comparable provisions in the *Competition Act 2002*.

¹²⁵ [1997] 2 IR 193, at 204.

¹²⁶ Provision 4.39.

breach of terms and conditions attaching to any loan secured on that property. The [insurer]... must inform the consumer that they can request that this information be provided on paper or on another durable medium and must provide this information, on paper or on another durable medium, to the consumer if so requested.”

(a) Australia

10.85 The question of whether or not insurers should be compelled to provide reasons for cancelling or refusing to renew policies was addressed by the Australian Law Reform Commission (ALRC) in its 1982 *Report on Insurance Contracts*. It recognised that as a general rule insurers, in light of their commercial enterprise, should be free to differentiate between risks but such freedom can cause “significant subsequent prejudice to an intending insured”¹²⁷ (for example, in the *Carna* case the plaintiff argued that the absence of reasons made it virtually impossible for them to obtain alternative cover).

During the risk assessment process insurers usually ask if the proposer has ever been refused insurance cover or if an insurer has ever cancelled a policy with them. In the absence of such questions, the prevailing Australian law of disclosure (and, currently, the law in Ireland) required a proposer to disclose to the insurer any such refusal or cancellation.¹²⁸

Insurers could supplement these answers by seeking explanations from former insurers and, even without these explanations, inferences can be drawn which may be unfair. These answers often affect the terms upon which the contract of insurance is offered or indeed if it is offered at all.

In such circumstances a policyholder is left in a precarious position where they do not know why their previous insurer cancelled their policy. They are also unable to correct any possible misinformation communicated in error as they are not privy to the communication from the original insurer.¹²⁹

The ALRC noted that developments in the area of public law supported the view that an insurer should be required to disclose reasons for refusing cover.¹³⁰ Consequently the ALRC recommended that an insurer should be required, upon request by the policyholder, to give precise details of any reasons for refusing cover, cancelling cover or for offering cover on special terms.

10.86 An exception was recommended in circumstances where such a disclosure might unreasonably put at risk the interest or safety of the insurer or some other person.¹³¹ For example the possibility that insurance coverage might be declined on the ground that the proposer is a suspected arsonist. Disclosing such a reason might put the “insurer, an employee or informant at risk”.¹³²

The explanatory memorandum accompanying the Australian *Insurance Contracts Act 1984*, which followed from the ALRC Report, explained that some protection may be necessary in the case of “certain moral risks.” For example, it was suggested that insurance cover might be refused in circumstances where a policyholder is suspected of having connections with organised crime. Section 75(7) of the 1984 Act provides:

¹²⁷ Australian Law Reform Commission *Report on Insurance Contracts* (Report No. 20,1982) at paragraph 214.

¹²⁸ *Ibid.*

¹²⁹ *Ibid.* This comment may now be considered in the context of data protection legislation, such as the *Data Protection Acts 1988 and 2003*, under which a data subject is entitled to have any inaccurate data corrected.

¹³⁰ However the ALRC added: “Both the Administrative Appeals Tribunal Act 1975 (Cwlth) and the Administrative Decisions (Judicial Review) Act 1977 (Cwlth) contain provisions requiring the giving of reasons, upon request, for decisions adverse to an individual’s interests.” Australian Law Reform Commission *Report on Insurance Contracts* (Report No. 20,1982) at paragraph 214.

¹³¹ See section 75(1) and (2) of the Australian *Insurance Contracts Act 1984* for details of the specific legislative provisions. Australian Law Reform Commission *Report on Insurance Contracts* (Report No. 20,1982) at paragraph 214.

¹³² *Ibid.*

“It is a defence to a prosecution for an offence arising under this section if the insurer proves that compliance with this section would have unreasonably put at risk the interests of the insurer or of some other person.”

10.87 The ALRC acknowledged that special problems arise in relation to life insurance.

“First, it might not be appropriate to require disclosure of medical information to the policyholder who is not also the life insured or the parent or guardian of a minor who is the life insured. It is the life insured himself who should be entitled to request that type of information.

Secondly, it might not be in the life insured’s interests for medical information to be disclosed to him rather than to his medical practitioner. For that reason, a life office should be entitled to refuse to make direct disclosure of information to a life insured and to require him to nominate a medical practitioner to whom the disclosure should be made, instead.”¹³³

Section 75(3)-(6) of the 1984 Act provides for these matters.

(b) Principles of European Insurance Contract Law (PEICL)

10.88 The authors of PEICL in Article 2:602(1) provide that the insurance period shall be prolonged unless the insurer has given written notice to the contrary at least one month before the expiry of the contract period stating the reasons for its decision.

This information is meant to equip the policyholder or the proposer (if this is an application in the first instance) with knowledge that might be useful for him when applying for coverage with another insurer; and that the reasons given should not be subject to judicial review unless they are contrary to the good faith principle or public policy, such as a decision based on the individual’s ethnicity.¹³⁴

(c) Conclusion and recommendation

10.89 A proposal for insurance may be declined, or a renewal refused, for a number of reasons including organisational or underwriting considerations that are unrelated to the risk in question. In the absence of some express undertaking, the *Consumer Protection Code 2012* contains the only enforceable duty to explain why a proposal has been declined or an expiring policy not renewed, and is limited to motor and property insurers only.

While accepting the ALRC’s conclusion that a decision not to grant cover can cause “significant subsequent prejudice to an intending insured”¹³⁵ the Commission is reluctant to extend protection beyond that offered by the *Consumer Protection Code 2012*.

A requirement to provide reasons for refusal of insurance cover could expose an insurer to unwanted litigation including claims for defamation where fraud, arson or other criminal activity is strongly suspected but cannot be proved.

Nor does the Commission wish to adopt the proposal made by the authors of PEICL that any right to a statement of reasons would not in general be amenable to review by the courts; such an unenforceable provision would not be of any practical assistance.

10.90 The Commission recommends that there should not be a general statutory obligation requiring insurers to issue statements in writing, or otherwise, identifying the reasons as to why a consumer insurance contract has been cancelled, declined, not renewed or offered on less advantageous terms (this does not affect the provisions in the *Consumer Protection Code 2012*, or in any similar replacement Code, that require reasons for declining cover to be given in specific insurance contracts).

¹³³ *Ibid.*

¹³⁴ Basedow et al (eds), *Principles of European Insurance Contract Law* (Sellier, 2009) at 147, paragraph C4.

¹³⁵ Australian Law Reform Commission *Report on Insurance Contracts* (Report No. 20,1982) at paragraph 214.

(10) Consequences of non-compliance with duties

10.91 In Chapters 3 and 8 the Commission made detailed recommendations concerning misrepresentation in particular, which were related to a set of proportionate remedies related to the consumer's level of negligence or innocence as the case may be (with fraudulent misrepresentation continuing to attract the appropriate right of the insurer to repudiate liability). These remedies are intended, and are indeed necessary, to ensure that any breaches of duty carry clear contractual consequences.

Equally, the Commission considers that, in order for the duties set out in this Chapter to have real effect, it is important they too must be accompanied by clear consequences for non-compliance.

10.92 Regulations 6(6) and 9(5) of the *European Communities (Distance Marketing of Consumer Financial Services) Regulations 2004*¹³⁶ set out a clear set of consequences for non-compliance with the requirements concerning the provision of certain information in a distance consumer financial services contract, including an insurance contract. Both Regulations 6(6) and 9(5)¹³⁷ are in identical terms and provide:

“(a) Subject to subparagraph (b), a distance contract for the supply of a financial service is not enforceable against the consumer if the supplier has failed to comply with an obligation imposed on the supplier by this Regulation.

(b) Where a court of competent jurisdiction is satisfied that—

(i) the failure to comply with an obligation imposed on the supplier by this Regulation was not deliberate and has not prejudiced the consumer, and

(ii) it would be just and equitable in the circumstances to dispense with the obligation,

then, the court may, subject to any conditions that it sees fit to impose, decide that the agreement shall be enforceable.”

Regulation 9(6) of the 2004 Regulations also prohibits the supplier of the financial service, such as an insurer, from transferring the burden of proof to the insured:

“A term or condition of a distance contract for the supply of a financial service is void if it purports to impose on the consumer the burden of proving that the supplier has complied or not complied with an obligation imposed on the supplier by these Regulations.”

10.93 These provisions in Regulations 6 and 9 of the 2004 Regulations emphasise that the 2004 Regulations operate not only as requirements which may be enforced by the Central Bank in its statutory regulatory capacity but also as mandatory requirements of insurance contract law.

Similarly, the judicial discretion in Regulations 6(6) and 9(5) to dispense with compliance by the insurer if it would be “just and equitable in the circumstances” and the requirement that the burden of proof rests on the insurer under Regulation 9(6) are consistent with the common law “fair and reasonable” test in contract law and the statutory “good faith” test in the *European Communities (Unfair Terms in Consumer Contracts) Regulations 1995*, discussed in Chapter 9, above.¹³⁸

¹³⁶ SI No.853 of 2004, which implemented Directive 2002/65/EC, the 2002 Directive on Distance Marketing of Consumer Financial Services.

¹³⁷ Regulations 6(6) and 9(5) of the 2004 Regulations, as amended by the *European Communities (Distance Marketing of Consumer Financial Services) (Amendment) Regulations 2005* (SI No.63 of 2005).

¹³⁸ Regulation 9(6) of the 2004 Regulations implemented Article 12 of Directive 2002/65/EC, the 2002 Directive on Distance Marketing of Consumer Financial Services, which provides that any contractual term or condition that would impose on the consumer the burden of proving that the supplier complied with the 2002 Directive “shall be an unfair term” under Directive 93/13/EEC, the 1993 Directive on Unfair Terms in Consumer Contracts. The 1993 Directive was implemented by the *European Communities (Unfair Terms in Consumer Contracts) Regulations 1995* (SI No.27 of 1995): see the discussion of the 1995 Regulations in Chapter 9, above.

Since the 2004 Regulations already apply to insurance contracts entered into at a distance, including online (an increasingly important location for entering into insurance contracts),¹³⁹ and since many of the duties recommended in this Chapter reflect those in the 2004 Regulations (as well as duties in other existing statutory provisions on insurance contracts), it is important that non-compliance with those duties also carries suitable consequences.

It is understandable that the 2004 Regulations, which apply to a very wide range of financial services, including a loan, should provide that non-compliance by suppliers of such services with the duties imposed on them would make the contracts unenforceable against the consumer; this is a common feature of consumer protection legislation.

The Commission considers, however, that in the context of an insurance contract, this may not be a suitable consequence because it raises this question: if the contract is not enforceable against the consumer, is it enforceable by the consumer? It may be that a court would answer that Regulations 6(6) and 9(5) operate in one direction only, and that applied to an insurance contract they mean that the consumer has a choice whether to enforce the contract, and that it is voidable only. To anticipate or to rely on such an uncertain interpretation is not, in the Commission's view, satisfactory.

10.94 The Commission has therefore concluded that, to complement the proportionate remedies provided for in Chapters 3 and 8, above, separate but similar arrangements should apply to non-compliance with all other duties and obligations recommended in this Report. Applying this proportionate approach, the sum otherwise recoverable in a claim under an insurance contract could be reduced in the event of a consumer breaching his or her obligations.

In the case of an insurer breaching its obligations, it may be difficult to envisage an increased sum that would be recoverable in a claim under an insurance contract over and above the consumer's actual loss suffered (bearing in mind that non-life insurance is based on indemnity, and that the Commission has separately recommended in Chapter 8 that a consumer may claim damages for consequential loss).

Nonetheless the Commission considers that provision should be made for an unusual instance where this may be relevant, such as if the insurer's non-compliance has been intentional and has caused avoidable distress to the consumer. In such a case, an order to pay an increased sum, over and above actual loss suffered, even if of a modest amount, would serve to indicate suitable disapproval of such behaviour.

The Commission considers that two elements of the 2004 Regulations are also worthy of being reflected in this context. First, that a court may decline to make any such order where: (a) non-compliance was not deliberate and (b) it would be just and equitable in the circumstances to dispense with the obligation. Second, that a term or condition of a consumer contract of insurance is void if it purports to impose on the consumer the burden of proving that the insurer has complied or not complied with an obligation imposed on the insurer: this would apply to all obligations on the insurer referred to in this Report (including those in Chapters 3 and 8).

10.95 The Commission recommends that, without prejudice to the proportionate remedies provided for in Chapters 3 and 8 of the Report, a court may in its discretion: (a) order that where the consumer is in breach of any duties (other than those referred to in Chapters 3 and 8) the sum otherwise recoverable in a claim under an insurance contract be reduced in proportion to the breach involved; and (b) order that where the insurer is in breach of any duties (other than those referred to in Chapters 3 and 8) the sum otherwise recoverable in a claim under an insurance contract be increased in proportion to the breach involved. The Commission also recommends that the court may decline to make any such order where (a) the breach was not deliberate and (b) it would be just and equitable in the circumstances to dispense with the obligation.

10.96 The Commission recommends that a term or condition of a consumer contract of insurance should be deemed void if it purports to impose on the consumer the burden of proving that the insurer has complied or not complied with an obligation imposed on the insurer in this Report (including those in Chapters 3 and 8).

¹³⁹ See Appendix C, below, for discussion of the increasing percentage of insurance contracts being concluded online.

APPENDIX A LIST OF RECOMMENDATIONS IN THE REPORT

The recommendations made by the Commission in this Report are as follows.

Chapter 1: Scope of Report: Consumer Insurance Contracts

The Commission recommends:

1. the legislative framework proposed in this Report should apply to consumers as defined for the purposes of the jurisdiction of the Financial Services Ombudsman and in the Central Bank's *Consumer Protection Code 2012*, namely, natural persons and a person or group of persons (including limited companies and unincorporated bodies such as partnerships, charities, clubs, trusts and sole traders) having an annual turnover of €3 million or less in the preceding financial year. (paragraph 1.24)
2. a code of practice, whether made under statutory authority or otherwise, which contains practical guidance that would assist a court or other adjudicatory body such as the FSO in determining any issue before it in connection with a consumer insurance contract, should be admissible and may be taken into account for that purpose. (paragraph 1.32)
3. except where otherwise provided, the legislative framework proposed in this Report applies in general to contracts of insurance, both life and non-life, made between a consumer and an insurer (that is, an insurance undertaking licensed by the Central Bank of Ireland to provide life insurance or non-life insurance in the State, or an undertaking otherwise lawfully carrying on the business of an insurance undertaking in the State). (paragraph 1.37)
4. the legislative framework proposed in this Report does not alter or affect any rights or obligations concerning or arising from: (a) the duties of an insurance broker or insurance intermediary, (b) contracts of reinsurance, or (c) contracts of marine, air or transport (MAT) insurance. (paragraph 1.38)
5. no provision of the *Marine Insurance Act 1906* should apply to a contract of insurance with which this Report is concerned. (paragraph 1.39)

Chapter 2: Pre-Contractual Duties: Utmost Good Faith and the Duty of Disclosure

The Commission recommends:

6. the abolition of the pre-contractual principle of utmost good faith (whether statutory or at common law) as it applies to consumer insurance contracts. (paragraph 2.61)
7. the abolition of the pre-contractual duty of disclosure (whether statutory or at common law) as it applies to consumer insurance contracts and its replacement with specified statutory duties and obligations. (paragraph 2.62)

Chapter 3: Pre-Contractual Disclosure: Specific Recommendations and Proportionate Remedies

The Commission recommends:

8. the statutory pre-contractual duty of disclosure of a consumer should be confined to providing responses to questions asked by the insurer, and that consumers should not be under a duty to volunteer any information over and above that required by such questions. (paragraph 3.07)
9. it should be the duty of consumers to answer the questions posed by insurers honestly and with reasonable care (the test of reasonable care being by reference to that of an “ average consumer”). (paragraph 3.30)
10. in determining whether the consumer has complied with this duty, regard should be had to the following matters: (a) the type of consumer insurance contract in question and its target market, (b) any relevant explanatory material or publicity produced or authorised by the insurer, (c) how clear, and how specific, the insurer’s questions have been, (d) whether the consumer is represented by an agent, and (e) certain consumers can be expected to be in possession of more information than others. (paragraph 3.31)
11. in light of the reformulated duty of disclosure recommended in this Report, it is not necessary to include in the draft *Consumer Insurance Contracts Bill* appended to this Report the exceptions to the common law pre-contractual duty of disclosure (paragraph 3.35)
12. where insurers request consumers at the pre-contractual stage to provide information to the insurer, the insurer should be under a duty to ask specific questions, in writing, and should not ask general questions. (paragraph 3.47)
13. it should be presumed, unless the contrary is shown, that a consumer will know that a matter about which an insurer asks a specific question is material to the risk undertaken by that insurer or the calculation of the premium by that insurer, or both. (paragraph 3.53)
14. all questions provided by an insurer should be drafted in plain and intelligible language and where there is doubt or ambiguity about the meaning of the wording of any question so provided, the interpretation most favourable to the consumer should prevail, and the onus of proving that the questions are plain and intelligible should rest with the insurer. (paragraph 3.58)
15. an insurer’s failure to investigate an absent or obviously incomplete answer to a relevant material question should be deemed a waiver by the insurer of any further duty of disclosure by the consumer (other than the duty not to engage in fraudulent, intentional or reckless conduct). (paragraph 3.64)
16. the test of what is material, and consequently the scope of questions that the insurer may ask the consumer are without prejudice to the requirements of the *Data Protection Acts 1988 and 2003* and to the provisions of the *Criminal Justice (Spent Convictions) Bill 2012*, if enacted. (paragraph 3.72)
17. an insurer should be entitled to repudiate liability and to refuse to indemnify only if it can prove on the balance of probabilities that non-disclosure of material information was an effective cause of the insurer entering into the relevant contract of insurance on the terms on which it did. (paragraph 3.82)
18. insurers should be under a statutory duty to inform consumers in writing, before a contract of insurance is entered into, or renewed, of the general nature and effect of the reformulated duty of disclosure. (paragraph 3.84)
19. the consequences of non-compliance with the reformulated duty of disclosure should be related to the presence or absence of fault by the consumer in making the misrepresentation and be proportionate to the effects of the misrepresentation upon the interests of the insurer and the consumer. (paragraph 3.96)

20. where consumers discharge their duty to answer questions honestly and with reasonable care and where a misrepresentation is innocent, insurers should pay the claim and should not be entitled to avoid the policy on the ground that there was a misrepresentation. (paragraph 3.105)
21. where it has been established that a consumer has made a negligent misrepresentation, that is, where the consumer has not taken reasonable care but has not acted fraudulently, the remedy available to an insurer should reflect what the insurer would have done had it been aware of the full facts, and should be based on a compensatory and proportionate test as follows: (a) if the insurer would not have entered into the insurance contract on any terms, the insurer should be able to avoid the contract and refuse all claims, but should return the premiums paid, (b) if the insurer would have entered into the insurance contract, but on different terms (excluding terms relating to the premium), the contract should be treated as if it had been entered into on those different terms if the insurer so requires, (c) if the insurer would have entered into the insurance contract (whether the terms relating to matters other than the premium would have been the same or different), but would have charged a higher premium, the insurer should be entitled to reduce proportionately the amount to be paid on a claim. However where there is not any outstanding claim under the insurance contract, the insurer should be entitled to either: (i) give notice to the consumer that in the event of a claim it will exercise the remedies in paragraphs (a) to (c), or (ii) in the case of a non-life insurance contract only, terminate the contract by giving reasonable notice to the consumer. (paragraph 3.112)
22. an insurer should continue to be entitled to avoid the contract of insurance where an answer by a consumer comprises a fraudulent misrepresentation, which should be defined as one which is false or misleading in any material respect and which the consumer either (a) knows to be false or misleading or (b) consciously disregards whether it is false or misleading; and “fraud” and “fraudulent” should be interpreted in the same manner where they are used elsewhere in this Report. (paragraph 3.131)
23. the duty of disclosure should not be taken to imply that a consumer who has on a previous occasion discharged that duty of disclosure is under an obligation at renewal of the contract of insurance to provide the insurer with any additional information, whether concerning matters that have changed or otherwise, unless the insurer has expressly required the consumer to do so. (paragraph 3.143)
24. where an insurer intends that the consumer is to provide additional information at renewal concerning a particular matter, it should either: (a) ask the consumer a specific question in writing regarding the matter, or (b) request the consumer in writing to update information previously provided concerning that matter, which the insurer should specifically describe and should provide to the consumer a written copy of the matter previously disclosed. (paragraph 3.144)
25. where an insurer requests the consumer at renewal to provide information to the insurer, the insurer should be under a duty to ask specific questions, in writing, and should not use general questions. (paragraph 3.145)
26. the consumer should be under a duty to respond honestly and with reasonable care to any requests by the insurer at the renewal of the contract of insurance and, if the consumer does not provide any new information in response to the insurer’s request and where the consumer continues to pay the renewal premium, it should be presumed that the information previously provided has not altered. (paragraph 3.146)
27. the renewal by the insurer of the contract of insurance should not, in itself, be taken to cure any previous breach of any duty of disclosure arising under the contract of insurance. (paragraph 3.147)
28. an insurer should, within a reasonable time before renewal of a contract of insurance (and in any event no later than 15 working days prior to the renewal) notify its consumer policyholder in writing of any alteration to the terms and conditions of the policy, using plain intelligible language in doing so. (paragraph 3.148)

Chapter 4: Warranties and Terms that Describe the Risk

The Commission recommends:

29. the abolition of warranties in consumer insurance contracts (whether that law arose at common law or under an enactment) and their replacement with specific provisions. (paragraph 4.21)
30. any statement made by a consumer in or in connection with a contract of insurance, being a statement made by or attributable to a consumer with respect to the existence of a state of affairs or a statement of opinion, should have effect solely as a representation made by the consumer to the insurer prior to entering into the contract. (paragraph 4.34)
31. any provision which purports to convert any such statement into a contractual warranty, including by means of a declared “basis of contract” clause or by any comparable clause (including one described as a warranty, a future warranty, a promissory or a continuing warranty), should be invalid. (paragraph 4.35)
32. all terms designed to impose continuing restrictive conditions on a consumer during the course of the insurance contract should be treated in the same manner. (paragraph 4.53)
33. any contract term (however such a term is described including being described as a warranty, a future warranty, a promissory or a continuing warranty) that imposes a continuing restrictive condition on a consumer during the course of the insurance contract should be treated as a suspensive condition in that, upon a breach of such a condition, an insurer’s liability for the whole contract is suspended for the duration of the breach but if the breach has been remedied by the time a loss has occurred, an insurer should be obliged to pay the claim (in the absence of any other defence to the claim). (paragraph 4.54)
34. breach of any contract term that is intended to reduce the risk of a particular type of loss, or the risk of loss at a particular time or in a particular location (however such a term is described, including being described as a warranty, a future warranty, a promissory or a continuing warranty) should only suspend liability in respect of that type of loss, or a loss at that time or in that place and an insurer should be unable to rely on the breach of such a term in respect of a loss of a different kind, or loss at a different location or time. (paragraph 4.55)

Chapter 5: Insurable Interest

The Commission recommends:

35. a claim by a consumer under an otherwise valid contract of insurance should not be rejected by the insurer by reason only that the consumer does not have, or did not have at the time when the contract was entered into, an interest in the subject-matter of the contract. (paragraph 5.82)
36. where the consumer is required, because the contract of insurance is also a contract of indemnity, to have an interest in the subject-matter of the contract, the interest required should not extend beyond a factual expectation either of an economic benefit from the preservation of the subject matter, or of an economic loss on its destruction, damage or loss that would arise in the ordinary course of events. (paragraph 5.83)
37. an insurer should not be relieved of liability under the contract of insurance by reason only that the name(s) of the person(s) who may benefit under the contract are not specified in a policy document. (paragraph 5.84)
38. no provision of the *Life Assurance Act 1774*, as extended to Ireland by the *Life Insurance (Ireland) Act 1866*, should apply to a contract of insurance with which this Report is concerned. (paragraph 5.84)

Chapter 6: Privity of Contract and Third Party Rights

The Commission recommends:

39. a third party should be defined for the purposes of this Report as a consumer who is, or may be, entitled to benefit under the terms of a contract of insurance, whether by way of indemnity or as a party who incurs an injury or loss to which the contract of insurance applies. (paragraph 6.32)
40. nothing should be interpreted as requiring that the third party be in existence either at the time the contract of insurance was entered into or at the time of assent of such a contract by another third party. (paragraph 6.33)
41. for the purpose of third party rights in a consumer insurance contract only, an insured person should be defined to include: an individual, a partnership, or any corporate body. (paragraph 6.34)
42. where an insured person is insured under a contract of insurance against a liability which may be incurred to a third party, and where (a) the person has died, or cannot be found, or is insolvent, or (b) where for any other reason it appears to a court to be just and equitable to so order, the third party should enjoy the rights vested in the insured person under that contract of insurance and should be entitled to enforce those rights directly against the insurer, notwithstanding anything to the contrary in any enactment or rule of law, including the doctrine of privity of contract. (paragraph 6.35)
43. the term “cannot be found” means in the case of an individual a “missing person” as defined in the *Report on Civil Law Aspects of Missing Persons* (LRC 106-2013) that is a person who is observed to be missing from his or her normal patterns of life, where those who are likely to have heard from the missing person are unaware of his or her whereabouts and where the circumstances of the person being missing raise concerns for the person’s safety and well-being. (paragraph 6.36)
44. the term “cannot be found” includes, in the case of a company, an “insolvent company”; and that where such a company has been struck off the register of companies, the third party should not be required to restore it to the register before proceeding directly against the insurer. (paragraph 6.37)
45. “insolvency” for the purposes of third party rights should be defined as: (a) in the case of an individual, (i) entering into a Debt Relief Notice, (ii) entering into a Debt Settlement Arrangement, (iii) entering into a Personal Insolvency Arrangement, or (iv) becoming bankrupt; (b) in the case of a corporate body, (i) entering into examinership, (ii) entering into receivership, or (iii) winding up; and (c) in the case of a partnership, being dissolved. (paragraph 6.38)
46. in circumstances of bankruptcy or insolvency, moneys payable to a third party under the policy should be applicable only to discharging in full all valid claims by that third party against a person who is insured against that injury or loss in respect of which those moneys are payable, and no part of those moneys should be deemed assets of that person or applicable to the payment of the debts (other than those claims) of that person in the insolvency or in the administration of the estate of that person, and no such claim should be provable in the insolvency or in the administration of the estate of that person. (paragraph 6.39)
47. third parties should be entitled to issue proceedings directly against insurers before the liability of the relevant insured person has been established, but that the insured person’s liability must be established during the course of those proceedings before those rights of the third party can be enforced. (paragraph 6.45)
48. where a third party reasonably believes that an insured person has incurred a liability to him or her, that third party should be entitled, by way of written notice, to seek information from the insurer or from any person who is able to provide it concerning: (a) the existence of an insurance contract that covers the supposed liability or might be regarded as covering it, (b) if there exists such a contract who the insurer is, (c) the terms of the contract and (d) whether the insurer has informed the consumer that it intends to refuse liability under the contract in respect of the person’s supposed liability. (paragraph 6.53)

49. a third party should owe the same obligations to the insurer as the insured person and may discharge the insured person's obligations under the contract, whereupon anything that would have amounted to, or contributed to fulfilment of a condition of the insurance contract should be treated as if done by the insured person. (paragraph 6.58)
50. the insurer should have the same defences to such an action as the insurer would have in an action by the insured person. (paragraph 6.59)
51. the insurer should be entitled to set off any liabilities incurred by the insured person in favour of the insurer against any liability owed by the insurer to the third party. (paragraph 6.60)
52. the rights of the third party should not be subject to a term in the insurance contract that requires the insured person to provide information or assistance to the insurer if that term cannot be fulfilled because the insured person is an individual who has died or cannot be found; but that "term that requires the insured person to provide information or assistance to the insurer" should not include a term that requires the insured person to notify the insurer of the existence of a claim under the consumer contract of insurance. (paragraph 6.61)
53. the rights of the third party should not be subject to a term in the insurance contract that requires the prior discharge by the insured person of the insured person's liability to the third party. (paragraph 6.62)
54. where a consumer contract of insurance refers to a liability which the insured person may incur to a third party, this includes a liability that is or was incurred voluntarily by the insured person and that a third party may make a direct claim against the insurer in such a case. (paragraph 6.65)
55. where, in respect of any one act of negligence or any one series of acts of negligence collectively constituting one event, there are two or more claimants and the total of the sums claimed for damages for injury to property or for which judgment has been recovered for damages for such injury exceeds the sum which the insurer or guarantor has insured or guaranteed, the liability, as regards each claimant, of the insurer or guarantor in relation to such damages should be reduced to the appropriate proportionate part of the sum insured or guaranteed. (paragraph 6.68)

Chapter 7: Subrogation

The Commission recommends:

56. the subrogation rights of insurers to recover payments from persons in family or other personal relationships with consumers should be modified. The modification should apply where an insurer is liable under a contract of insurance in respect of a loss and where but for this modification the insurer would be entitled to be subrogated to the rights of the consumer against some other person and the consumer has not exercised those rights and might reasonably be expected not to exercise those rights by reason of (a) a family or other personal relationship between the consumer and the other person, or (b) the consumer having expressly or impliedly consented to the use, by the other person, of a motor vehicle that is the subject matter of the contract. The modification should not apply where the conduct of the other person that gave rise to the loss was serious or wilful misconduct. The modification would mean that where the other person is not insured in respect of that other person's liability to the consumer, the insurer would not have the right to be subrogated to the rights of the consumer against the other person in respect of the loss. It also would mean that where the other person is so insured, the insurer would not, in the exercise of the insurer's rights of subrogation, recover from the other person an amount that exceeds the amount that the other person may recover under the other person's contract of insurance in respect of the loss. (paragraph 7.08)
57. an insurer should not be entitled to exercise rights of subrogation against an employee of an insured employer except when it proves that the loss was caused by such a person intentionally or recklessly and with knowledge that the loss would probably result. (paragraph 7.20)
58. the application of the common law "recovery down" principle and the enactment of legislation providing for the distribution of funds recovered by subrogation. (paragraph 7.28)

59. where a consumer contract of insurance includes a provision that has the effect of excluding or limiting the insurer's liability in respect of a loss because the consumer is a party to an agreement that excludes or limits a right of the consumer to recover damages from a person other than the insurer in respect of the loss, the insurer may not rely on the provision unless the insurer clearly informed the insured in writing, before the contract of insurance was entered into, of the effect of the provision. (paragraph 7.32)
60. for the purposes of subrogation a reference to a consumer includes a reference to a third party. (paragraph 7.35)

Chapter 8: Post-contractual Duties

The Commission recommends:

61. the abolition in consumer insurance contracts of the post-contractual principle of good faith and its replacement with specified statutory duties and obligations.(paragraph 8.02)
62. a consumer should be under a duty to pay the premium within a reasonable time or in accordance with the terms of the contract, provided those terms comply with the requirements concerning unfair or otherwise onerous terms. (paragraph 8.05)
63. an insurer may refuse to honour a contract of insurance where there is a change in the subject matter of the contract and circumstances have so changed that it can properly be said by the insurer that the new risk is something which, on the true construction of the policy, it did not agree to cover. (paragraph 8.17)
64. an "alteration of risk" clause should only apply in circumstances where the subject matter of the contract of insurance has altered. (paragraph 8.18)
65. an "alteration of risk" clause should be void where it purports to apply where there is a modification of the risk insured only. (paragraph 8.19)
66. any clause in an insurance contract that refers to a "material change" should be interpreted as referring to changes that take the risk outside that which was within the reasonable contemplation of the contracting parties when the contract was concluded. (paragraph 8.20)
67. an insurer who intends to exclude certain matters from coverage should do so explicitly in writing prior to the commencement of the contract. (paragraph 8.21)
68. consumers should cooperate with their insurers in the investigation of insured events by responding to reasonable requests honestly and with reasonable care. (paragraph 8.27)
69. the consumer should be required to notify the insurer of the occurrence of an insured event within a reasonable time or in accordance with the terms of the contract, provided those terms comply with the requirements concerning unfair or otherwise onerous terms. (paragraph 8.34)
70. where non-compliance with a specified notification period does not prejudice an insurer, the insurer should not be entitled to refuse liability under the claim on that ground alone. (paragraph 8.35)
71. insurers should be under a duty to handle claims promptly and fairly. (paragraph 8.51)
72. insurers should not engage in either of the following practices in relation to consumers' claims on their insurance policies: (i) requiring consumers to produce documents irrelevant to the validity of their claims; or (ii) persistently failing to respond to consumers' correspondence on the matter, in order to dissuade the consumer from exercising contractual rights in respect of their claims. (paragraph 8.52)
73. an insurer should pay any sums due to the consumer in respect of the claim within a reasonable time. (paragraph 8.53)

74. where it is not possible to quantify the total value of the claim within a reasonable time but where part of the total value has been quantified the insurer should pay that part to the consumer within a reasonable time. (paragraph 8.54)
75. an insurer must disclose to its consumer policyholders any information discovered during the course of the investigation of claims, and consumer policyholders must disclose to insurers any information of which they become aware after making a claim, where that information goes to the validity of the claim; and this mutual obligation to disclose applies even where any such information would otherwise be subject to litigation privilege. (paragraph 8.66)
76. where an insurer unreasonably withholds payment of a valid claim or unreasonably delays in making a payment under a valid claim, the consumer may, in addition to the right to enforce payment of the sums due and any right to interest on those sums, seek damages in accordance with the general law of contract for any consequential loss suffered including non-pecuniary loss such as stress.(paragraph 0)
77. where a claim made by a consumer under a contract of insurance contains information that is false or misleading in any material respect and which the consumer either (a) knows to be false or misleading or (b) consciously disregards whether it is false or misleading, the insurer should be entitled to refuse to pay the claim and should be entitled to terminate the contract. (paragraph 8.86)
78. a valid claim made under an insurance contract should not be affected where, under the same contract, the consumer makes a subsequent fraudulent claim or where fraudulent evidence or information is submitted or adduced in support of the subsequent claim. (paragraph 8.91)
79. where an insurer becomes aware that a consumer has made a fraudulent claim it may, as soon as is practicable after becoming aware of that fact, notify the consumer in writing that it is avoiding the insurance contract; and if the insurer so notifies the consumer, the insurance contract will be treated as having been terminated with effect from the date of the submission of the fraudulent claim (referred to as “the date of the fraudulent act”), whereupon (a) the insurer may refuse all liability to the consumer under the insurance contract in respect of any claim made after the date of the fraudulent act, and (b) the insurer need not return any of the premiums paid under the insurance contract. (paragraph 8.97)
80. The Commission recommends that an insurer should not be empowered to claim against the consumer to recover the cost of investigating a fraudulent claim. (paragraph 8.100)
81. where a consumer makes a fraudulent claim or where fraudulent evidence or information is submitted or adduced in its support or where a contract contains a term or condition excluding coverage for loss or damage to property caused by a criminal or intentional act or omission of an insured or any other person, the exclusion applies only to the claim of a person: (i) whose act or omission caused the loss or damage, (ii) who abetted or colluded in the act or omission, or (iii) who consented to the act or omission and knew or ought to have known that the act or omission would cause the loss or damage. Nothing in this recommendation should be interpreted to allow a person whose property is insured under the contract to recover more than their proportionate interest in the lost or damaged property and an innocent co-insured must cooperate fully with the relevant insurer during the course of the relevant investigation in order to be entitled to their portion of the claim.(paragraph 8.113)

Chapter 9: Unfair or Otherwise Onerous Terms

The Commission recommends:

82. an insurer who seeks to rely on an unfair or otherwise onerous term should, in order to incorporate the term into the contract, take reasonable steps to bring such a term to the attention of the consumer. (paragraph 9.48)
83. the definition of “consumer” in the statutory framework proposed in this Report should include reference to an “average consumer,” that is, a consumer who is reasonably well informed and reasonably observant and circumspect, taking into account social, cultural and linguistic factors. If

a contract of insurance is directed at a particular group of consumers, “average consumer” shall be read as “the average member of that group” and if the contract of insurance would be likely materially to distort the economic behaviour only of a clearly identifiable group of consumers who are natural persons, and whom the insurer could reasonably be expected to foresee as being particularly vulnerable because of their mental or physical infirmity, age or credulity, “average consumer” shall be read as “the average member of that vulnerable group. (paragraph 9.49)

84. in determining whether a term is an unfair or otherwise onerous term, regard should be had to whether it was one which in all the circumstances was, or ought reasonably to have been, known to or in the contemplation of the insurer and the consumer both at the pre-contractual stage and when the contract of insurance was entered into. (paragraph 9.50)
85. in determining whether a term is an unfair or otherwise onerous term, regard should also be had to any of the following which appear to be relevant: (a) the strength of the bargaining positions of the insurer and the consumer relative to each other, (b) whether the consumer had an inducement to agree to the term, (c) whether the contract of insurance was supplied to the special order of the consumer, and (d) the extent to which the insurer has dealt fairly and equitably with the consumer whose legitimate interests the insurer has to take into account. (paragraph 9.51)
86. the following non-exhaustive types of terms may be presumed (the presumption being rebuttable) to be unfair or otherwise onerous terms: (a) terms that are not fully intelligible to the consumer, terms which cross refer to legal provisions not disclosed in the contract, and provisions that use small print, (b) terms that exclude or limit liability for non-performance or defective performance, and one sided performance obligations, (c) terms that include evidentiary obstacles, onerous rules on maintaining and proving a claim, arbitration or mediation clauses, and clauses that otherwise enable slow payment of a claim, (d) terms that confer on the insurers unilateral rights to cancel, particularly when this can be done without the consumer being able to arrange cover or recover the premium, (e) terms under which the insurer, without good cause, may unilaterally vary either the cover or the premium, or assign the policy, and (f) terms that impose a disproportionate penalty for breach by the consumer. (paragraph 9.52)
87. without prejudice to Regulation 4 of the *European Communities (Unfair Terms in Consumer Contracts) Regulations 1995*, a term in a consumer contract of insurance should not in itself be regarded as unfair where the subject matter of the term has actually been considered by the insurer in the calculation of the premium and where the term has been drawn to the attention of the consumer in writing. (paragraph 9.68)

Chapter 10: Form of the Contract

The Commission recommends:

88. the essential requirements concerning the form of insurance contracts should be consolidated in a single general legislative framework; and that, having regard to the wide-ranging nature of the reforms recommended in this Report, a period of 18 months should be allowed after the enactment of the relevant legislation before the reforms would come into force. (paragraph 10.18)
89. within a reasonable time before a consumer is bound by a contract of insurance, the insurer should provide the consumer with the following pre-contractual information: (a) the name and address of the contracting parties, (b) the name and address of the insured and of the beneficiary, (c) the name and address of the intermediary, if any, (d) the subject matter of the insurance and the risks covered, (e) the sum insured and any deductibles, (f) the amount of the premium or the method of calculating it, (g) when the premium falls due as well as the place and mode of payment, (h) the contract period and the liability period, (i) the right to avoid or terminate the contract, including in accordance with the recommendations in this Report, (j) the law applicable to the contract, (k) the existence of an out-of-court complaint and redress mechanism for the policyholder and the methods for having access to it, and (l) the existence of guarantee funds or other compensation arrangements. (paragraph 10.37)
90. within a reasonable time after concluding a contract of insurance, the insurer should provide the consumer in writing with the following contractual information where relevant to the specific

contract of insurance: (a) the completed application or proposal form, if any, (b) the insurance policy and (c) the information required under the above recommendation unless that information is already included in the insurance policy. (paragraph 10.38)

91. where a consumer applies to the insurer for a second or subsequent copy of one or all of the documents referred to above, the insurer should provide the consumer with the document or documents and may charge a reasonable fee to cover its expenses for providing a second or subsequent copy. (paragraph 10.39)
92. the enforceability of a contract of insurance should not be dependent upon whether its terms have been reduced to writing and recommends also that particular terms of the contract may be proved by any means, including oral testimony. (paragraph 10.42)
93. all documents provided by the insurer to the consumer should be drafted in plain and intelligible language. (paragraph 10.48)
94. where there is ambiguity or doubt about the meaning of the wording of any document or information provided by the insurer to the consumer the interpretation most favourable to the consumer will prevail. (paragraph 10.53)
95. any formalities in a consumer insurance contract, such as prescribed notices, notification and forms, should be brought to the attention of the consumer at the commencement of the contract and should comply with the requirements concerning unfair or otherwise onerous terms. (paragraph 10.56)
96. further details (that is, in addition to those recommended in this Report) concerning any formalities in a consumer insurance contract, such as prescribed notices, notification and forms, should be set out either in Regulations to be made by the Minister for Finance or in a Code of Practice to be issued by the Central Bank of Ireland. (paragraph 10.57)
97. a consumer should be entitled to avoid an insurance contract by giving written notice, in the case of non-life insurance within 14 working days and in the case of life assurance within 30 working days, after receipt of acceptance or delivery of the post-contractual documents, whichever is the later. The notice provisions are subject to the following exceptions: (i) the duration of the contract is less than one month; (ii) an existing contract is renewed on substantially the same terms and conditions as the original agreement; and (iii) it is preliminary insurance, liability insurance or group insurance. (paragraph 10.65)
98. where the insurer gives written notice of avoidance, the insurer cannot charge anything other than the premium for the period of cover. (paragraph 10.66)
99. in circumstances where an insurer cancels an insurance contract during the term of the contract, it should communicate this to the consumer by notice in writing and by a method of recorded delivery (which may be by email, SMS text or other electronic means using the internet where the insurer can establish receipt of the notification by the consumer). (paragraph 10.72)
100. where an insurer so cancels an insurance contract they must refund the balance of the premium for the unexpired period of insurance without any further cost to the consumer. (paragraph 10.73)
101. in the case of renewal of non-life consumer insurance contracts, the 15 day renewal notice period in the *Non-Life Insurance (Provision of Information) (Renewal of Policy Insurance) Regulations 2007* should apply, and that the renewal notification from the insurer to the consumer should be accompanied by the terms of the renewal. (paragraph 10.81)
102. in the case of a life insurance policy (other than an industrial assurance policy) consumers should be provided on a yearly basis and on the policy anniversary with the following by the insurer: current premium payable; opening policy surrender value; current surrender or maturity value; amount paid in by consumer in the year; details of charges related to risk benefits deducted in the year (if any); other charges deducted in the year; investment growth in the year; closing policy surrender value; details of risk benefits covered (if any); and such further information as the insurer considers appropriate. (paragraph 10.82)

103. there should not be a general statutory obligation requiring insurers to issue statements in writing, or otherwise, identifying the reasons as to why a consumer insurance contract has been cancelled, declined, not renewed or offered on less advantageous terms (this does not affect the provisions in the *Consumer Protection Code 2012*, or in any similar replacement Code, that requires reasons for declining cover to be given in specific insurance contracts). (paragraph 10.92)
104. without prejudice to the proportionate remedies provided for in Chapter 3 and 8 of the Report, a court may in its discretion: (a) order that where the consumer is in breach of any duties (other than those referred to in Chapters 3 and 8) the sum otherwise recoverable in a claim under an insurance contract be reduced in proportion to the breach involved; and (b) order that where the insurer is in breach of any duties (other than those referred to in Chapters 3 and 8) the sum otherwise recoverable in a claim under an insurance contract be increased in proportion to the breach involved. The court may decline to make any such order under where (a) the breach was not deliberate and (b) it would be just and equitable in the circumstances to dispense with the obligation. (paragraph 10.95)
105. a term or condition of a consumer contract of insurance should be deemed void if it purports to impose on the consumer the burden of proving that the insurer has complied or not complied with an obligation imposed on the insurer in this Report (including those in Chapters 3 and 8) (paragraph 10.96).

DRAFT CONSUMER INSURANCE CONTRACTS BILL 2015

CONTENTS

Section

1. Short title and commencement
2. Interpretation
3. Scope of Act
4. Regulations and Codes of Practice
5. Effect of Codes of Practice
6. Insurable interest
7. Pre-contractual duties of the consumer and insurer
8. Proportionate remedies for misrepresentation
9. Form of the contract of insurance and information to be provided by the insurer
10. Right to withdraw from the contract of insurance by notice: cooling-off period
11. Notice of renewal of the contract of insurance
12. Cancellation of contract of insurance
13. Duties of the consumer and insurer at renewal
14. Post-contractual duties of the consumer and insurer
15. Claims handling: duties of the consumer and the insurer
16. Proportionate remedies and claims handling
17. Representations by the consumer and terms that reduce the risk being underwritten (replacing insurance warranties)
18. Unfair or onerous terms
19. Right of third party to claim against insurer
20. Subrogation: modification in family and personal relationships and in employment
21. Subrogation: distribution of recovered funds
22. Contracts affecting subrogation and third parties
23. Effect of failure to comply with duties in Act

ACTS AND BILLS REFERRED TO

Assisted Decision-Making (Capacity) Bill 2013
Companies Act 2014 (No.38 of 2014)
Criminal Justice (Spent Convictions) Bill 2012
Data Protection Acts 1988 and 2003
Life Assurance Act 1774 (14 Geo 3, c.48)
Life Insurance (Ireland) Act 1866 (29 & 30 Vict, c.42)
Marine Insurance Act 1906 (8 Edw. 7 c.41)

DRAFT CONSUMER INSURANCE CONTRACTS BILL 2015

BILL

entitled

An Act to reform the law of consumer insurance contracts and to provide for related matters.

Be it enacted by the Oireachtas as follows:

Short title and commencement

1. — (1) This Act may be cited as the Consumer Insurance Contracts Act 2015.

(2) This Act comes into operation 18 months after enactment.

Explanatory Note

Section 1(1) contains the Short Title of the Bill.

Section 1(2) implements the recommendation in paragraph 10.18 that, having regard to the wide-ranging nature of the reforms in the consolidated general legislative framework for consumer insurance contracts which this Bill represents, a period of 18 months should be allowed after its enactment before the reforms would come into force. This is intended to enable the insurance sector to put in place the practical arrangements needed to implement these reforms and to allow relevant consumer bodies to communicate their effects to the public.

Interpretation

2. — In this Act —

“average consumer” means a consumer who is reasonably well informed and reasonably observant and circumspect, taking into account social, cultural and linguistic factors; and if a contract of insurance is directed at a particular group of consumers, “average consumer” shall be read as “the average member of that group”; and if the contract of insurance would be likely materially to distort the economic behaviour only of a clearly identifiable group of consumers who are natural persons, and whom the insurer could reasonably be expected to foresee as being particularly vulnerable because of their mental or physical infirmity, age or credulity, “average consumer” shall be read as “the average member of that vulnerable group”;

“consumer” means—

(a) a natural person who is acting for purposes that are wholly or mainly outside his or her trade, business, craft or profession, or

(b) a person or group of persons having an annual turnover of €3 million or less in the financial year preceding the year in which such person or persons enters into a contract of insurance, provided that such person or persons shall not be a member of a group of persons having a combined turnover greater than €3 million,

and includes both a consumer who at the pre-contractual stage of a contract of insurance proposes to enter into a contract of insurance and also a consumer who has entered into a contract of insurance, and includes, where relevant, an “average consumer”;

“contract of insurance” means, except where otherwise provided in this Act, a contract of life insurance or non-life insurance made between an insurer and a consumer;

“fraudulent misrepresentation” means a misrepresentation that is false or misleading in any material respect and which the consumer either (a) knows to be false or misleading or (b) consciously disregards whether it is false or misleading, and “fraudulent” or “fraud” shall be construed accordingly;

“group of persons” means—

(a) a company incorporated under the Companies Act 2014, or

(b) an unincorporated body, including a charity, club, partnership, sole trader or trust;

“insurer” means an insurance undertaking licensed by the Central Bank of Ireland to provide life insurance or non-life insurance in the State, or an undertaking otherwise lawfully carrying on the business of an insurance undertaking in the State;

“the Minister” means the Minister for Finance;

“turnover” shall be determined by calculating the income received from the sales and services of the person or group of persons, falling within the ordinary activities of the person or group of persons after deduction of sales rebates;

“writing” includes on paper or other suitable durable medium, including where made available by easily accessible and retrievable online means or, where agreed by the insurer and the consumer, by email or SMS text.

Explanatory Note

Section 2 contains definitions for the purposes of the Bill.

The definition of “consumer” implements the recommendation in paragraph 1.24 that the legislative framework proposed in this Report should apply to consumers as defined for the purposes of the jurisdiction of the Financial Service Ombudsman and in the Central Bank’s *Consumer Protection Code 2012*, that is: (a) a natural person who is acting for purposes that are wholly or mainly outside his or her trade, business, craft or profession (the formula proposed in the Government’s *Scheme of a Consumer Rights Bill* published in May 2015), or (b) a person or group of persons having an annual turnover of €3 million or less in the financial year preceding the year in which such person or persons enters into a contract of insurance, provided that such person or persons shall not be a member of a group of persons having a combined turnover greater than €3 million.

The definition of “average consumer” implements the recommendation in paragraph 9.49 that the definition of “consumer” in the statutory framework proposed in this Bill should include reference to an “average consumer” and be based on the definition in section 2(2) of the *Consumer Protection Act 2007*, which is in turn derived from the 2005 EU Directive on Unfair Commercial Practices, Directive 2005/29/EC. The definition therefore refers to a consumer who is reasonably well informed and reasonably observant and circumspect, taking into account social, cultural and linguistic factors. If a contract of insurance is directed at a particular group of consumers, “average consumer” shall be read as “the average member of that group” and if the contract of insurance would be likely materially to distort the economic behaviour only of a clearly identifiable group of consumers who are natural persons, and whom the insurer could reasonably be expected to foresee as being particularly vulnerable because of their mental or physical infirmity, age or credulity, “average consumer” shall be read as “the average member of that vulnerable group. This definition is, for example, relevant to determining whether a consumer has complied with the duty in *section 5(7)* of the Bill to take reasonable care in answering questions.

The definition of “fraudulent misrepresentation” implements the recommendation in paragraph 3.131 that fraudulent misrepresentation should be defined as a misrepresentation that is false or misleading in any material respect and which the consumer either (a) knows to be false or misleading or (b)

consciously disregards whether it is false or misleading. The addition that “fraudulent” or “fraud” are to interpreted in the same manner wherever they appear in the Bill implements the analysis throughout the Report, for example in paragraph 8.86, that fraudulent behaviour should be so defined.

Scope of Act

3. — (1) Except where otherwise provided, this Act applies to an insurance contract, whether life insurance or non-life insurance, entered into between an insurer and a consumer.

(2) This Act does not alter or affect any rights or obligations concerning or arising from—

(a) the duties of an insurance broker or insurance intermediary,

(b) a contract of reinsurance, or

(c) a contract of marine, air or transport insurance.

(3) No provision of the Marine Insurance Act 1906 applies to a contract of insurance to which this Act applies.

(4) No provision of the Life Assurance Act 1774, as extended to Ireland by the Life Insurance (Ireland) Act 1866, applies to a contract of insurance to which this Act applies.

Explanatory Note

Section 3(1) implements the recommendation in paragraph 1.37 that the legislative framework proposed in this Report applies in general to contracts of insurance, both life and non-life, between insurance undertakings and consumers. The proviso that this is “[e]xcept where otherwise provided” allows for the specific situations in the Bill where provisions apply only to life insurance or, as the case may be, non-life insurance: see for example *section 11* of the Bill.

Section 3(2) implements the recommendation in paragraph 1.38 that the Report, and therefore the Bill, does not alter or affect any rights or obligations concerning or arising from: (a) the duties of an insurance broker or insurance intermediary, (b) contracts of reinsurance, and (c) contracts of marine, air or transport (MAT) insurance. These are excluded from the Report and the Bill because they are already separately regulated.

Section 3(3) implements the recommendation in paragraph 1.39 that no provision of the *Marine Insurance Act 1906* should apply to a contract of insurance to which the Bill applies. As discussed in the Report, the 1906 Act contains a number of provisions that codified some common law rules of insurance contract law, and thus it is prudent in order to remove any doubt to provide that nothing in the 1906 Act applies to the insurance contracts to which the Bill applies.

Section 3(4) implements the recommendation in paragraph 5.85 that no provision of the *Life Assurance Act 1774*, as extended to Ireland by the *Life Insurance (Ireland) Act 1866*, applies to a contract of insurance to which this Act applies. As discussed in the Report, the 1774 Act as applied by the 1866 Act, imported insurable interest into life contracts; it is therefore prudent, in order to reinforce the Commission’s recommendation to abolish the requirement of insurable interest in consumer insurance contracts, to provide that nothing in these Acts applies to the consumer insurance contracts to which the Bill applies.

Regulations and Codes of Practice

4. — (1) The Minister may make Regulations for the purpose of giving full effect to this Act, including with respect to the form of, or any other requirements related to, a consumer insurance contract as set out in this Act.

(2) The Central Bank of Ireland may issue a Code of Practice concerning the form of, or any other requirements related to, a consumer insurance contract as set out in this Act.

Explanatory Note

Section 4 implements the recommendation in paragraph 10.57 that further details concerning any formalities in a consumer insurance contract (that is, in addition to those recommended in this Report), such as prescribed notices, notification and forms, should be set out either in Regulations to be made by the Minister for Finance or in a Code of Practice to be issued by the Central Bank of Ireland. As to Regulations, this recommendation reflects the current position that a number of detailed requirements concerning the content of insurance contracts are set out in Regulations, such as the *Life Assurance (Provision of Information) Regulations 2001*,¹ the *European Communities (Distance Marketing of Consumer Financial Services) Regulations 2004*² and the *Non-Life Insurance (Provision of Information) (Renewal of Policy Insurance) Regulations 2007*.³ Similarly, the Central Bank's *Consumer Protection Code 2012* currently contains general requirements concerning insurance contracts, as well as detailed requirements concerning, for example, notification periods and dispute handling.

Effect of Codes of Practice

5. — A code of practice, whether made under statutory authority or otherwise, which contains practical guidance that would assist a court or other adjudicatory body such as the Financial Services Ombudsman in determining any issue before it in connection with a consumer insurance contract to which this Act applies, shall be admissible for that purpose and may be taken into account.

Explanatory Note

Section 5 implements the recommendations in paragraph 1.32 that a code of practice, whether statutory or otherwise, which contains practical guidance that would assist a court or other adjudicatory body such as the Financial Services Ombudsman (FSO) in determining any issue before it in connection with a consumer insurance contract shall be admissible for that purpose and may be taken into account.

Insurable interest

6. — (1) A claim by a consumer under an otherwise valid contract of insurance shall not be rejected by the insurer by reason only that the consumer does not have, or did not have at the time when the contract was entered into, an interest in the subject-matter of the contract.

(2) Where the consumer is required, because the contract of insurance is also a contract of indemnity, to have an interest in the subject-matter of the contract, the interest required shall not extend beyond a factual expectation either of an economic benefit from the preservation of the subject matter, or of an economic loss on its destruction, damage or loss that would arise in the ordinary course of events.

(3) An insurer is not relieved of liability under the contract of insurance by reason only that the name of the person who may benefit under the contract is not specified in a policy document.

¹ SI No.15 of 2001, as amended by the *Life Assurance (Provision of Information) (Amendment) Regulations 2002* (SI No.161 of 2002).

² SI No.853 of 2004, as amended by the *European Communities (Distance Marketing of Consumer Financial Services) (Amendment) Regulations 2005* (SI No.63 of 2005).

³ SI No.74 of 2007. The 2007 Regulations also revoked the *Motor Insurance (Provision of Information) (Renewal of Policy of Insurance) Regulations 2002* (SI No.389 of 2002).

Explanatory Note

Section 6(1) implements the recommendation in paragraph 5.82 that a claim by a consumer under an otherwise valid contract of insurance cannot be rejected by the insurer by reason only that the consumer does not have, or did not have at the time when the contract was entered into, an interest in the subject-matter of the contract.

Section 6(2) implements the recommendation in paragraph 5.83 that an interest that is required where the insurance is also an indemnity insurance should, in the interests of certainty, be defined as an interest that subsists when there is a factual expectation either of an economic benefit from the preservation of the contract's subject matter, or of an economic loss on its destruction, damage or loss, which would arise in the ordinary course of events.

Section 6(3) implements the recommendation in paragraph 5.84 that an insurer is not relieved of liability under a contract of insurance by reason only that the names of the persons who may benefit under the contract are not specified in the policy document.

Pre-contractual duties of the consumer and insurer

7. — (1) The duties in this section replace, at the pre-contractual stage of a consumer contract of insurance, the principle of utmost good faith (*uberrima fides*) and any duty of disclosure (including any duty on the consumer to volunteer information) that applied prior to the coming into force of this section (whether that principle or duty arose at common law or under an enactment).

(2) The pre-contractual duty of disclosure of a consumer is confined to providing responses from questions asked by the insurer, and the consumer shall not be under any duty to volunteer any information over and above that required by such questions.

(3) Where the insurer requests the consumer at the pre-contractual stage to provide information to the insurer, the insurer shall be under a duty to ask specific questions, in writing, and shall not use general questions.

(4) It shall be presumed, unless the contrary is shown, that the consumer knows that a matter about which the insurer asks a specific question is material to the risk undertaken by that insurer or the calculation of the premium by that insurer, or both.

(5) (a) Where the insurer asks questions these shall be drafted in plain and intelligible language, and the onus of proving that the questions are plain and intelligible shall rest with the insurer.

(b) Where there is an ambiguity or a doubt about the meaning of a question the interpretation most favourable to the consumer shall prevail.

(6) An insurer may use the remedies available under this Act (including the remedy to repudiate liability or to limit the amount paid on foot of the contract of insurance) only if it establishes that non-disclosure of material information was an effective cause of the insurer entering into the relevant contract of insurance and on the terms on which it did.

(7) (a) The consumer shall be under a duty to answer all questions posed by the insurer honestly and with reasonable care (the test of reasonable care being by reference to that of the average consumer).

(b) In determining whether the consumer has complied with this duty, regard shall be had to the following matters—

(i) the type of insurance contract in question and its target market,

(ii) any relevant explanatory material or publicity produced or authorised by the insurer,

- (iii) how clear and specific are the insurer's questions,
- (iv) whether the consumer is represented by an agent, and
- (v) that some consumers can be expected to be in possession of more information than others.

(8) The test of what is material, and consequently the scope of questions that the insurer may ask the consumer, are without prejudice to —

- (a) the requirements of the *Data Protection Acts 1988 and 2003*, and
- (b) the provisions of the *Criminal Justice (Spent Convictions) Bill 2012*.⁴

(9) Every insurer shall, before a contract of insurance is entered into, or renewed, inform the consumer in writing of the general nature and effect of the pre-contractual duty of disclosure.

(10) (a) An insurer shall be deemed to have waived any further duty of disclosure of the consumer where it fails to investigate an absent or obviously incomplete answer to a question.

(b) The waiver in *paragraph (a)* does not apply where the non-disclosure arises from fraudulent, intentional or reckless concealment.

Explanatory Note

Section 7(1) implements the recommendations in paragraphs 2.61 and 2.62 that, at the pre-contractual stage of a consumer contract of insurance, the principle of utmost good faith (*uberrima fides*) and any duty of disclosure (including any duty on the consumer to volunteer information) are replaced by the duties recommended in this Report and which are set out in the following subsections of *section 7*.

Section 7(2) implements the recommendations in paragraph 3.07 that the pre-contractual duty of disclosure in consumer insurance contracts is confined to responses elicited from questions posed by the insurer and that the consumer should no longer be required to volunteer information.

Section 7(3) implements the recommendations in paragraph 3.47 that insurers are under a duty to ask specific questions, in writing, and shall not be permitted to use general or “catch all” questions.

Section 7(4) implements the recommendation in paragraph 3.53 that, to complement the insurer's duty to ask specific questions, there is to be a rebuttable presumption that, unless the contrary is shown, the consumer knows that a matter about which the insurer asks a specific question is material to the risk undertaken by that insurer or the calculation of the premium by that insurer, or both. The

⁴ At the time of writing (June 2015) the *Criminal Justice (Spent Convictions) Bill 2012* is awaiting Report Stage in Dáil Éireann, having passed all Stages in Seanad Éireann. The enactment of the 2012 Bill has been delayed pending consideration of the effect of the decision of the UK Supreme Court in *R (T) v Chief Constable of Greater Manchester Police* [2014] UKSC 35, in which it was held that some aspects of comparable British legislation, the *Rehabilitation of Offenders Act 1974*, were not compatible with the right to protection of private life under Article 8 of the European Convention on Human Rights. The 2012 Bill provides for the circumstances in which a conviction is to be regarded as spent and therefore need not be disclosed. Section 7(2) of the 2012 Bill provides that any person who has been convicted of fraud, deceit or dishonesty in connection with a claim under a contract of life or non-life insurance is not excused under the terms of the Bill from disclosing such a conviction in a life or non-life insurance proposal or form. Assuming its enactment, section 7(2) of the 2012 Bill would ensure that convictions for fraudulent insurance claims would never be regarded as spent convictions and would therefore continue to be a matter that must be disclosed.

reference in this subsection to “that insurer” is to underline that the matter in question must be material to the particular insurer, rather than to a hypothetical “prudent” insurer (the test under the existing law).

Section 7(5) implements the recommendations in paragraph 3.58 that questions asked in writing to consumers must be drafted in plain, intelligible language (the onus of proving this being on the insurer); and that, where there is a doubt about the meaning of any question, the interpretation most favourable to the consumer is to prevail.

Section 7(6) implements the recommendations in paragraph 3.82 that the legislation recommended in the Report should include an inducement test to the effect that an insurer may use the remedies available under it (including the remedy to repudiate liability or to limit the amount paid on foot of the contract of insurance) only if it establishes that non-disclosure of material information was an effective cause of the insurer entering into the relevant contract of insurance on the terms on which it did.

Section 7(7) implements the recommendation in paragraph 3.30 that the common law duty on a consumer to furnish “true” answers, which was codified in section 20 of the *Marine Insurance Act 1906*, should be replaced in consumer insurance contracts by a duty to answer all questions honestly and with reasonable care (the test of reasonable care being that of the average consumer as defined in *section 7(12)* below, which is derived from section 2(2) of the *Consumer Protection Act 2007*, in turn derived from the 2005 EU Directive on Unfair Commercial Practices, Directive 2005/29/EC).

Section 7(7) also implements the recommendation in paragraph 3.31 that this duty to answer questions should have regard to the following specific matters: (a) the type of consumer insurance contract in question, and its target market, (b) any relevant explanatory material or publicity produced or authorised by the insurer, (c) how clear, and how specific, the insurer’s questions have been, (d) whether the consumer is represented by an agent, and (e) that certain consumers can be expected to be in possession of more information than others.

Section 7(8) implements the recommendation in paragraph 3.72 that the test of what is material in consumer insurance contracts, and the consequent scope of questions that may be asked of the consumer by an insurer, are without prejudice to: (a) the requirements of the *Data Protection Acts 1988 and 2003*; and (b) the provisions of the *Criminal Justice (Spent Convictions) Bill 2012*, assuming its enactment.⁵

Section 7(9) implements the recommendation in paragraph 3.84 that insurers are to be under a statutory duty to inform consumers in writing, before a contract of insurance is entered into, of the general nature and effect of the duty of disclosure.

Section 7(10) implements the recommendation in paragraph 3.64 that an insurer will be deemed to have waived any further duty of disclosure of the consumer where it fails to investigate an absent or obviously incomplete answer to a question; but that this deemed waiver does not apply where the non-disclosure arises from fraudulent, intentional or reckless concealment.

Proportionate remedies for misrepresentation

8. — (1) This section sets out remedies that are proportionate to the effects of any misrepresentation on the interests of the insurer and the consumer.

(2) Where a claim is made under a contract of insurance and where the consumer has discharged the duty under *section 7* to answer questions honestly and with reasonable care but where an answer involves an innocent misrepresentation, the insurer shall be required to pay the claim made and shall not be entitled to avoid the contract on the ground that there was a misrepresentation.

⁵ See fn4, above, on the status of the 2012 Bill at the time of writing (June 2015).

(3) Where a claim is made under a contract of insurance and where the consumer has discharged the duty under *section 7* to answer questions honestly and with reasonable care but where an answer involves a negligent misrepresentation (that is, not a deliberate or reckless misrepresentation), the remedy available to the insurer shall reflect what the insurer would have done had it been aware of the full facts and shall be based on a compensatory and proportionate test.

(4) Without prejudice to the generality of *subsection (3)*, where an answer given by the consumer involves a negligent misrepresentation—

- (a) if the insurer would not have entered into the insurance contract on any terms, the insurer may avoid the contract and refuse all claims, but shall return the premiums paid,
- (b) if the insurer would have entered into the insurance contract, but on different terms (excluding terms relating to the premium), the contract is to be treated as if it had been entered into on those different terms if the insurer so requires,
- (c) if the insurer would have entered into the insurance contract (whether the terms relating to matters other than the premium would have been the same or different), but would have charged a higher premium, the insurer may reduce proportionately the amount to be paid on a claim,
- (d) where there is not any outstanding claim under the insurance contract, the insurer may either—
 - (i) give notice to the consumer that in the event of a claim it will exercise the remedies in *paragraphs (a) to (c)*, or
 - (ii) in the case of a non-life insurance contract only, terminate the contract by giving reasonable notice to the consumer.

(5) Where a claim is made under a contract of insurance and where an answer by the consumer involves a fraudulent misrepresentation or where any conduct by the consumer involves fraud of any other kind, the insurer shall be entitled to avoid the contract of insurance.

Explanatory Note

Section 8(1) implements the recommendation in paragraph 3.96 that remedies should be calculated in a manner that is proportionate to the effects of any misrepresentation upon the interests of insurers and consumers.

Section 8(2) implements the recommendation in paragraph 3.105 that, where the consumer discharges the duty to answer questions honestly and with reasonable care (set out in *section 7* of the Bill) but where an answer involves an innocent misrepresentation, the insurer must pay the claim made and is not entitled to avoid the policy on the ground that there was a misrepresentation.

Section 8(3) implements the recommendations in paragraphs 3.96 and 3.112 that where it has been established that a consumer has made a negligent misrepresentation the remedy available to an insurer will reflect what the insurer would have done had it been aware of the full facts, that is, a compensatory or proportionate test should be applied; and that it is not necessary to define negligent misrepresentation beyond stating that it arises where the consumer has not taken reasonable care but has not acted deliberately or recklessly.

Section 8(4) implements the recommendation in paragraph 3.112 that, without prejudice to the general compensatory or proportionate test in *section 8(3)*, a non-exhaustive list of the remedies available to the insurer where a consumer has made a negligent misrepresentation should be set out. Four examples are given: (a) if the insurer would not have entered into the insurance contract on any terms, the insurer may avoid the contract and refuse all claims, but must return the premiums paid; (b) if the insurer would have entered into the insurance contract, but on different terms (excluding terms relating to the premium), the contract is to be treated as if it had been entered into on those different

terms if the insurer so requires; (c) if the insurer would have entered into the insurance contract (whether the terms relating to matters other than the premium would have been the same or different), but would have charged a higher premium, the insurer may reduce proportionately the amount to be paid on a claim; (d) where there is not any outstanding claim under the insurance contract, the insurer may either: (i) give notice to the consumer that in the event of a claim it will exercise the remedies in paragraphs (a) to (c), or (ii) in the case of a non-life insurance contract only, terminate the contract by giving reasonable notice to the consumer. These examples broadly reflect those in the UK *Consumer Insurance (Disclosure and Representations) Act 2012*.

Section 8(5) implements the recommendation in paragraph 3.131 that, where an answer by the consumer involves a fraudulent misrepresentation (that is, which the consumer either knows to be false or misleading or else consciously disregards whether it is false or misleading: see the definition in *section 2* of the Bill) or where any conduct by the consumer involves fraud of any other kind, the insurer is entitled to avoid the contract of insurance. The second element of this duty, which refers to fraud of any kind, applies both at the pre-contractual stage (to which *section 7* applies) and also after a claim has been made; and it therefore complements the provisions on fraudulent claims in *section 16* of the Bill.

Form of the contract of insurance and information to be provided by the insurer

9. — (1) Within a reasonable time before a consumer is bound by a contract of insurance, the insurer shall provide the consumer in writing with the following pre-contractual information where relevant to the specific contract of insurance—

- (a) the name and address of the contracting parties,
- (b) the name and address of the consumer and of the beneficiary,
- (c) the name and address of the intermediary, if any,
- (d) the subject matter of the insurance and the risks covered,
- (e) the sum insured and any deductibles,
- (f) the amount of the premium or the method of calculating it,
- (g) when the premium falls due as well as the place and mode of payment,
- (h) the contract period and the liability period,
- (i) the right to revoke the application or to terminate the contract, including in accordance with this Act,
- (j) the law applicable to the contract or, if a choice of law is permitted, the law proposed by the insurer,
- (k) the existence of an out-of-court complaint and redress mechanism for the consumer and the methods for having access to it, and
- (l) the existence of guarantee funds or other compensation arrangements.

(2) Within a reasonable time after concluding a contract of insurance, the insurer shall provide the consumer in writing with the following contractual information where relevant to the specific contract of insurance—

- (a) the completed application or proposal form, if any,
- (b) the insurance policy document, and

(c) the information required under *subsection (1)*, unless that information is already included in the insurance policy.

(3) Where, although an insurer has complied with *subsection (2)*, the consumer subsequently applies to the insurer for a second or subsequent copy of one or all of the documents referred to in *subsection (2)*, the insurer shall provide the consumer with the document or documents and may charge a reasonable fee to cover its expenses in so providing a second or subsequent copy.

(4) The terms of a contract of insurance are not confined to the documents required by *subsection (2)*, and other terms (if any) of the contract need not be reduced to writing and may be proved by any means, including oral testimony.

(5) (a) The documents required by *subsection (1)* and *subsection (2)* shall be drafted in plain, intelligible language.

(b) Where there is an ambiguity or doubt about the meaning of a term in any such document, the interpretation most favourable to the consumer, or beneficiary, as appropriate, shall prevail.

(6) Any formalities, such as prescribed notices, notification and forms, in a consumer insurance contract shall be brought to the attention of the consumer at the commencement of the contract and shall comply with the requirements in *section 18*.

Explanatory Note

Section 9 implements the recommendation in paragraph 10.18 that the essential requirements concerning the form of an insurance contract should be consolidated in a single general legislative framework. This is important because, as the Commission notes in the Report, a number of such requirements are currently scattered in a diverse range of Acts and Regulations, including the *Life Assurance Act 1774*, section 43B of the *Insurance Act 1989* (inserted into the 1989 Act by the *Insurance Act 2000*), the *Life Assurance (Provision of Information) Regulations 2001*,⁶ the *European Communities (Distance Marketing of Consumer Financial Services) Regulations 2004*⁷ and the *Non-Life Insurance (Provision of Information) (Renewal of Policy Insurance) Regulations 2007*.⁸

Section 9(1) implements the recommendations in paragraph 10.37 that, within a reasonable time before a consumer is bound by a contract of insurance, the insurer must provide the consumer with the following pre-contractual information: (a) the name and address of the contracting parties, (b) the name and address of the consumer and of the beneficiary, (c) the name and address of the intermediary, if any, (d) the subject matter of the insurance and the risks covered, (e) the sum insured and any deductibles, (f) the amount of the premium or the method of calculating it, (g) when the premium falls due as well as the place and mode of payment, (h) the contract period and the liability period, (i) the right to avoid or terminate the contract, including in accordance with this Bill, (j) the law applicable to the contract, (k) the existence of an out-of-court complaint and redress mechanism for the consumer and the methods for having access to it, and (l) the existence of guarantee funds or other compensation arrangements. These are broadly derived from Article 2:201(1) and (2) of the Principles of European Insurance Contract Law (PEICL) and also reflect a number of existing requirements in the Acts and Regulations mentioned above.

Section 9(2) implements the recommendations in paragraph 10.38 that, within a reasonable time after concluding a contract of insurance, the insurer must provide the consumer in writing with the following

⁶ SI No.15 of 2001, as amended by the *Life Assurance (Provision of Information) (Amendment) Regulations 2002* (SI No.161 of 2002).

⁷ SI No.853 of 2004, as amended by the *European Communities (Distance Marketing of Consumer Financial Services) (Amendment) Regulations 2005* (SI No.63 of 2005).

⁸ SI No.74 of 2007. The 2007 Regulations also revoked the *Motor Insurance (Provision of Information) (Renewal of Policy of Insurance) Regulations 2002* (SI No.389 of 2002).

contractual information where relevant to the specific contract of insurance: (a) the completed application or proposal form, if any, (b) the insurance policy and (c) the information required under *section 9(1)*, unless that information is already included in the insurance policy. These are broadly derived from Articles 2:201(3) and 2:501 of the Principles of European Insurance Contract Law (PEICL) and also reflect a number of existing requirements in the Acts and Regulations mentioned above.

Section 9(3) implements the recommendation in paragraph 10.39 that where, although an insurer has complied with *section 9(2)*, the consumer subsequently applies to the insurer for a second or subsequent copy of one or all of the documents referred to in *section 9(2)*, the insurer must provide the consumer with the document or documents and may charge a reasonable fee to cover its expenses in providing a second or subsequent copy.

Section 9(4) implements the recommendation in paragraph 10.42 that the terms of a contract of insurance are not confined to the documents required by *section 9(2)*, and other terms (if any) of the contract need not be reduced to writing and may be proved by any means, including oral testimony.

Section 9(5) implements the recommendations in paragraphs 10.48 and 10.53 that the documents required by *section 9(1) and (2)* must be drafted in plain, intelligible language; and that where there is an ambiguity or doubt about the meaning of a term in any such document, the interpretation most favourable to the consumer, or beneficiary as appropriate, is to prevail.

Section 9(6) implements the recommendation in paragraphs 10.56 that any formalities in a consumer insurance contract, such as prescribed notices, notification and forms, are to be brought to the attention of the consumer at the commencement of the contract and should comply with the requirements concerning unfair or otherwise onerous terms in *section 18* of the Bill, below. It also complements the recommendation in paragraph 10.57 that further details (that is, in addition to those recommended in the Report) concerning any formalities in a consumer insurance contract, such as prescribed notices, notification and forms, should be set out either in Regulations to be made by the Minister for Finance or in a Code of Practice to be issued by the Central Bank of Ireland, as to which see *section 4* of the Bill.

Right to withdraw from the contract of insurance by notice: cooling-off periods

10. — (1) Subject to *subsection (2)*, a consumer may avoid a contract of insurance by giving notice in writing to the insurer, in the case of non-life insurance within 14 working days and in the case of life assurance within 30 working days (the “cooling off” periods), after receipt of acceptance or delivery of the post-contractual documents, whichever is the later.

(2) The right to avoid a contract of insurance under *subsection (1)* does not apply—

- (a) where the duration of the contract is less than one month,
- (b) where an existing contract is renewed on substantially the same terms and conditions as the original agreement, or
- (c) the contract is preliminary insurance, liability insurance or group insurance.

(3) Where the consumer avoids the contract of insurance under *subsection (1)*, the insurer shall not impose any financial cost on the consumer other than the cost of the premium for the period of cover.

Explanatory Note

Section 10 implements the recommendations in paragraphs 10.65 and 10.66 concerning the right of the consumer to withdraw from an insurance contract by giving written notice, which is often referred to as a “cooling off” period.

Section 10(1) implements the recommendation in paragraph 10.65 that in the case of non-life insurance this may be done within 14 working days and in the case of life insurance within 30 working days (the “cooling off” periods), after receipt of acceptance or delivery of the post-contractual documents, whichever is the later.

Section 10(2) implements the recommendation in paragraph 10.65 that the notice provisions are subject to the following exceptions: (a) the duration of the contract is less than one month; (b) an existing contract is renewed on substantially the same terms and conditions as the original agreement; and (c) it is preliminary insurance, liability insurance or group insurance.

Section 10(3) implements the recommendation in paragraph 10.66 that where the consumer avoids the contract of insurance under *subsection (1)*, the insurer cannot impose any financial cost on the consumer other than the cost of the premium for the period of cover.

Renewal of the contract of insurance

11. — (1) In the case of a non-life insurance contract, the insurer shall, not less than 15 working days prior to the date of expiry of a policy of insurance —

- (a) where the insurer wishes to invite a renewal, issue to the consumer in writing a notification of renewal of the policy of insurance, or
- (b) issue to the consumer in writing a notification that it does not wish to invite a renewal, unless in the case of this *paragraph (b)* the insurer has reason to believe that the consumer would not wish to renew the policy.

(2) In the case of a non-life insurance contract, the insurer shall, where it is giving notification of renewal of the policy in accordance with *subsection (1)(a)*, provide in writing to the consumer the terms of the renewal.

(3) In the case of a life insurance policy (other than an industrial assurance policy) and acquiring a surrender or maturity value, the insurer shall provide the consumer with an annual written statement which shall contain—

- (a) current premium payable,
- (b) opening policy surrender value,
- (c) current surrender or maturity value,
- (d) closing policy surrender value,
- (e) amount paid in by consumer in the year,
- (f) details of charges related to risk benefits deducted in the year (if any),
- (g) other charges deducted in the year,
- (h) investment growth in the year,
- (i) details of risk benefits covered (if any), and
- (j) such further information as the insurer considers appropriate.

(4) In the case of industrial assurance policies and acquiring a surrender or maturity value, the insurer shall provide the consumer, in respect of the policy concerned, with an annual written statement which shall contain—

- (a) the current surrender or maturity value and the current premium payable for a standard policy of that type,
- (b) guidance on how to calculate, specific to that consumer, the current surrender or maturity value and premium payable in respect of the policy, and
- (c) such further information as the insurer considers appropriate.

(5) This section is without prejudice to more detailed requirements set out in other enactments concerning the provision of information in the circumstances specified in *subsections (1) to (4)*.

Explanatory Note

Section 11(1) implements the recommendation in paragraph 10.81 that in non-life consumer insurance contracts the general 15 day notice period in Regulation 5 of the *Non-Life Insurance (Provision of Information) (Renewal of Policy of Insurance) Regulations 2007* (SI No.74 of 2007) should apply.

Section 11(2) implements the recommendation in paragraph 10.81 that in a non-life insurance contract, the insurer shall provide in writing to the consumer the terms of the renewal with the notification of renewal of the policy.

Section 11(3) and 11(4) implement the recommendations in paragraph 10.82 that the requirements currently contained in the *Life Assurance (Provision of Information) Regulations 2001* as to what the insurer must provide annually in writing to the consumer should be amended to add the matters set out in the Central Bank's 2008 consultative review of the 2001 Regulations. *Section 11(3)* therefore provides that, in the case of life insurance, the insurer must provide consumers on a yearly basis with the following: (a) current premium payable; (b) opening policy surrender value (new); (c) current surrender or maturity value; (d) closing policy surrender value; (e) amount paid in by consumer in the year (new); (f) details of charges related to risk benefits deducted in the year, if any (new); (g) other charges deducted in the year (new); (h) investment growth in the year (new); (i) details of risk benefits covered, if any (new), and (j) such further information as the insurer considers appropriate. *Section 11(4)* provides that, in the case of industrial assurance policies (typically take out for funeral-related expenses) and acquiring a surrender or maturity value, the insurer must provide the consumer with the following: (a) the current surrender or maturity value and the current premium payable for a standard policy of that type; (b) guidance on how to calculate, specific to that consumer, the current surrender or maturity value and premium payable in respect of the policy; and (c) such further information as the insurer considers appropriate.

Section 11(5) complements the recommendation in paragraph 10.57 that further detailed requirements are to be set out in Regulations or Codes of Practice. It therefore ensures that existing provisions are retained unless and until Regulations are made in the future. For example, the *Life Assurance (Provision of Information) Regulations 2001* (SI No.15 of 2001) set out detailed warnings and illustrative rates of return for life insurance, and the *Non-Life Insurance (Provision of Information) (Renewal of Policy of Insurance) Regulations 2007* (SI No.74 of 2007) contain specific requirements as to the provision of a person's no-claims bonus certificate prior to renewal of a motor policy.

Cancellation of contract of insurance

12.—(1) Where, in accordance with this section, an insurer notifies a consumer that the insurer is cancelling a contract of insurance, the insurer shall repay to the consumer the balance of the premium for the unexpired term of the contract.

(2) Any notification by the insurer under this section shall be by recorded delivery (which may be by email, SMS text or other electronic means using the internet where the insurer can establish receipt of the notification by the consumer).

(3) The insurer shall not impose any financial cost on the consumer where, in accordance with this section, a contract of insurance is cancelled.

Explanatory Note

Section 12(1) implements the recommendation in paragraph 10.73 that, where an insurer notifies the consumer that the insurer is cancelling a contract of insurance, the insurer must repay to the consumer the balance of the premium for the unexpired term of the contract.

Section 12(2) implements the recommendation in paragraph 10.72 that any written notification of cancellation by the insurer must be by recorded delivery (which may be by email, SMS text or other electronic means using the internet where the insurer can establish receipt of the notification by the consumer).

Section 12(3) implements the recommendation in paragraph 10.73 that the insurer must not impose any financial cost on the consumer where, in accordance with this section, a contract of insurance is cancelled.

Duties of the consumer and insurer at renewal

13. — (1) The duty of disclosure in *section 7* shall not be taken to imply that a consumer who has on a previous occasion discharged that duty of disclosure is under an obligation at renewal of the contract of insurance to provide the insurer with any additional information, whether concerning matters that have changed or otherwise, unless the insurer has expressly required the consumer to do so in accordance with *subsection (2)*.

(2) Where an insurer intends that the consumer is to provide additional information at renewal concerning a particular matter, it shall either —

(a) ask the consumer a specific question in writing regarding the matter, or

(b) request the consumer in writing to update information previously provided concerning that matter, which the insurer shall specifically describe and shall provide to the consumer a written copy of the matter previously disclosed.

(3) Where the insurer requests the consumer at renewal to provide information to the insurer, the insurer shall be under a duty to ask specific questions, in writing, and shall not use general questions.

(4) The consumer shall be under a duty to respond honestly and with reasonable care, (which has the same meaning as in *section 7*), to any requests by the insurer at the renewal of the contract of insurance and, if the consumer does not provide any new information in response to the insurer's request and where the consumer continues to pay the renewal premium, it shall be presumed that the information previously provided has not altered.

(5) The renewal by the insurer of the contract of insurance shall not, in itself, be taken to cure any previous breach of any duty of disclosure arising under this Act.

(6) The insurer shall, within a reasonable time before renewal of a contract of insurance (and in any event no later than 15 days before renewal), notify the consumer in writing of any alteration to the terms and conditions of the policy, using plain intelligible language in doing so.

Explanatory Note

Section 13(1) implements the recommendation in paragraph 3.143 that the duty of disclosure recommended in this Report, as set out in *section 7* of this Bill, shall not be taken to imply that a consumer who has on a previous occasion discharged that duty of disclosure is under an obligation at renewal of the contract of insurance to provide the insurer with any additional information, whether concerning matters that have changed or otherwise, unless the insurer has expressly required the consumer to do so in accordance with *section 13(2)*.

Section 13(2) implements the recommendation in paragraph 3.144 that where an insurer intends that the consumer is to provide additional information at renewal concerning a particular matter, it must either: (a) ask the consumer a specific question in writing regarding the matter, or (b) request the consumer in writing to update information previously provided concerning that matter, which the insurer must specifically describe and must provide to the consumer a written copy of the matter previously disclosed.

Section 13(3) implements the recommendation in paragraph 3.145 that where the insurer requests the consumer at renewal to provide information to the insurer, the insurer must ask specific questions, in writing, and must not use general questions.

Section 13(4) implements the recommendation in paragraph 3.146 that the consumer is under a duty to respond honestly and with reasonable care (which has the same meaning as in *section 7*) to any requests by the insurer at the renewal of the contract of insurance and, if the consumer does not provide any new information in response to the insurer's request and where the consumer continues to pay the renewal premium, it is to be presumed that the information previously provided has not altered.

Section 13(5) implements the recommendation in paragraph 3.147 that the renewal by the insurer of the contract of insurance does not, in itself, cure any previous breach of any duty of disclosure recommended in this Report and set out in this Bill.

Section 13(6) implements the recommendation in paragraph 3.148 that the insurer shall, within a reasonable time before renewal of a contract of insurance (and in any event no later than 15 days before renewal), notify the consumer in writing of any alteration to the terms and conditions of the policy, using plain intelligible language in doing so.

Post-contractual duties of the consumer and insurer

14. — (1) The duties in this section replace, at the post-contractual stage of a consumer contract of insurance, the principle of utmost good faith (*uberrima fides*) that applied prior to the coming into force of this section (whether that principle arose at common law or under an enactment).

(2) A consumer shall be under a duty to pay the premium within a reasonable time, or in accordance with the terms of the contract, provided those terms comply with the requirements of *section 18*.

(3) An insurer may refuse a claim made by a consumer under a contract of insurance where there is a change in the subject matter of the contract of insurance, including as described in an "alteration of risk" clause, and circumstances have so changed that it can properly be said by the insurer that the new risk is something which, on the true construction of the policy, it did not agree to cover.

(4) (a) An "alteration of risk" clause in a contract of insurance shall apply only in circumstances where the subject matter of the contract of insurance has altered.

(b) An "alteration of risk" clause shall be void where it purports to apply where there is a modification only of the risk insured.

(c) Any clause in a contract of insurance that refers to a "material change" shall be interpreted as referring to changes that take the risk outside that which was within the reasonable contemplation of the contracting parties when the contract of insurance was concluded.

(5) An insurer who intends to exclude certain matters from coverage under the contract of insurance shall do so explicitly in writing prior to the commencement of the contract.

Explanatory Note

Section 14(1) implements the recommendation in paragraph 8.02 that, at the post-contractual stage of a consumer contract of insurance, the principle of utmost good faith (*uberrima fides*) is replaced by the duties recommended in this Report and which are set out in the following subsections of *section 14*.

Section 14(2) implements the recommendation in paragraph 8.05 that a consumer be under a duty to pay the premium within a reasonable time, or in accordance with the terms of the contract provided those terms comply with the requirements concerning unfair or otherwise onerous terms, as to which see *section 18* of the Bill.

Section 14(3) implements the recommendation in paragraph 8.17 that an insurer may refuse a claim made by a consumer under a contract of insurance where there is a change in the subject matter of the contract of insurance, including as described in an “alteration of risk” clause, and circumstances have so changed that it can properly be said by the insurer that the new risk is something which, on the true construction of the policy, it did not agree to cover.

Section 14(4) implements the recommendations in paragraphs 8.18, 8.19 and 9.20 that: (a) an “alteration of risk” clause in a contract of insurance shall apply only in circumstances where the subject matter of the contract of insurance has altered; (b) an “alteration of risk” clause shall be void where it purports to apply where there is a modification of the risk insured only; and (c) any clause in an insurance contract that refers to a “material change” shall be interpreted as referring to changes that take the risk outside that which was within the reasonable contemplation of the contracting parties when the policy was concluded.

Section 14(5) implements the recommendation in paragraph 8.21 that an insurer wishing to exclude certain matters from coverage under the contract of insurance must do so explicitly in writing prior to the commencement of the contract.

Claims handling: duties of the consumer and the insurer

15. — (1) The consumer shall cooperate with the insurer in the investigation of insured events, including by responding to reasonable requests for information in an honest and reasonably careful manner.

(2) (a) The consumer shall notify the insurer of the occurrence of an insured event within a reasonable time or in accordance with the terms of the contract, provided those terms comply with the requirements of *section 18*.

(b) Where non-compliance by the consumer with a specified notification period does not prejudice the insurer, the insurer shall not be entitled to refuse liability under the claim on that ground alone.

(3) Without prejudice to any other duties in this section, the insurer shall be under a duty to handle claims promptly and fairly.

(4) An insurer shall not engage in either of the following in relation to a consumer’s claim on an insurance policy —

(a) requiring the consumer to produce documents irrelevant to the validity of the claim, or

(b) persistently failing to respond to the consumer’s correspondence on the matter, in order to dissuade the consumer from exercising contractual rights in respect of that claim.

(5) (a) The insurer shall pay any sums due to the consumer in respect of the claim within a reasonable time.

- (b) Where it is not possible to quantify the total value of the claim within a reasonable time but where part of the total value has been quantified, the insurer shall pay that part to the consumer within a reasonable time.

(6) If, after a claim has been made under a contract of insurance, the consumer or the insurer becomes aware of information (including information that would otherwise be subject to privilege) that would either support or, as the case may be, would prejudice the validity of the claim made by the consumer, the consumer or, as the case may be, the insurer shall be under a duty to disclose such information to the other party.

Explanatory Note

Section 15(1) implements the recommendation in paragraph 8.27 that consumers must cooperate with their insurers in the investigation of insured events, including by responding to reasonable requests for information in an honest and reasonably careful manner.

Section 15(2) implements the recommendations in paragraphs 8.34 and 8.35 that: (a) the consumer must notify the insurer of the occurrence of an insured event within a reasonable time or in accordance with the terms of the contract, provided those terms comply with the requirements concerning unfair or otherwise onerous terms (as to which see *section 18* of the Bill); and (b) where non-compliance by the consumer with a specified notification period does not prejudice the insurer, the insurer shall not be entitled to refuse liability under the claim on that ground alone.

Section 15(3) implements the recommendation in paragraph 8.51 that a duty be imposed upon insurers to handle claims promptly and fairly.

Section 15(4) implements the recommendation in paragraph 8.52 that the protections in section 55(3) of the *Consumer Protection Act 2007* where insurers have been: (a) requiring consumers to produce documents irrelevant to the validity of their claims; or (b) persistently failing to respond to the consumer's correspondence on the matter in order to dissuade the consumer from exercising contractual rights in respect of that claim, are to apply to consumers as defined for the purposes of this Report.

Section 15(5) implements the recommendations in paragraphs 8.53 and 8.54 that: (a) the insurer must pay any sums due to the consumer in respect of the claim within a reasonable time; and (b) where it is not possible to quantify the total value of the claim within a reasonable time but where part of the total value has been quantified, the insurer shall pay that part to the consumer within a reasonable time.

Section 15(6) implements the recommendation in paragraph 8.66 that if, after a claim has been made under a contract of insurance, the consumer or the insurer becomes aware of information (including information that would otherwise be subject to privilege) that would either support or, as the case may be, would prejudice the validity of the claim made by the consumer, the consumer or, as the case may be, the insurer is under a duty to disclose such information to the other party. This requirement is based on the comparable duty to exchange information that applies to High Court personal injuries claims under section 45 of the *Court and Court Officers Act 1995*.

Proportionate remedies and claims handling

16. — (1) Where an insurer unreasonably withholds payment of a valid claim or unreasonably delays making a payment under a valid claim, the consumer may, in addition to the right to enforce payment of the sums due and any right to interest on those sums, seek damages in accordance with the general law of contract for any consequential loss suffered as a result, and for any non-pecuniary loss and damages, including for stress.

(2) Where a claim made by a consumer under a contract of insurance contains information that is false or misleading in any material respect and which the consumer either knows to be false or misleading or consciously disregards whether it is false or misleading, the insurer shall be entitled to refuse to pay the claim and shall be entitled to terminate the contract.

(3) A valid claim made under a policy is not affected where, under the same policy, the consumer makes a subsequent fraudulent claim or where fraudulent evidence or information is submitted or adduced in its support.

(4) Where an insurer becomes aware that a consumer has made a fraudulent claim, the insurer may, as soon as is practicable after becoming aware of that fact, notify the consumer in writing that it is avoiding the insurance contract, and if the insurer so notifies the consumer, the insurance contract shall be treated as having been terminated with effect from the date of the submission of the fraudulent claim (referred to in this subsection as “the date of the fraudulent act”), whereupon —

(a) the insurer may refuse all liability to the consumer under the insurance contract in respect of any claim made after the date of the fraudulent act, and

(b) the insurer need not return any of the premiums paid under the insurance contract.

(5) (a) Notwithstanding any other provision of this Act, where the consumer makes a fraudulent claim or where fraudulent evidence or information is submitted or adduced in its support or where a contract of insurance contains a term or condition excluding coverage for loss or damage to property caused by a criminal or intentional act or omission of a consumer or any other person, the exclusion applies only to the claim of a person—

(i) whose act or omission caused the loss or damage,

(ii) who abetted or colluded in the act or omission, or

(iii) who consented to the act or omission and knew or ought to have known that the act or omission would cause the loss or damage.

(b) Nothing in *paragraph (a)* shall be interpreted as allowing a person whose property is insured under the contract of insurance to recover more than that person’s proportionate interest in the lost or damaged property.

(c) A consumer whose coverage under the contract of insurance would be excluded but for *paragraph (a)* shall cooperate with the insurer in respect of the investigation of the loss, including—

(i) by submitting a statutory declaration if requested by the insurer, and

(ii) by producing for examination at a reasonable time and place designated by the insurer documents specified by the insurer that relate to the loss.

(6) An insurer shall not be entitled to claim against the consumer the cost of investigating a fraudulent claim.

Explanatory Note

Section 16(1) implements the recommendation in paragraph 8.79 that where an insurer unreasonably withholds payment of a valid claim or unreasonably delays in making a payment under a valid claim, the consumer may, in addition to the right to enforce payment of the sums due and any right to interest on those sums, seek damages in accordance with the general law of contract for any consequential loss, and for any non-pecuniary loss and damages, including for stress.

Section 16(2) implements the recommendation in paragraph 8.86 that it should continue to be the case that where a claim made by a consumer under a contract of insurance contains information that is false or misleading in any material respect and which the consumer either (a) knows to be false or misleading or (b) consciously disregards whether it is false or misleading, the insurer should be entitled to refuse to pay the claim and should be entitled to terminate the contract.

Section 16(3) implements the recommendation in paragraph 8.91 that a valid claim made under a policy is not affected where, under the same policy, the consumer makes a subsequent fraudulent claim or where fraudulent evidence or information is submitted or adduced in its support.

Section 16(4) implements the recommendations in paragraph 8.97 that where an insurer becomes aware that a consumer has made a fraudulent claim it may, as soon as is practicable after becoming aware of that fact, notify the consumer in writing that it is avoiding the insurance contract; and if the insurer so notifies the consumer, the insurance contract will be treated as having been terminated with effect from the date of the submission of the fraudulent claim (referred to as “the date of the fraudulent act”), whereupon (a) the insurer may refuse all liability to the consumer under the insurance contract in respect of any claim made after the date of the fraudulent act, and (b) the insurer need not return any of the premiums paid under the insurance contract.

Section 16(5) implements the recommendation in paragraph 8.113 to facilitate recovery under a contract of insurance by an innocent co-insured who cooperates fully with the insurer during the course of the investigation of a claim. It provides that where a consumer makes a fraudulent claim or where fraudulent evidence or information is submitted or adduced in its support or where a contract of insurance contains a term or condition excluding coverage for loss or damage to property caused by a criminal or intentional act or omission of a consumer or any other person, the exclusion applies only to the claim of a person whose act or omission caused the loss or damage, or who abetted or colluded in the act or omission, or who consented to the act or omission and knew or ought to have known that the act or omission would cause the loss or damage. It also provides a person whose property is insured under the contract of insurance cannot recover more than that person’s proportionate interest in the lost or damaged property. As to cooperation by an innocent co-insured, it provides that that person must cooperate with the insurer in respect of the investigation of the loss, including by submitting a statutory declaration (which is a sworn document) if requested by the insurer, and by producing for examination at a reasonable time and place designated by the insurer documents specified by the insurer that relate to the loss. This provision is derived from section 35 of the British Columbia *Insurance Act 2012*.

Section 16(6) implements the recommendation in paragraph 8.100 that an insurer should not be entitled to claim against the consumer the cost of investigating a fraudulent claim.

Representations by the consumer and terms that reduce the risk being underwritten (replacing insurance warranties)

17.—(1) The provisions in this section replace, in a consumer contract of insurance, the law concerning insurance warranties that applied prior to the coming into force of this section (whether that law arose at common law or under an enactment).

(2) Any statement made by a consumer in or in connection with a contract of insurance, being a statement made by or attributable to a consumer with respect to the existence of a state of affairs or a statement of opinion, shall have effect solely as a representation made by the consumer to the insurer prior to entering into the contract.

(3) Any term in a consumer contract of insurance which purports to convert any statement referred to in *subsection (2)* into a warranty (as understood in the law concerning insurance warranties prior to the coming into force of this section), including by means of a declared “basis of contract” clause or by any comparable clause (including one described as a warranty, a future warranty, a promissory warranty or a continuing warranty), shall be invalid.

(4) In a consumer insurance contract, any contract term however described that imposes a continuing restrictive condition on the consumer during the course of the insurance contract shall be treated as a suspensive condition in that, upon a breach of such a condition, the insurer’s liability is suspended for the duration of the breach but if the breach has been remedied by the time a loss has occurred, the insurer shall (in the absence of any other defence to the claim) be obliged to pay any claim made under the contract of insurance.

- (5) (a) This subsection applies to any term in a consumer contract of insurance however described that has the effect of reducing the risk underwritten by the insurer related to—
- (i) a particular type of loss,
 - (ii) loss at a particular time, or
 - (iii) loss in a particular location.

(b) Without prejudice to the generality of *subsection (4)*, any breach by the consumer of the type of contract term referred to in *paragraph (a)* shall only suspend the liability of the consumer in respect of that particular type of loss, or loss at a particular time or loss in a particular location, as the case may be, and if the breach has been remedied by the time a loss has occurred, the insurer shall (in the absence of any other defence to the claim) be obliged to pay any claim made under the contract of insurance.

Explanatory Note

Section 17(1) implements the recommendation in paragraph 4.21 that in consumer insurance contracts the current law on insurance warranties should be abolished and replaced with specific rules that are consistent with the recommendations already made in this Report.

Section 17(2) implements the recommendation in paragraph 4.34 that statements made in or in connection with consumer contracts of insurance, being statements made by or attributable to a consumer with respect to the existence of a state of affairs or a statement of opinion, shall not have effect as a warranty but shall have effect as a representation made to the insurer by the consumer during the negotiations for the contract but before it was entered into.

Section 17(3) implements the recommendation in paragraph 4.35 that any provision in a consumer insurance contract which purports to convert any statement that comes within *section 17(2)* into a warranty (as understood in the current law concerning insurance warranties), including by means of a declared “basis of contract” clause or by any comparable clause (including one described as a warranty, a future warranty, a promissory or a continuing warranty), shall be invalid.

Section 17(4) implements the recommendation in paragraph 4.54 that any insurance contract term however described that imposes a continuing restrictive condition on the consumer during the course of the insurance contract shall be treated as a suspensive condition in that, upon a breach of such a condition, the insurer’s liability is suspended for the duration of the breach but if the breach has been remedied by the time a loss has occurred, the insurer must (in the absence of any other defence to the claim) pay any claim made under the contract of insurance.

Section 17(5) implements the recommendation in paragraph 4.55 concerning any term in a consumer contract of insurance, however described, that has the effect of reducing the risk underwritten by the insurer related to: (a) a particular type of loss, or (b) loss at a particular time, or (c) loss in a particular location. These constitute a sub-class of the clauses dealt with in *section 17(4)*, above, and have sometimes been used under the current law of insurance warranties to repudiate claims even where the consumer has remedied any breach of such a condition before any claim has been made. *Section 17(5)* therefore provides that, without prejudice to the generality of *section 17(4)*, any breach by the consumer of any such contract term will only suspend the liability of the consumer in respect of that particular type of loss, or loss at a particular time or loss in a particular location, as the case may be; and if the breach has been remedied by the time a loss has occurred, the insurer must (in the absence of any other defence to the claim) pay any claim made under the contract of insurance.

Unfair or onerous terms

18.— (1) (a) An insurer who seeks to rely on an unfair or otherwise onerous term shall, in order to incorporate the term into the contract, take reasonable steps to bring such a term to the attention of the consumer.

(b) In determining whether a term is unfair or otherwise onerous, regard is to be had to whether it is one which in all the circumstances was a term that is, or ought reasonably to have been, known to or in contemplation of the insurer and the consumer both at the pre-contractual stage and when the contract of insurance was entered into.

(2) (a) A term in a consumer contract of insurance shall not in itself be regarded as unfair where the subject matter of the term has actually been considered by the insurer in the calculation of the premium and where the term has been drawn to the attention of the consumer in writing.

(b) *Paragraph (a)* shall apply without prejudice to Regulation 4 of the European Communities (Unfair Terms in Consumer Contracts) Regulations 1995 (SI No.27 of 1995).

(3) In determining whether a term is unfair or otherwise onerous, regard is to be had in particular to any of the following which appear to be relevant —

- (a) the strength of the bargaining positions of the insurer and the consumer relative to each other,
 - (b) whether the consumer had an inducement to agree to the term,
 - (c) whether the contract of insurance was supplied to the special order of the consumer, and
 - (d) the extent to which the insurer has dealt fairly and equitably with the consumer whose legitimate interests the insurer has to take into account.
- (4) Without prejudice to the generality of *subsections (1) to (3)*, the following non-exhaustive types of terms are presumed (the presumption being rebuttable) be be unfair or otherwise onerous terms —
- (a) terms that are not fully intelligible to the consumer, terms which cross refer to legal provisions not disclosed in the contract, and provisions that use small print,
 - (b) terms that exclude or limit liability for non-performance or defective performance, and one sided performance obligations,
 - (c) terms that include evidentiary obstacles, onerous rules on maintaining and proving a claim, arbitration or mediation clauses, and clauses that otherwise enable slow payment of a claim,
 - (d) terms that confer on the insurers unilateral rights to cancel, particularly when this can be done without the consumer being able to arrange cover or recover the premium,
 - (e) terms under which the insurer, without good cause, may unilaterally vary either the cover or the premium, or assign the policy, and
 - (f) terms that impose a disproportionate penalty for breach by the consumer.

Explanatory Note

Section 18(1) implements the recommendations in paragraphs 9.48 and 9.50 that an insurer who seeks to rely on an unfair or otherwise onerous term must, in order to incorporate the term into the contract, take reasonable steps to bring such a term to the attention of the consumer; and that in determining whether a term is unfair or otherwise onerous, regard is to be had to whether it is one that in all the circumstances is, or ought reasonably to have been, known to or in contemplation of the insurer and the consumer both at the pre-contractual stage and when the contract of insurance was entered into.

Section 18(2) implements the recommendation in paragraph 9.68 that a term in a consumer contract of insurance shall not in itself be regarded as unfair where the subject matter of the term has actually

been considered by the insurer in the calculation of the premium and where the term has been drawn to the attention of the consumer in writing; and that this is without prejudice to Regulation 4 of the *European Communities (Unfair Terms in Consumer Contracts) Regulations 1995* (SI No. 27 of 1995), which implemented Directive 93/13/EEC, the 1993 EU Directive on Unfair Terms in Consumer Contracts.

Section 18(3) implements the recommendation in paragraph 9.51 that in determining whether a term is unfair or otherwise onerous, regard is to be had in particular to any of the following which appear to be relevant: (a) the strength of the bargaining positions of the insurer and the consumer relative to each other; (b) whether the consumer had an inducement to agree to the term; (c) whether the contract of insurance was supplied to the special order of the consumer; and (d) the extent to which the insurer has dealt fairly and equitably with the consumer whose legitimate interests the insurer has to take into account. These factors are derived from those set out in Schedule 2 to the *European Communities (Unfair Terms in Consumer Contracts) Regulations 1995*.

Section 18(4) implements the recommendation in paragraph 9.52 that a non-exhaustive list of types of terms that may be presumed (the presumption being rebuttable) to be unfair or otherwise onerous should be set out in the Bill. These are based on the list in the Principles of European Insurance Contract Law (PEICL), which were in turn derived from the non-exhaustive list in Annex 3 of the 1993 EU Directive on Unfair Terms in Consumer Contracts, implemented in Schedule 3 to the *European Communities (Unfair Terms in Consumer Contracts) Regulations 1995*. This non-exhaustive list is: (a) terms that are not fully intelligible to the consumer, terms which cross refer to legal provisions not disclosed in the contract, and provisions that use small print; (b) terms that exclude or limit liability for non-performance or defective performance, and one sided performance obligations; (c) terms that include evidentiary obstacles, onerous rules on maintaining and proving a claim, arbitration or mediation clauses, and clauses that otherwise enable slow payment of a claim; (d) terms that confer on the insurers unilateral rights to cancel, particularly when this can be done without the consumer being able to arrange cover or recover the premium; (e) terms under which the insurer, without good cause, may unilaterally vary either the cover or the premium, or assign the policy; and (f) terms that impose a disproportionate penalty for breach by the consumer. *Section 18(4)* (mirroring the 1993 Directive and 1995 Regulations) provides that such terms may be, not necessarily are, unfair or onerous.

Right of third party to claim against insurer

19. — (1) Where a person (in this section referred to as “the person”) is insured under a contract of insurance against a liability which the person may incur to a third party, and where —

- (a) the person has died, or cannot be found, or is insolvent, or
- (b) where for any other reason it appears to a court to be just and equitable to so order,

the rights of the person under the contract against the insurer in respect of the liabilities shall, notwithstanding anything in any enactment or rule of law, be transferred to and vest in the third party to whom the liability was so incurred.

(2) Accordingly, a third party, in the circumstances described in *subsection (1)*, has a right to recover from the insurer, in accordance with the contract of insurance, the amount of any loss suffered by the third party even though the third party is not a party to the contract of insurance.

(3) Where a third party reasonably believes that the person has incurred a liability to which this section applies, the third party shall be entitled, by way of notice in writing, to seek and obtain information from the insurer or from any other person who is able to provide it (neither of whom shall unreasonably refuse such information) concerning—

- (a) the existence of a contract of insurance that covers the supposed liability or which might be regarded as covering it,
- (b) if there exists such a contract, who the insurer is,

(c) the terms of the contract and

(d) whether the insurer has informed the person that the insurer intends to refuse liability under the contract in respect of the person's supposed liability.

(4) A third party shall be entitled to issue proceedings directly against the insurer to enforce the terms of the contract of insurance without having first established the liability of the person, but before the terms of the contract can be enforced against the insurer in the proceedings the third party shall be required to establish the person's liability.

(5) (a) Where a third party proceeds directly against an insurer, anything done by the third party which, if done by the person, would have amounted to or contributed to fulfilment of a condition of the insurance contract is to be treated as if done by the person.

(b) Without prejudice to *paragraph (a)*, the third party has, in relation to the third party's claim, the same obligations to the insurer as the third party would have if the third party were the person, and may discharge the person's obligations in relation to the loss.

(c) The insurer has the same defences to an action brought by the third party as the insurer would have in an action by the person.

(d) Without prejudice to *paragraph (c)*, the insurer shall be entitled to set off any liabilities incurred by the person in favour of the insurer against any liability owed by the insurer to the third party.

(6) The rights of a third party in this section shall not be subject to a term in a contract of insurance that requires the person to provide information or assistance to the insurer if that term cannot be fulfilled because the person is an individual who has died or cannot be found; but "term that requires the insured person to provide information or assistance to the insurer" shall not include a term that requires the person to notify the insurer of the existence of a claim under the contract of insurance.

(7) The rights of a third party in this section shall not be subject to a term in a contract of insurance that requires the prior discharge by the person of the person's liability to a third party.

(8) Nothing in this section shall be interpreted as requiring that the third party be in existence either at the time the contract of insurance was entered into or at the time of assent to such a contract by another third party.

(9) In this section, "cannot be found"—

(a) means, in the case of an individual, a missing person, that is, a person who is observed to be missing from his or her normal patterns of life, where those who are likely to have heard from the missing person are unaware of his or her whereabouts and where the circumstances of the person being missing raise concerns for the person's safety and well-being, and

(b) includes, in the case of a company, an insolvent company, and where such a company has been struck off the register of companies the third party shall (subject to the other requirements of this section) not be required to restore it to the register before proceeding directly against the insurer.

(10) In the case of an insolvency, moneys that would otherwise be payable to the person under the policy shall be applicable only to discharging in full all valid claims by the third party against the person in respect of which those moneys are payable, and no part of those moneys shall be assets of the person or applicable to the payment of the debts (other than those claims) of the person in the insolvency or in the administration of the estate of the person, and no such claim shall be provable in the insolvency or in the administration of the estate of the person.

(11) In this section, “insolvency” means —

- (a) in the case of an individual,
 - (i) entering into a Debt Relief Notice,
 - (ii) entering into a Debt Settlement Arrangement,
 - (iii) entering into the Personal Insolvency Arrangement, or
 - (iv) becoming bankrupt;
- (b) in the case of a corporate body,
 - (i) entering into examinership,
 - (ii) entering into receivership, or
 - (iii) winding up;
- (c) in the case of a partnership, being dissolved.

(12) Where, in respect of any one act of negligence or any one series of acts of negligence collectively constituting one event, there are two or more claimants and the total of the sums claimed for damages for injury to property or for which judgment has been recovered for damages for such injury exceeds the sum which the insurer or guarantor has insured or guaranteed, the liability, as regards each claimant, of the insurer or guarantor in relation to such damages shall be reduced to the appropriate proportionate part of the sum insured or guaranteed.

(13) In this section, “the person” includes an individual, a partnership, or any corporate body.

(14) In this section, a “third party” means a consumer who is or may be entitled to benefit under the terms of a contract of insurance, whether by way of indemnity or as a person who incurs an injury or loss to which the contract of insurance applies.

(15) It is irrelevant for the purposes of this section whether or not the liability of the insured person is or was incurred voluntarily.

Explanatory Note

Section 19 implements the recommendations in Chapter 6 to provide for a general right of third parties who are intended to benefit under an insurance policy to enforce the terms of the policy. The result is that a third party has a right to claim directly from the insurer the entitlements provided for in the contract of insurance, even though the third party was not a party to the contract. This involves an important exception to the general privity of contract principle and is a significant extension of the implicit and limited third party rights currently contained in section 62 of the *Civil Liability Act 1961*.

Section 19(1) and (2) implement the recommendation in paragraph 6.35 that where an insured “person” (which is defined in *section 19(13)*, below) is insured under a contract of insurance against a liability which the person may incur to a third party, and where: (a) the person has died, or cannot be found, or is insolvent, or (b) where for any other reason it appears to a court to be just and equitable to so order, then the third party should be entitled to enforce the terms of the contract. Accordingly, *section 19(2)* provides that a third party has a right to recover by way of indemnity from the insurer, in accordance with the contract of insurance, the amount of any loss suffered by the third party even though the third party is not a party to the contract of insurance.

Section 19(3) implements the recommendation in paragraph 6.53 that where a party reasonably believes that the person has incurred a liability to which this section applies, the third party shall be entitled, by way of notice in writing, to seek and obtain information from the insurer or from any other person who is able to provide it (neither of whom shall unreasonably refuse such information)

concerning: (a) the existence of an insurance contract that covers the supposed liability or which might be regarded as covering it, (b) if there exists such a contract, who the insurer is, (c) the terms of the contract and (d) whether the insurer has informed the person that the insurer intends to refuse liability under the contract in respect of the person's supposed liability.

Section 19(4) implements the recommendation in paragraph 6.45 that a third party is to be entitled to issue proceedings directly against the insurer to enforce the terms of the contract of insurance without having first established the liability of the person, but before the terms of the contract can be enforced against the person in the proceedings the third party shall be required to establish the person's liability.

Section 19(5) implements the recommendations in paragraphs 6.58, 6.59 and 6.60 that: (a) where a third party proceeds directly against an insurer, anything done by the third party which, if done by the person, would have amounted to or contributed to fulfilment of a condition of the insurance contract is to be treated as if done by the person; (b), the third party has, in relation to the third party's claim, the same obligations to the insurer as the third party would have if the third party were the person, and may discharge the person's obligations in relation to the loss; (c) the insurer has the same defences to an action brought by the third party as the insurer would have in an action by the person; (d), the insurer shall be entitled to set off any liabilities incurred by the person in favour of the insurer against any liability owed by the insurer to the third party.

Section 19(6) implements the recommendation in paragraph 6.61 that the rights of the third party should not be subject to a term in the insurance contract that requires the insured person to provide information or assistance to the insurer if that term cannot be fulfilled because the insured person is an individual who has died or cannot be found; but that "term that requires the insured person to provide information or assistance to the insurer" should not include a term that requires the insured person to notify the insurer of the existence of a claim under the consumer contract of insurance.

Section 19(7) implements the recommendation in paragraph 6.62 that the rights of the third party should not be subject to a term in the insurance contract that requires the prior discharge by the insured person of the insured person's liability to the third party.

Section 19(8) implements the recommendation in paragraph 6.33 that the third party need not be in existence either at the time the consumer contract of insurance was entered into or at the time of assent to such a contract by another party.

Section 19(9)(a) implements the recommendation in paragraph 6.36 that the term "cannot be found" means in the case of an individual a "missing person" as defined in the Commission's *Report on Civil Law Aspects of Missing Persons* (LRC 106-2013), that is, a person who is observed to be missing from his or her normal patterns of life, where those who are likely to have heard from the missing person are unaware of his or her whereabouts and where the circumstances of the person being missing raise concerns for the person's safety and well-being. *Section 19(9)(b)* implements the recommendation in paragraph 6.37 that the term "cannot be found" includes, in the case of a company, an "insolvent company"; and that where such a company has been struck off the register of companies, the third party should not be required to restore it to the register before proceeding directly against the insurer.

Section 19(10) implements the recommendation in paragraph 6.39 that the general rule concerning insolvency in section 62 of the *Civil Liability Act 1961* should be retained, namely, that in the case of an insolvency, moneys that would otherwise be payable to the person under the policy shall be applicable only to discharging in full all valid claims by the third party against the person in respect of which those moneys are payable, and no part of those moneys shall be assets of the person or applicable to the payment of the debts (other than those claims) of the person in the insolvency or in the administration of the estate of the person, and no such claim shall be provable in the insolvency or in the administration of the estate of the person.

Section 19(11) implements the recommendation in paragraph 6.38 that the third party provisions in this Bill which retain the general rule concerning insolvency in section 62 of the *Civil Liability Act 1961* (see *section 19(10)*, above) should reflect the different forms of insolvency, both individual and corporate, that have come into existence since 1961. Thus, in the case of an individual "insolvency"

means entering into a Debt Relief Notice, a Debt Settlement Arrangement or a Personal Insolvency Arrangement (under the *Personal Insolvency Act 2012*) or becoming bankrupt (under the *Bankruptcy Act 1988*). In the case of a corporate body, “insolvency” means entering into examinership, entering into receivership, or winding up. In the case of a partnership, “insolvency” means being dissolved.

Section 19(12) implements the recommendation in paragraph 6.68 that where, in respect of any one act of negligence or any one series of acts of negligence collectively constituting one event, there are two or more claimants and the total of the sums claimed for damages for injury to property or for which judgment has been recovered for damages for such injury exceeds the sum which the insurer or guarantor has insured or guaranteed, the liability, as regards each claimant, of the insurer or guarantor in relation to such damages shall be reduced to the appropriate proportionate part of the sum insured or guaranteed.

Section 19(13) implements the recommendation in paragraph 6.34 that, for the purposes of third party rights, “the insured person” includes an individual, a partnership, or any corporate body.

Section 19(14) implements the recommendation in paragraph 6.32 that a third party should be defined as being limited to a consumer who is or may be entitled to benefit under the terms of a contract of insurance, whether by way of indemnity or as a person who incurs an injury or loss to which the contract of insurance applies.

Section 19(15) implements the recommendation in paragraph 6.65 that, when referring to a contract of insurance against a liability which the person may incur to a third party, it is irrelevant whether or not the liability of the insured person is or was incurred voluntarily.

Subrogation: modification in family and personal relationships and in employment

20.— (1) (a) This subsection applies where an insurer is liable under a contract of insurance in respect of a loss and but for this subsection the insurer would be entitled to be subrogated to the rights of the consumer against some other person (in this subsection referred to as the other person) and the consumer has not exercised those rights and might reasonably be expected not to exercise those rights by reason of—

(i) a family or other personal relationship between the consumer and the other person,
or

(ii) the consumer having expressly or impliedly consented to the use, by the other person, of a motor vehicle that is the subject matter of the contract.

(b) This subsection does not apply where the conduct of the other person that gave rise to the loss was serious or wilful misconduct.

(c) Where the other person is not insured in respect of that other person’s liability to the consumer, the insurer does not have the right to be subrogated to the rights of the consumer against the other person in respect of the loss.

(d) Where the other person is so insured, the insurer may not, in the exercise of the insurer’s rights of subrogation, recover from the other person an amount that exceeds the amount that the other person may recover under the other person’s contract of insurance in respect of the loss.

(e) (i) A consumer need not comply with a condition requiring the consumer to assign those rights to the insurer in order to be entitled to payment in respect of the loss and an insurer shall not purport to impose such a condition on the making of such a payment or, before making such a payment, invite the consumer so to assign those rights, or suggest that the consumer so assign them.

(ii) An assignment made in compliance with such a condition or in pursuance of such an invitation or suggestion is void.

(2) An insurer should not be entitled to exercise rights of subrogation against an employee of the insured employer except when it proves that the loss was caused by such a person intentionally or recklessly and with knowledge that the loss would probably result.

Explanatory Note

Section 20(1) implements the recommendations in paragraph 7.08 that the subrogation rights of insurers to recover payments from persons in family or other personal relationships with consumers should be modified. The modification applies where an insurer is liable under a contract of insurance in respect of a loss and where but for this modification the insurer would be entitled to be subrogated to the rights of the consumer against some other person and the consumer has not exercised those rights and might reasonably be expected not to exercise those rights by reason of (a) a family or other personal relationship between the consumer and the other person, or (b) the consumer having expressly or impliedly consented to the use, by the other person, of a motor vehicle that is the subject matter of the contract. The modification would not apply where the conduct of the other person that gave rise to the loss was serious or wilful misconduct. The modification means that where the other person is not insured in respect of that other person's liability to the consumer, the insurer does not have the right to be subrogated to the rights of the consumer against the other person in respect of the loss. It also means that where the other person is so insured, the insurer may not, in the exercise of the insurer's rights of subrogation, recover from the other person an amount that exceeds the amount that the other person may recover under the other person's contract of insurance in respect of the loss. These modifications are broadly along the lines in section 65 of the Australian *Insurance Contracts Act 1984*.

Section 20(2) implements the recommendations in paragraph 7.20 that the subrogation rights of insurers as they apply to the employer-employee situation should be modified. The modification means that an insurer should not be entitled to exercise rights of subrogation against an employee of the insured employer except when it proves that the loss was caused by such a person intentionally or recklessly and with knowledge that the loss would probably result. These modifications are broadly along the lines with Article 10:101(3) of the PEICL.

Subrogation: distribution of recovered funds

21.— (1) This section applies where—

- (a) an insurer is liable under a contract of insurance in respect of a loss, and
 - (b) the insurer has a right of subrogation in respect of the loss, and
 - (c) an amount is recovered (whether by the insurer or the consumer) from another person in respect of the loss.
- (2) If the amount is recovered by the insurer in exercising the insurer's right of subrogation in respect of the loss—
- (a) the insurer is entitled under this paragraph to so much of the amount as does not exceed the sum of—
 - (i) the amount paid by the insurer to the consumer in respect of the loss, and
 - (ii) the amount paid by the insurer for administrative and legal costs incurred in connection with the recovery; and
 - (b) if the amount recovered exceeds the amount to which the insurer is entitled under *paragraph (a)*, the consumer is entitled under this paragraph to so much of the excess as does not exceed the consumer's overall loss; and
 - (c) if the amount recovered exceeds the sum of—

- (i) the amount to which the insurer is entitled under *paragraph (a)*, and
 - (ii) the amount (if any) to which the consumer is entitled under *paragraph (b)*,
- the insurer is entitled to the excess.
- (3) If the amount is recovered by the consumer—
- (a) the consumer is entitled under this paragraph to so much of the amount as does not exceed the sum of—
 - (i) the consumer’s overall loss, and
 - (ii) the amount paid by the consumer for administrative and legal costs incurred in connection with the recovery; and
 - (b) if the amount recovered exceeds the amount to which the consumer is entitled under *paragraph (a)*, the insurer is entitled to so much of the excess as does not exceed the amount paid by the insurer to the consumer in respect of the loss; and
 - (c) if the amount recovered exceeds the sum of—
 - (i) the amount to which the consumer is entitled under *paragraph (a)*, and
 - (ii) the amount (if any) to which the insurer is entitled under *paragraph (b)*,
 the consumer is entitled to the excess.

Explanatory Note

Section 21 implements the recommendation in paragraph 7.28 to apply the common law “recovery down” principle to the distribution of funds recovered by subrogation. This is broadly along the lines in section 67 of the Australian *Insurance Contracts Act 1984*.

Contracts affecting subrogation and third parties

22.— (1) Where a contract of insurance includes a provision that has the effect of excluding or limiting the insurer’s liability in respect of a loss because the consumer is a party to an agreement that excludes or limits a right of the consumer to recover damages from a person other than the insurer in respect of the loss, the insurer may not rely on the provision unless the insurer clearly informed the consumer in writing, before the contract of insurance was entered into, of the effect of the provision.

(2) For the purposes of any matter related to subrogation under this Act, a reference to a consumer includes a reference to a third party.

Explanatory Note

Section 22(1) implements the recommendation in paragraph 7.32 that where a contract of insurance includes a provision that has the effect of excluding or limiting the insurer’s liability in respect of a loss because the consumer is a party to an agreement that excludes or limits a right of the consumer to recover damages from a person other than the insurer in respect of the loss, the insurer may not rely on the provision unless the insurer clearly informed the consumer in writing, before the contract of insurance was entered into, of the effect of the provision. This is broadly along the lines in section 68 of the Australian *Insurance Contracts Act 1984*.

Section 22(2) implements the recommendation in paragraph 7.35 that for the purposes of subrogation under this Bill a reference to a consumer includes a reference to a third party. This is also broadly

along the lines in the Australian *Insurance Contracts Act 1984*, as amended by the *Insurance Contracts Amendment Act 2013*.

Effect of failure to comply with Act

23. — (1) Without prejudice to the remedies provided for in *section 8* and *section 16*, and subject to *subsection (2)*, a court of competent jurisdiction may in its discretion—

- (a) where a consumer is in breach of any duties under this Act (other than those to which *section 8* and *section 16* apply) order that the sum otherwise recoverable in a claim under an insurance contract shall be reduced in proportion to the breach involved, or
 - (b) where an insurer is in breach of any duties under this Act (other than those to which *section 8* and *section 16* apply) order that the sum otherwise payable in a claim under an insurance contract shall be increased in proportion to the breach involved.
- (2) Where there has been a breach by the consumer or, as the case may be, by the insured of any duty under this Act, the court may decline to make any order under *subsection (1)* where —
- (a) the breach of the duty was not deliberate, and
 - (b) it would be just and equitable in the circumstances to dispense with compliance with the duty for the purposes of *subsection (1)*.

(3) A term or condition of a consumer contract of insurance is void if it purports to impose on the consumer the burden of proving that the insurer has complied or not complied with an obligation imposed on the insurer in accordance with this Act (including those to which *section 8* and *section 16* apply).

Explanatory Note

Section 23(1) implements the recommendations in paragraph 10.95 that, without prejudice to the proportionate remedies provided for in *sections 8 and 16* of the Bill, a court may in its discretion (a) order that where the consumer is in breach of any duties (other than those referred to in *sections 8 and 16*) an award in an insurance contract claim be reduced in proportion to the breach involved; and (b) order that where the insurer is in breach of any duties (other than those referred to in *sections 8 and 16*) an award in an insurance contract claim be increased in proportion to the breach involved.

Section 23(2) implements the recommendation in paragraph 10.95 that non-compliance with any duties (other than those referred to in *sections 8 and 16*) should not have any contractual effect where: (a) it was not deliberate and (b) it would be just and equitable in the circumstances to dispense with the obligation.

Section 23(3) implements the recommendation in paragraph 10.96 that a term or condition of a consumer contract of insurance is void if it purports to impose on the consumer the burden of proving that the insurer has complied or not complied with an obligation imposed on the insurer in this Report (including those in *sections 8 and 16*).

APPENDIX C DEVELOPMENT OF INSURANCE REGULATION IN IRELAND AND IN COMPARABLE JURISDICTIONS

A Scale and Nature of Insurance Business in Ireland

(1) *Insurance constitutes an important financial services sector in Ireland*

C.01 Insurance companies and insurance intermediaries (insurance agents and brokers) represent an important service sector in the State. Throughout the State over 220 insurance companies employ more than 13,500 people, and a further 4,000 people are employed in insurance undertakings based in the Irish Financial Services Centre (IFSC) in Dublin.¹ In addition, over 5,500 people are employed in more than 500 insurance broker firms.²

(2) *Financial value of life and non-life insurance in Ireland*

C.02 Insurance contracts are divided into two general types, life insurance and non-life insurance. Insurance policies concerning a person's life can be further categorised into, for instance, life policies related to a mortgage, life policies related to pension schemes, life policies where a specified benefit is paid on death and life policies which provide for a specified death benefit but which may also include benefits that may be encashed during the policyholder's life.

C.03 In 2013, life insurance relating to individual assurances and annuities (41.5%), pension schemes (38.9%) and self-employed pensions (including PRSAs) (17.2%) continued to be the three main segments of life insurance gross premium income.

C.04 Since the 1970s, non-life insurance contracts have been divided into 18 classes³ which replaced the 10 categories adopted in the 1930s.⁴

¹ Insurance Europe *European Insurance in Figures* (Statistics No.48, February 2014), available at insuranceeurope.eu.

² Source: website of the Irish Brokers Association, iba.ie

³ Annex I of the *European Communities (Non-Life Insurance) Framework Regulations 1994* (SI No.359 of 1994) (which is also discussed in Chapter 10, above) lists 18 classes of non-life insurance risk to which they apply, which is based on the identical list in the Annex to Directive 73/239/EEC, the 1973 First EU Non-Life Directive (and now consolidated in Annex 1 of Directive 2009/138/EC, the 2009 Solvency II Framework Directive, which brings together in a single text 13 EU Insurance Directives). The 18 classes are: Class 1: Accident (including fixed pecuniary benefits or benefits in the nature of indemnity). Class 2: Sickness (including fixed pecuniary benefits or benefits in the nature of indemnity). Class 3: Land Vehicles, other than railway rolling stock (all damage to or loss of such vehicles). Class 4: Railway rolling stock (all damage to or loss of railway rolling stock). Class 5: Aircraft (all damage to or loss of aircraft). Class 6: Ships (all damage or loss to sea, lake and river and canal vessels). Class 7: Goods in transit (all damage or loss to merchandise, baggage, and all other goods). Class 8: Fire and natural forces (all damage to or loss of property, other than property in classes 3, 4, 5, 6 and 7, due to: fire, explosion, storm, natural forces other than storm, nuclear energy or land subsidence). Class 9: Other damage to property (all damage to or loss of property, other than property included in classes 3, 4, 5, 6 and 7, due to hail or frost, and any event such as theft, other than those mentioned under class 8). Class 10: Motor vehicle liability (all liability arising out of the use of motor vehicles operating on the land, including carrier's liability). Class 11: Aircraft liability (all liability arising out of use of aircraft, including carrier's liability). Class 12: Liability for ships (all liability arising out of the use of ships, vessels or boats on the sea, lakes,

In 2013 motor insurance remained the largest class of non-life insurance (43% of non-life insurance premiums in 2013, reflecting its long-standing mandatory nature), followed by property insurance, notably fire insurance (33% of non-life insurance in 2013), and then health insurance.

The Table below shows the total value of written life and non-life insurance premiums, and of benefits and payments made, between 2009 and 2013 in Ireland.⁵

Life and Non-Life Premiums Written and Benefits and Claims Paid in Ireland: 2009-2013

Year	Total Premiums Written	Total Benefits and Claims Paid	Total Life Premiums Written	Total Life Benefits Paid	Total Non-Life Premiums Written	Total Non-Life Claims Paid
2009	€12.470 billion	€11.326 billion	€9.346 billion	€8.576 billion	€3.124 billion	€2.750 billion
2010	€12.724 billion	€10.738 billion	€9.688 billion	€8.222 billion	€3.036 billion	€2.516 billion
2011	€11.365 billion	€10.573 billion	€8.485 billion	€8.736 billion	€2.880 billion	€1.837 billion
2012	€10.603 billion	€10.407 billion	€8.200 billion	€9.007 billion	€2.403 billion	€1.400 billion
2013	€11.313 billion	€9.815 billion	€8.739 billion	€8.922 billion	€2.196 billion	€1.693 billion

C.05 In 2013, €8.739 billion in life premiums were underwritten, and €8.922 billion in benefits were paid by life insurance companies in Ireland.⁶ These benefits consisted primarily of: income and

rivers or canals, including carrier's liability). Class 13: General liability (all liability other than those forms mentioned under classes 10, 11 and 12). Class 14: Credit (insolvency, export credit, instalment credit, mortgages and agricultural credit). Class 15: Suretyship (direct and indirect suretyship). Class 16: Miscellaneous financial loss (employment risks, insufficiency of income, bad weather, loss of benefits, continuing general expenses, unforeseen trading expenses, loss of market value, loss of rent or revenue, indirect trading losses other than those mentioned above, and other financial loss (non-trading)). Class 17: Legal expenses (including costs of litigation). Class 18: Touring assistance (assistance for persons who get into difficulties while travelling, while away from home or while away from their permanent residence). In 1984, the OECD *Recommendation Concerning a Common Classification of the Classes of Insurance Contracts* (C(83)178/FINAL), available at webnet.oecd.org, recommended that most OECD member States adopt the 18 classes for non-life insurance contained in the 1973 Directive. The 1984 OECD Recommendation does not apply to Australia, Canada or the United States.

⁴ Annex I of the *European Communities (Non-Life Insurance) Framework Regulations 1994* (S.I. No. 359 of 1994) also contains the following correspondence between the classes in the 1994 Regulations and the 10 categories of non-life insurance in the *Insurance Act 1936*. Fire: class 8. Accident: classes 1 and 2. Employers Liability: class 13. Mechanically Propelled Vehicle: classes 1, 3, 7 and 10. Public Liability: class 13. Engineering: classes 9 and 13. Glass: class 9. Guarantee: classes 9 and 15. Burglary: class 9. Bond Investment: class 16.

⁵ See Insurance Ireland *Factfile 2012* (January 2014) and Insurance Ireland *Factfile 2013* (January 2015), both available at insuranceireland.eu; and Insurance Europe *European Insurance in Figures* (Statistics No.48, February 2014), Tables 1 to 7, available at www.insuranceeurope.eu.

payouts on investment policies for policyholders; payment of death benefits which protect family income; payment of annuity income to pension policy holders; repayment of mortgages in the event of death of a policyholder; and lump sum payouts to policyholders with serious illness cover.⁷

C.06 In 2013, €2.196 billion in non-life premiums were underwritten and €1.693 billion in claims were paid. During 2013, the number of new claims notified to members of Insurance Ireland was 441,214. Of these, 53% were motor claims while 23% were made on property insurance policies (household and commercial property).⁸

(3) Increasing movement towards online insurance activity

C.07 In recent years, there has been an increasing movement towards arranging insurance through online means, which reflects general trends in consumer purchases of goods and services in the digital age. A survey conducted in 2012 concerning trends in consumer insurance worldwide, including in EU states, indicated that online insurance sites have become an increasingly important aspect of insurance selling. This began with consumers using online price comparison sites, which then developed to an increasing percentage of consumers arranging insurance online, and this trend is likely to increase further in the future.⁹

C.08 A separate survey of media consumption in Europe showed that 80% of Irish people were online in 2012 compared to the EU average of 65%. These higher percentages for Irish people are broadly in line with figures for the UK in the 2012 survey referred to above, indicating that UK and Irish consumers were already more active online in 2012 than in other EU states. The media consumption survey also indicated that the internet is more important for Irish users when deciding to purchase goods and services, including insurance, by comparison with the EU average:¹⁰

Online Purchases	Ireland	EU average
Travel Tickets	76%	57%
Holidays	73%	53%
Mobiles	57%	50%
Financial products/ services	50%	47%
Insurance	67%	39%

C.09 These surveys emphasise the need to ensure that the legislative framework for consumer insurance contracts reflects current and future trends in the insurance market in the 21st century.

⁶ See Insurance Ireland *Factfile 2013* (January 2015), at pp.10-11, available at insuranceireland.eu. Insurance Ireland, formerly the Irish Insurance Federation (IIF), is the main representative organisation for insurance undertakings in Ireland, representing 95% of the domestic market and 70% of Ireland's international life insurance market: *ibid* at 1.

⁷ See Insurance Ireland *Factfile 2013* (January 2015), at pp.10-11.

⁸ *Ibid*, at p.17.

⁹ See EY (formerly Ernst & Young) *Global Consumer Insurance Survey 2012*, p.19ff, available at ey.com.

¹⁰ See "More Irish online than EU average - and more of us are using mobile devices" *Irish Independent*, 5 July 2012, available at irishindependent.ie, citing Mediascope, an analysis of media consumption in Europe.

B The Limited Regulation of Insurance Contract Law and the Need for Further Reform

(1) Insurance contracts, asymmetric information and the need for statutory regulation

C.10 In 2005, the Competition Authority (now the Competition and Consumer Protection Commission¹¹) noted that an important feature of contracts of insurance is that they involve “asymmetric information”¹² because both the insurer and the proposer/policyholder possess important, though very different, information relevant to the determination of the risk that is being insured.

C.11 In the modern era, insurance undertakings are large (often multi-national) entities that have at their disposal a significant amount of information on the nature and extent of the risk related to specific life and non-life insurance products which they place on the market.

C.12 The legislation regulating insurance undertakings (outlined further below) requires insurers to have in place detailed risk management systems, with the benefit of advice from Chief Risk Officers and Chief Actuaries, who plan and review the undertaking’s appropriate prudential and solvency margins, and the appropriate “risk appetite” for the insurer in connection with the insurance products it offers to the public.¹³

C.13 While proposers/policyholders do not ordinarily possess the level of financial and risk management knowledge of an insurance undertaking, they have important information concerning the risks involved in specific contracts. The state of health of the proposer entering into a life insurance policy or a non-life health policy is highly relevant to the risk being assessed by the insurer.

Equally, the proposer’s previous history of claims is of great importance to the insurer entering into a non-life fire policy for a house or commercial premises.

C.14 If this “asymmetric information” is not appropriately regulated, it is likely that the insurance market will not operate efficiently in at least two important respects.¹⁴

From the perspective of the insurance undertaking, the failure to use the financial and actuarial knowledge at its disposal may lead to the provision of unsuitable, and unprofitable, insurance products, which could ultimately lead to insolvency and liquidation and the consequent damage to society. Equally, failure to communicate effectively the known benefits, or limits, of a specific policy, may result in a policyholder entering into, or continuing with, an unsuitable insurance contract.

¹¹ In accordance with the *Competition and Consumer Protection Act 2014*, the Competition Authority and the National Consumer Agency amalgamated to form the Competition and Consumer Protection Commission (CCPC), which has a dual mandate to enforce competition and consumer protection law: see ccpc.ie.

¹² See Competition Authority *Competition Issues in the Non-Life Insurance Market: Final Report and Recommendations* (2005, in two volumes), Vol.1, at paragraphs 4.4-4.9, available at www.tca.ie.

¹³ The relevant corporate governance arrangements are set out in the Central Bank of Ireland’s *Corporate Governance Code for Credit Institutions and Insurance Undertakings 2013*, which replaced the *Corporate Governance Code for Credit Institutions and Insurance Undertakings 2010*, both available at centralbank.ie. On the changes made in the 2013 Code from the 2010 Code, see the 2013 *Feedback Statement on the Consultation Paper on the Review of the Corporate Governance Code for Credit Institutions and Insurance Undertakings (CP 69)*, also available at centralbank.ie. The legal basis for the Corporate Governance Code includes the *European Communities (Non-Life Insurance) Framework Regulations 1994* (SI No.359 of 1994) and the *European Communities (Life Assurance) Framework Regulations 1994* (SI No.360 of 1994), which form part of the implementation of the EU-wide licensing and supervisory regime for insurance undertakings.

¹⁴ See Competition Authority *Competition Issues in the Non-Life Insurance Market: Final Report and Recommendations* (2005, in two volumes), Vol.1, at paragraphs 4.4-4.9, available at www.tca.ie.

Similarly, if a proposer or insurer does not disclose relevant information concerning the risk being covered by the insurance policy, accurate pricing of the policy is not possible and there is the potential that a person may claim under a policy in a manner that is unfair to other similar policyholders who are paying a higher premium because they have made full disclosure.

In respect of all these instances of “asymmetric information” suitable regulation should ensure that there is an appropriate balancing of the bargaining position of both the insurer and the policyholder.

(2) General principles and rules of contract law apply to insurance contracts

C.15 A number of general contract law principles and rules apply to insurance contracts. These comprise, in part, long-established common law (judge-made) principles and rules and, in part, statutory rules of relatively recent origin.

C.16 The common law rules of contract applicable to insurance include those concerning the formation of the contract, notably that there must be a clear offer by one party that is communicated to and accepted by the other party (offer and acceptance) and that there must be an exchange of economic value between the parties (consideration).

C.17 Similarly, there are well-established requirements under which exemption clauses and other unfair or onerous terms that have been drafted by one party must be brought to the attention of the other party, and must also meet general requirements that prevent a consumer from being bound by unfair terms.¹⁵

As to legislation, the *Sale of Goods and Supply of Services Act 1980* provides that contracts for the supply of a service must be carried out with due care and skill, that exemption clauses in consumer contracts must be fair and reasonable (the 1980 Act is limited in this context to consumer contracts, unlike the common law rules which it broadly mirrors).

The *European Communities (Unfair Terms in Consumer Contracts) Regulations 1995*¹⁶ and the *Consumer Protection Act 2007* regulate, respectively, unfair terms and unfair commercial practices in consumer contracts.

This legislation forms part of the “general good requirements” with which insurers must comply.¹⁷

(3) Specific principles and rules of contract law apply to insurance contracts

C.18 Insurance contracts are subject to additional specific common law and statutory principles and rules. Because of the wide range of classes of insurance contracts, it is difficult to define in prescriptive terms the nature and scope of an insurance contract.

¹⁵ The Commission discusses in detail the relevant common law and statutory requirements in Chapter 9, above.

¹⁶ SI No.27 of 1995, as amended. As discussed in Chapter 9, above, in May 2015 the Department of Jobs, Enterprise and Innovation published the *Scheme of a Consumer Rights Bill* (following the Department’s 2014 *Consultation Paper on Reform of the Law on Consumer Contract Rights*, both available at djei.ie), which if enacted would revoke and replace the 1995 Regulations and also repeal, with significant reforms, the *Sale of Goods Act 1893* and the *Sale of Goods and Supply of Services Act 1980* insofar as those Acts deal with consumer contracts. If enacted, the *Scheme of a Consumer Rights Bill* would also implement the key recommendations in the 2011 *Report of the Sales Law Review Group*, available at djei.ie.

¹⁷ The EU-derived law that regulates insurance undertakings, discussed below, imposes on insurers “general good requirements” which require them to comply with the general principles and rules of contract law, notably the statutory rules concerning supply of services, unfair terms and unfair commercial practices discussed in Chapter 9, above. See Article 24 of the *European Communities (Non-Life Insurance) Framework Regulations 1994* (SI No.359 of 1994) and Article 43 of the *European Communities (Life Assurance) Framework Regulations 1994* (SI No.360 of 1994).

Nonetheless case law has established a useful generally applicable definition which assists in distinguishing between insurance and other types of contracts that share some common features, such as gambling contracts and contracts of guarantee.¹⁸

The common law has also developed principles and concepts that are specific to insurance contracts, including the principle of utmost good faith (*uberrima fides*)¹⁹ and the concept of insurable interest.²⁰

While comprehensive provisions are in place to regulate insurance undertakings in relation to licensing, prudential and solvency matters (discussed below), there is limited statutory regulation of insurance contracts.

(4) The current limited statutory regulation of insurance contract law

C.19 In 1922 the State inherited the common law rules of insurance contract law and a large body of pre-1922 insurance legislation, commencing with the *Life Assurance Act 1774*.

The antiquity of the 1774 Act has created difficult issues of interpretation,²¹ and legislation such as the *Marine Insurance Act 1906* has been criticised as producing a legal context “wholly inappropriate, in part at least, to the purpose of the transaction being effected.”²²

Nonetheless, Irish courts have, in general, agreed that a number of general provisions in the 1906 Act comprise a codification of the common law rules on insurance that apply “across the board.” As the 1906 Act remains in force it has, by default, coloured the way in which even consumer insurance transactions are to be tested. Reform of insurance contract law is now required, particularly because of the increased level of regulatory supervision introduced in the 20th and 21st centuries and because of the additional influence of EU law.

C.20 Ellis and Wiltshire²³ observe that statutory supervision of insurance companies in Ireland dates from the *Life Assurance Companies Act 1870*.²⁴ The 1870 Act required the deposit of £20,000 with the Accountant General of the Court of Chancery, a requirement to keep life funds separate from other business transacted by companies engaging in life assurance and the preparation and filing of annual accounts of life and other assurance business.

The *Assurance Companies Act 1909* repealed the 1870 Act and extended the regulatory structure in relation to life assurance to fire insurance, accident insurance, employer’s liability and bond investment business, insofar as that business was not already the subject of friendly society or trade union registration.

¹⁸ See Chapter 5, above.

¹⁹ See Chapters 2 and 3, above. As noted in paragraph 2.04 of the Report, above, the principle of “utmost good faith” in insurance contract law is to be distinguished from the separate, though related, requirement of “good faith” that now forms part of the statutory consumer protection regime in, for example, the *European Communities (Unfair Terms in Consumer Contracts) Regulations 1995* and the *Consumer Protection Act 2007* (discussed in Chapter 9, above), which apply to insurance contracts. Regardless, therefore, of any reforms proposed in this Report concerning “utmost good faith” as it applies in insurance contract law, the separate “good faith” principle in the 1995 Regulations and the 2007 Act will continue to apply to insurance contracts.

²⁰ See Chapter 5, above.

²¹ See *Church and General Insurance Co v Connolly*, High Court, 7 May 1981, discussed in Chapter 5, above.

²² Finlay CJ in *Brady v Irish National Insurance Co Ltd* [1986] ILRM 669, at 679.

²³ Ellis and Wiltshire, *Regulation of Insurance in the UK, Ireland and the EU* (Thomson Reuters Looseleaf) C.1-01.

²⁴ 33 & 34 Vict. c.61.

The 1909 Act did not address industrial life assurance, that is, the activities of friendly societies and life assurance entities that granted life assurance via a mechanism for collecting premiums through collectors at periodical intervals of less than two months. The legislation in this area was consolidated by the *Friendly Societies Act 1896*²⁵ and the *Collecting Societies and Industrial Assurance Companies Act 1896*.²⁶ This was the key legislation in force in 1922 when the State was established.

C.21 The Oireachtas first made provision in respect of motor insurance in the *Road Traffic Act 1933*, but it was the *Insurance Act 1936* that ushered in general licensing and deposit-making requirements for Irish companies wishing to transact business in ordinary and industrial life assurance, fire, bond, employer's liability, motor insurance, public liability, engineering, glass, guarantee and burglary insurance.

Ellis and Wiltshire have explained that, following the enactment of the 1936 Act, "it became almost impossible for foreign companies to enter the Irish market."²⁷ Although a "reciprocity provision" was contained in the *Insurance Act 1953* to facilitate limited entry to the Irish market by foreign companies, it was only through the market liberalisation provision of the EU regulatory regime (introduced from the 1970s onwards) that Irish insurance regulation lost its protectionist character.

C.22 Much of the EU-derived legislative regime for insurance undertakings is set out in the *European Communities (Non-Life Insurance) Framework Regulations 1994*²⁸ and the *European Communities (Life Assurance) Framework Regulations 1994*²⁹ which involve the implementation of 13 separate directives on life and non-life insurance.

This EU-wide legislation imposes "general good requirements"³⁰ on insurance undertakings which require them to comply with the general principles and rules of contract law, notably the statutory rules concerning supply of services, unfair terms and unfair commercial practices referred to above.

The legislative regime predominantly focuses on the right of establishment through national licensing of insurers, and on external regulatory supervision and internal management of prudential and solvency requirements (although it includes some limited regulation of insurance contracts).

The 1994 Regulations will be replaced from 2016 onwards with the implementation of Directive 2009/138/EC, the 2009 "Solvency II" Framework Directive, which consolidates and reforms the 13 EU Insurance Directives.

In the wake of the global financial crisis that emerged in 2008, EU Member States agreed to establish a Single Supervisory Mechanism (SSM) under the auspices of the European Central Bank to regulate financial services, including insurance undertakings. While the main focus of the SSM will remain on prudential and solvency regulation, one of its constituent bodies, the European Insurance and Occupational Pensions Authority (EIOPA), has a consumer protection mandate which has already

²⁵ 59 & 60 Vict. c.25. The *Friendly Societies Act 1896*, as amended, remains in force in the State.

²⁶ 59 & 60 Vict. c.26.

²⁷ Ellis and Wiltshire *Regulation of Insurance in the UK, Ireland and the EU* (Thomson Reuters Looseleaf) C.1-01.

²⁸ SI No.359 of 1994, as amended.

²⁹ SI No.360 of 1994, as amended.

³⁰ See Article 24 of the *European Communities (Non-Life Insurance) Framework Regulations 1994* (SI No.359 of 1994) and Article 43 of the *European Communities (Life Assurance) Framework Regulations 1994* (SI No.360 of 1994).

affected the content of the Central Bank of Ireland's *Consumer Protection Code 2012* concerning complaints handling by insurers.³¹

C.23 The *Insurance Act 1989* and the *Insurance Act 2000* have their origins in the 1976 *Report of the Committee of Inquiry into the Insurance Industry* (the O'Donoghue Report)³² which recommended significant reforms of the national regulatory regime (and anticipated some EU developments). It recommended insurance contract law reform by the enactment of legislation that would require life insurance undertakings to provide to a proposer "a statement of his rights under the contract in a form approved by the Supervisory Authority when he is signing the proposal."³³

Section 5 of the *Insurance Act 1989* contains a standard Regulation-making power which could have been used to implement this recommendation, and section 61 of the 1989 Act provides for the making of statutory codes of practice to deal with the duty of disclosure and insurance warranties. However, it was not until 2001 that the regulation-making power in section 5 of the 1989 Act was used and the power in section 61 of the 1989 Act was not used until 2006.

For life insurance contracts section 43B of the *Insurance Act 1989*³⁴ and the *Life Assurance (Provision of Information) Regulations 2001*³⁵ require insurance undertakings to provide specified pre-contractual information to proposers and specific post-contractual information to policyholders.³⁶

Similarly, the *Non-Life Insurance (Provision of Information) (Renewal of Policy Insurance) Regulations 2007*³⁷ require insurance undertakings to provide specified information to policyholders in advance of renewal of cover for 8 classes of non-life insurance, including motor and property insurance.³⁸

(5) Non-statutory industry Codes of Practice

C.24 The need for statutory reform of the current duty of disclosure³⁹ in insurance contract law, recognised in the O'Donoghue Report, was implemented in part by section 61 of the *Insurance Act 1989* which empowered the relevant Minister to prescribe codes of conduct to be observed by the insurance industry in respect *inter alia* of the duty of disclosure.

In 1990, the Insurance Federation of Ireland (now called Insurance Ireland) introduced voluntary codes of conduct and statements of insurance practice.⁴⁰ These industry codes have, in general,

³¹ See European Insurance and Occupational Pensions Authority *Guidelines on Complaints-Handling by Insurance Undertakings* (June 2012), available at eiopa.europa.eu. On this aspect of the *Consumer Protection Code 2012*, see Chapter 10, above.

³² *Report of the Committee of Inquiry into the Insurance Industry* (Prl. 5530, 1976). The Report is available at oireachtas.ie (in the digital archive of documents laid before the Houses of the Oireachtas).

³³ *Ibid*, at paragraph 11.5.2.

³⁴ Part IIIA of the *Insurance Act 1989*, comprising sections 43A to 43G of the 1989 Act, together with the associated Third Schedule to the 1989 Act, were inserted into the 1989 Act by sections 7 and 12 of the *Insurance Act 2000*.

³⁵ SI No.15 of 2001, as amended by the *Life Assurance (Provision of Information) (Amendment) Regulations 2002* (SI No.161 of 2002).

³⁶ These requirements are discussed in detail in Chapter 10, above.

³⁷ SINo.74 of 2007.

³⁸ The 8 classes of non-life insurance to which the 2007 Regulations apply and the advance information which must be provided under them are discussed in detail in Chapter 10, above.

³⁹ The duty of disclosure and its reform is discussed in Chapters 2 and 3, above.

⁴⁰ These include: *Code of Practice: Advertising and Sales Material*; *Code of Practice on Cooling-Off Notices*; *Code of Practice on Illustrations of Future Benefits for With-Profit and Unit-Linked Policies*; *Code of*

been binding on its members since 1992, when the industry's non-statutory Insurance Ombudsman of Ireland scheme was established.⁴¹ As to their general purpose, it has been commented that:

“[t]he clear intention behind the introduction of such Codes was to prevent an unreasonable insurer relying on what would have been perceived as overly harsh and technical defences that the law would have traditionally provided”.⁴²

C.25 Among other matters, the codes recommend that an insurer should in general ask specific questions in insurance proposal forms; that the insurer should not necessarily rely on the strict rules concerning non-disclosure if a proposer/policyholder has answered the specific questions posed honestly; that the insurer should provide certain pre-contractual and post-contractual information, including illustrations of future benefits; and that even if a policyholder is in breach of a warranty, (which would allow the insurer to repudiate the policy even where the breach is not connected to the risk undertaken), the insurer should in general honour the policy unless the claim is fraudulent.

C.26 Although the codes lack binding legal status, submissions received by the Commission in response to the Consultation Paper noted that they represent “best practice” in the insurance industry. The Commission welcomes the indication that there can be a departure from the strict application of current insurance contract law principles and rules. Nonetheless, it has been pointed out that in some instances insurers have continued to rely in litigation on the existing law, even where this would appear to be contrary to the recommended approach in the codes.

In a 2004 Circuit Court decision, *Justice (decd) v St Paul Ireland*,⁴³ it was held that non-compliance with a code was not admissible in determining whether the defendant insurer could repudiate liability. The deceased had included an innocent, rather than fraudulent, misrepresentation in completing his insurance proposal and this misrepresentation was not related to the insured loss.

The relevant code provided that, in such a case, the insurer should honour the policy and not repudiate, but the defendant nonetheless repudiated liability. The Circuit Court held that non-compliance with the code was not admissible in evidence and was not relevant to the application of the law on misrepresentation in insurance contracts. The Court considered that the misrepresentation may have affected the decision of a prudent insurer and therefore concluded that the defendant was entitled to repudiate the policy.

C.27 The codes are no substitute for legislative reform and in any event some of their provisions have since been superseded, in part by mandatory statutory requirements some of which involve the implementation of EU law,⁴⁴ and in part by the detailed provisions of the Central Bank of Ireland's

Practice on Life Assurance: Duty of Disclosure; Code of Practice on Life Assurance Selling; Code of Practice on Non-Life Insurance: Duty of Disclosure; and Code of Practice on Obtaining Life Insurance Medical Reports. The full text of these Insurance Ireland Codes is set out in O'Regan Cazabon, *Insurance Law in Ireland* (Round Hall Sweet & Maxwell, 1999), Appendix K. Since 1999, Insurance Ireland has published two further codes: *Code of Practice on HIV Testing Limits*; and *Code of Practice on Genetic Testing*.

⁴¹ It is noteworthy that the codes were consciously based on and derived from comparable industry codes developed in the 1970s in the United Kingdom.

⁴² Corrigan “Developments in Irish Insurance Law: The Last 25 Years – A General Overview” in *Landmarks in Insurance 1985-2010* (Insurance Institute of Ireland, 2010), Chapter 9, at 53.

⁴³ Circuit Court, 25 November 2004, discussed in Buckley “Insurers’ Self Regulation does not work” [2005] CLP 10 and Buckley *Insurance Law* 3rd ed (Thomson Round Hall, 2012), paragraphs 3-148 to 3-149.

⁴⁴ Section 43B was inserted into the *Insurance Act 1989* by the *Insurance Act 2000*, and the *Life Assurance (Provision of Information) Regulations 2001* which impose specific pre-contractual and post-contractual written information requirements for life insurance policies, which implemented the relevant obligations in Article 13 of Directive 92/96/EEC, the 1992 Third Life Assurance Framework Directive. Section 43B of the

Consumer Protection Code 2012 concerning pre-contractual and post-contractual information, claims handling and complaints handling.

(6) Previous recommendations for further reform of insurance contract law in Ireland

C.28 The O'Donoghue Report also recommended that legislation, envisaged at that time to protect consumers from misleading advertisements and to put in place statutory duties concerning the supply of services, should include insurance undertakings.⁴⁵ The legislation envisaged in the Report was enacted as the *Consumer Information Act 1978* (since incorporated into the *Consumer Protection Act 2007*) and the *Sale of Goods and Supply of Services Act 1980*.⁴⁶

The Report expressly declined to make more wide-ranging recommendations concerning the statutory regulation of insurance contracts because the Committee was conscious that “discussions are at present taking place on... the Draft Directive relating to the Harmonisation of Insurance Contract Law which will have the effect of harmonising the provisions of insurance contracts throughout the EEC.”⁴⁷

Such proposals were made and led to the publication in 1979 by the EU Commission of a draft 1979 Directive on Insurance Contracts, but this was ultimately withdrawn by the EU Commission because of objections raised by a number of EU member States.

Instead (subject to the limited number of areas, such as those provided for in section 43B of the *Insurance Act 1989*, on which harmonised rules have been agreed) at the time of writing the EU appears to be focused on preparing an “Optional Instrument” Regulation on insurance contracts, derived from the *Principles of European Contract Law* (PEICL), discussed below. Thus, the issue of reform of insurance contract law continues to be primarily a matter for each EU Member State.

C.29 Further reform of the insurance industry, and of insurance contract law, has also derived from predominantly local, rather than EU, influences.

The 2002 *Report of the Motor Insurance Advisory Board*⁴⁸ (the 2002 MIAB Report) made 67 recommendations for reform which were intended to improve the competitiveness of the insurance industry⁴⁹ and reduce the costs of insurance to policyholders. A number of these recommendations related to reform of court procedures and compensation arrangements, and are outside the scope of this Report.⁵⁰

1989 Act and the 2001 Regulations can also be seen as a belated implementation of the recommendation to the same general effect in the 1976 O'Donoghue Report. Similarly, the *Non-Life Insurance (Provision of Information) (Renewal of Policy Insurance) Regulations 2007*, which derived from the 2002 *Report of the Motor Insurance Advisory Board*, imposes mandatory requirements leading up to renewal of many types of non-life insurance, including motor and house property.

⁴⁵ *Report of the Committee of Inquiry into the Insurance Industry* (Prl. 5530, 1976) at paragraph 16.4.1.

⁴⁶ The Commission discusses this in detail in Chapter 9, above.

⁴⁷ *Report of the Committee of Inquiry into the Insurance Industry* (Prl. 5530, 1976), at paragraph 16.5.2.

⁴⁸ *Report of the Motor Insurance Advisory Board* (2002), available at djei.ie.

⁴⁹ While much of the focus of the 2002 MIAB Report was on motor insurance, a number of the 72 recommendations ranged beyond this class of non-life insurance.

⁵⁰ Many of the recommendations in the 2002 MIAB Report on court procedures and compensation arrangements were incorporated into the *Personal Injuries Assessment Board Act 2003* and the *Civil Liability and Courts Act 2004*. On the general effect of the 2003 and 2004 Acts see McMahon and Binchy *Law of Torts*, 4th ed (Bloomsbury Professional, 2013). Other recommendations in the 2002 MIAB Report, such as Recommendation 50 on the introduction of periodic payments in catastrophic injuries cases, are still awaiting implementation. In May 2015, the Government published the *Scheme of a Civil Liability (Amendment) Bill* to provide for periodic payment orders (PPOs). As well as involving a belated

Of relevance to this Report, the 2002 MIAB Report made general and specific recommendations on the contractual relationship between the insurer and insurance policyholders suggesting:

“That IFSRA [the Irish Financial Services Regulatory Authority, since replaced by the Central Bank of Ireland] agree standards of business practice with insurers governing dealings with private consumers and small businesses.”⁵¹

The 2002 MIAB Report also noted that the “fundamental principle” of good faith in insurance requires the proposer to provide material information to the insurer and to answer fully all questions asked by the insurer and added that:

“It is reasonable to expect that insurers should be bound by equal obligations of utmost good faith... [T]he underlying principle is one of balancing the rights of parties with unequal bargaining power as arises between insured and insurer. Guidance may be obtained from Civil Law jurisdictions and from the spirit of EU legislation such as the [1995] Regulations on Unfair Terms in Consumer Contracts.”⁵²

The Report therefore recommended:

“That IFSRA set rules for insurers to implement in concrete terms the duty of utmost good faith as it applies to insurers, as a corollary to the consumer’s duty of utmost good faith, to redress the imbalance in bargaining power between insurer and insured. The objectives of these rules should include ensuring that direct clients do not pay for unnecessary or inappropriate cover offered by insurers and to require an appropriate duty of consultation with policyholders before liability payments are made on their behalf.”⁵³

More specifically the Report also recommended that statutory regulations should prescribe a minimum period of notice, of not less than 15 working days, of the terms on which renewal is offered, and that the notice would include “no claims bonus” documents to enable clients to “shop around” for comparative quotes.⁵⁴ This specific recommendation was implemented in the *Motor Insurance (Provision of Information) (Renewal of Policy of Insurance) Regulations 2002*.⁵⁵

C.30 The Competition Authority, in its 2005 Final Report on *Competition Issues in the Non-Life Insurance Market*,⁵⁶ recommended that this approach should also be applied to a much wider range

implementation of Recommendation 50 in the 2002 MIAB Report, this would also implement the much more detailed recommendations in the 2010 *Report of the Working Group on Medical Negligence and Periodic Payments*, available at courts.ie, which also included a detailed draft *Civil Liability (Amendment) Bill* to implement these recommendations.

⁵¹ *Report of the Motor Insurance Advisory Board* (2002), p.38 (Recommendation 22). This was implemented by the publication in 2003 of IFSRA’s *Interim Code of Practice for Insurance Undertakings* whose relevant provisions were incorporated into the 2006 *Consumer Protection Code*, which set out duties applicable to all regulated financial service providers, and which was in turn replaced by the Central Bank’s *Consumer Protection Code 2012*.

⁵² *Report of the Motor Insurance Advisory Board* (2002) at 533, available at djei.ie.

⁵³ *Ibid*, at 38 (Recommendation 23).

⁵⁴ *Report of the Motor Insurance Advisory Board* (2002), pp.37-38 (Recommendations 13, 14 and 15) and pp.604-612, which included the text of draft *Motor Insurance (Provision of Information) Regulations*.

⁵⁵ SI No.389 of 2002.

⁵⁶ *Competition Issues in the Non-Life Insurance Market: Final Report and Recommendations* (in two volumes), Vol.1, at paragraphs 7.31-7.59, available at ccpc.ie.

of non-life insurance renewals. This was implemented in the *Non-Life Insurance (Provision of Information) (Renewal of Policy Insurance) Regulations 2007*.⁵⁷

The Insurance Acts and the Regulations made under them have focused primarily on regulatory matters such as prudential and solvency supervision of insurance undertakings. Regulations such as the 2007 Regulations have also affected individual insurance contract law, improving the consumer rights of policyholders at the post-contractual stage.

C.31 The *Life Assurance (Provision of Information) Regulations 2001*⁵⁸ prescribe in great detail the pre-contractual information which must be provided to a proposer contemplating taking out life insurance (the requirements go well beyond the EU-derived general requirements in section 43B of the *Insurance Act 1989*).

C.32 Some provisions have, in a number of respects, adjusted common law rules of insurance contract law that have evolved through case law. For example, the agency provisions in respect of tied insurance brokers were adjusted in favour of the proposer by section 51 of the *Insurance Act 1989*.⁵⁹

C.33 Nonetheless, it has been recognised that more fundamental reform of insurance contract law remains to be considered including the asymmetries of information that arise on both sides: the insurer having significant professional skills and sources of information on which to measure insurance risk, and the proposer having significant information on individual risk factors. The Commission has taken this analysis into account in considering the need for reform of insurance contract law.

(7) The EU influence on reform of insurance contract law, including the Principles of European Insurance Contract Law (PEICL)

C.34 Insurance case law and legislation have been supplemented by a significant number of Life Insurance Regulations and Non-Life Insurance Regulations made under the *European Communities Act 1972* that have implemented requirements under various EU insurance directives. The combined effect has been to enhance the rules by which insurers are supervised, to increase transparency relating to insurers and intermediaries and to bring intermediaries into a more rigorous regulatory environment.

C.35 In addition to considering legislative developments in other jurisdictions (notably in Australia and the United Kingdom), the Commission has carefully considered the 2009 publication, *Principles of European Insurance Contract Law* (PEICL), which is a codified model Act of European insurance contract law containing a detailed commentary by leading European writers on insurance law.⁶⁰ A

⁵⁷ SI No.74 of 2007. The 2007 Regulations also revoked the *Motor Insurance (Provision of Information) (Renewal of Policy of Insurance) Regulations 2002* (SI No.389 of 2002).

⁵⁸ SI No.15 of 2001.

⁵⁹ The regulation of insurance brokers and intermediaries is outside the scope of this Report: see Chapter 1, above.

⁶⁰ Basedow et al (eds), *Principles of European Insurance Contract Law* (PEICL) (Sellier, 2009). The PEICL were prepared by a Project Group entitled *Restatement of European Insurance Contract Law*. The Project Group is composed of leading academic writers on contract law from a number of European jurisdictions. It was founded in 1999 by the late Professor Fritz Reichert-Facilides, a leading contract law writer on German and Austrian contract law, and its Bureau and secretariat is located in the University of Innsbruck. The current (2014) chair of the Project Group is Professor Helmut Heiss, University of Zurich. Many of the Group members, such as its chair and Professor Jürgen Basedow, Max-Planck-Institut Hamburg, are from European civil law jurisdictions. It also currently (2014) includes two English members who thus represent a common law tradition, Professor John Birds, University of Manchester (co-editor of *MacGillivray on Insurance Law*, 12th ed (Sweet & Maxwell, 2014)), and Professor Malcolm Clarke, Cambridge University

comparable work, *Principles of European Contract Law* (PECL) had been published between 1999 and 2002.⁶¹ Both PEICL and PECL were developed against the general background of EU initiatives on the approximation or harmonisation of contract law rules, including insurance contract law rules.

C.36 EU Directives on general contract law and on insurance contract law have, to date, harmonised a limited number of contract law rules. In this respect, both PEICL and PECL seek to bring together in codified form a combination of: (a) contract law rules that have already been harmonised in EU law (often referred to as the Union's *acquis*) and (b) contract law rules from the national laws of EU Member States which have not been harmonised but which the drafters of PEICL and PECL consider broadly represent current law. It also notes differences between the laws of Member States.

C.37 While the concept of a codified set of rules appears to represent a Civil Law influence, both PEICL and PECL were also intentionally modelled on the comparable Restatements of the American Law Institute (ALI) and Uniform Acts of the US Uniform Law Commission (ULC).⁶²

ALI Restatements have been highly influential in the United States as authoritative legal texts on their subject; and both they and ULC Uniform Acts have formed the basis for much enacted legislation in the United States, including the statutory codification of contract law.

Reflecting their US comparators, the PEICL and PECL were submitted to the EU Commission as part of the further development of EU contract law. The development of a single set of contract law rules that would apply across the EU is consistent with two of the core freedoms, free movement of goods and services, on which the European Union was founded in 1958.⁶³

It is also clear that the history of the EU since the 1950s has been one of incremental harmonisation in specific areas concerning these two freedoms and the development of contract law (including insurance contract law) at EU level reflects this incremental approach.

The EU Commission recognised in 1962 that harmonisation of insurance contract law rules would assist in the creation of a single EU insurance market,⁶⁴ and there has been gradual progress since then.

In the wake of the development of the EU Single Market in the 1990s, there has been significant progress on the harmonisation of general regulatory requirements in the insurance market (such as

(author of *The Law of Insurance Contracts*, 6th ed (Informa, 2009)), who chairs the Group's drafting committee.

⁶¹ Lando and Beale (eds), *Principles of European Contract Law*, in 3 vols (Kluwer Law International, 1999 to 2002). The PECL were prepared by an independent Group entitled *Commission of European Contract Law* which was founded in 1980 by Professor Ole Lando, Copenhagen Business School. Like the PEICL Project Group, the *Commission of European Contract Law* was composed of leading academic writers on contract law from a number of European jurisdictions.

⁶² See <http://www.uibk.ac.at/zivilrecht/restatement/way.html>. Restatements prepared by the American Law Institute (ALI) also comprise a codified legislative scheme together with detailed annotations, often written by leading US jurists, concerning a particular area of law. The first ALI Restatement was its *Restatement of Contracts* (first published in 1932). The statutory codification element of a Restatement is similar to the concept of a "Uniform Act" as developed by the US Uniform Law Commission (ULC), an example being the *Uniform Sales Act* (1906).

⁶³ That is, under the Treaty Establishing the European Economic Community (under which the EEC was founded) which, since the Lisbon Treaty came into force in 2009, is known as the Treaty on the Functioning of the European Union (TFEU) (and which completed the alteration of the EEC to the EU).

⁶⁴ *General Programme on the Abolition of Restrictions on the Freedom of Establishment and the Freedom to provide Services*, OJ No.2, 51.1.1962, pp.36-62.

on freedom of establishment of insurance undertakings) and on related matters such as imposing solvency requirements.

This has been accompanied by some modest harmonisation of insurance contract law (such as imposing certain mandatory notification requirements in the context of life and non-life insurance, as implemented in section 43B of the *Insurance Act 1989*).

Similarly, the EU has harmonised a number of general contract law rules that also apply to insurance contracts (notably, those on unfair terms and unfair commercial practices, discussed above).

C.38 The O'Donoghue Report had noted that there had been discussions at EU level in the 1970s on the harmonisation of the main principles and rules on insurance contract law, including many of those discussed in this Report, and as a result in 1979 the EU Commission published a draft Directive on Insurance Contracts.⁶⁵

In a 1980 Oireachtas Committee Report, the draft Directive had been given a generally positive response.⁶⁶ On the duty of disclosure, the Committee's Report stated that it could see "no objection" to it "being mitigated in favour of the policyholder," although it considered that the proposed wording of the draft Directive on this question was ambiguous as it stood.

The Committee approved a proposal to replace an insurer's right to repudiate for non-disclosure with more proportionate remedies, in particular where a proposer had not acted fraudulently.

As to reform of warranties, the Committee considered that the draft Directive did not inhibit insurers from delineating the precise risk covered in proposing that insurers should, after the contract has been concluded, inform a policyholder of any changed circumstances which should be notified to the insurer. The Committee recommended, however, that any final text on this issue should be further examined.

However, a 1980 Report of the Law Commission of England and Wales rejected virtually every proposal in the draft Directive.⁶⁷ While accepting that English law in this area was in need of reform, the 1980 Report concluded that the draft Directive was likely to make the law even less satisfactory and more complex. Due to such objections, the draft Directive was ultimately withdrawn by the EU Commission and no similar proposal to harmonise insurance contract law has emerged from the EU since then.

C.39 A more cautious approach was taken when in 2003 the EU Commission published *A More Coherent European Contract Law – An Action Plan*,⁶⁸ which set out a number of approaches that could be considered in order to facilitate and ensure consistency with the principle of the free movement of goods and services in the EU.

One of these approaches involved using the PECL as a Draft Common Frame of Reference (DCFR) or "toolkit" which could then be used in the revision of current EU Directives or in the development of new Directives for general contract law. Another proposal was to develop PECL into an "opt-in" law or "Optional Instrument."

⁶⁵ OJ 1979 No.C 190/2.

⁶⁶ Joint Committee on the Secondary Legislation of the European Communities *Report on Commission Proposal Relating to Insurance Contracts* (Pl.8832, March 1980).

⁶⁷ Law Commission of England and Wales *Insurance Law: Non-Disclosure and Breach of Warranty* (Law Com No.104, 1980). As noted in Chapter 1, above and discussed below, since 2006 the Law Commission of England and Wales and Scottish Law Commission have been engaged in a wide ranging review of insurance contract law which has led to significant reform of UK insurance contract law.

⁶⁸ COM(2003) 68 final.

The EU Commission later established an Expert Group which developed the PECL further and, arising from this, in 2011 the EU Commission published a draft EU Regulation on a Common European Sales Law.⁶⁹

This draft EU Regulation proposed a set of contract law rules into which contracting parties could “opt in”; the rules would not be mandatory or have the “directly effective” status usually associated with an EU Regulation.⁷⁰

The EU Commission’s 2003 EU Action Plan⁷¹ noted that insurance contract law would benefit from the development of harmonised EU-wide rules facilitating the provision of cross-border insurance services and avoiding the need to develop country-specific insurance contracts.

In 2004 the EU Economic and Social Committee (EESC) published an *Opinion on the European Insurance Contract*⁷² which supported the full harmonisation of insurance contract law rules on a staged basis, the first stage of which would address: (a) pre-contractual duties, mainly information; (b) formation of the contract; (c) insurance policy, nature, effects and formal requirements; (d) duration of the contract, renewal and termination; (e) insurance intermediaries; (f) aggravation of risk; (g) insurance premium; and (h) insurance on account of third party.

C.40 It is notable that when the PEICL were being developed, its Project Group took account of the EU Commission’s 2003 Action Plan and the EESC’s 2004 Opinion. In 2005 the EU Commission included the PEICL Project Group in its Network of Excellence on European Contract Law (CoPECL), which thus formalised its inclusion in the wider EU project on general contract law.

Similarly, after the PEICL were published in 2009, the EU Commission established an Expert Group with a view to developing the PEICL for a possible draft EU “Optional Instrument” Regulation on a Common Insurance Contract Law. The Expert Group’s 2014 final report for the EU Commission pointed out that differences in insurance contract law between Member States involve additional costs for insurers and may also create difficulties for consumers, notably where an insurance claim has a cross-border element such as one dealing with a motor accident while travelling abroad.⁷³

C.41 It now appears likely that the outcome of current EU initiatives on insurance contract law may ultimately lead (like the 2011 draft Regulation on a Common European Sales Law),⁷⁴ to an “opt in” draft Regulation on insurance contract law that could be adopted by insurers for cross-border insurance contracts but which would not alter substantive insurance contract law in individual Member States.

C.42 It therefore will remain for each EU Member State to determine whether national insurance contract law requires reform. The specific matters itemised in the EESC’s 2004 Opinion and the proposals in PEICL have proved useful points of reference in this Report for consideration of reform of insurance contract law in Ireland.

C.43 Consideration of PEICL has also assisted in ensuring that the reforms of insurance contract law recommended in this Report are consistent with developments at EU level.

⁶⁹ COM(2011) 635 final.

⁷⁰ Due to its unusual status, such a rule or Regulation is sometimes referred to as a “29th Instrument” because it proposes a set of rules that would apply in addition to the contract law rules of the 28 EU Member States

⁷¹ *A More Coherent European Contract Law – An Action Plan* COM(2003) 68 final, p.47.

⁷² *Opinion on the European Insurance Contract* CESC 1626/2004.

⁷³ *Final Report of the Commission Expert Group on European Insurance Contract Law* (EU Commission, 2014), p.6.

⁷⁴ COM(2011) 635 final.

(8) Reform of insurance contract law in other common law jurisdictions, including Australia and the United Kingdom

C.44 Reform of insurance contract law has been considered by law reform bodies in a number of common law jurisdictions. The Australian Law Reform Commission's 1982 *Report on Insurance Contracts*⁷⁵ was implemented in the *Insurance Contracts Act 1984*, and the 1982 Report and 1984 Act have greatly influenced the reform of insurance contract law in other jurisdictions.

This has included the wide-ranging review of insurance contract law in which the Law Commission of England and Wales and Scottish Law Commission have been engaged since 2006.⁷⁶ This has already resulted in reforms through the enactment of the UK *Consumer Insurance (Disclosure and Representations) Act 2012* and the UK *Insurance Act 2015*.

The Commission is conscious of (a) the importance of developments in United Kingdom law and (b) the European Commission's concern that differences in the respective insurance contract laws of Member States can constitute a significant barrier to the further development of the insurance industry throughout the EU.⁷⁷

C Regulatory Oversight

C.45 The legislative developments, both domestic and EU, outlined above, have been supplemented in important respects by the regulatory functions of the Central Bank of Ireland⁷⁸ and the establishment of the Financial Services Ombudsman.⁷⁹

These statutory agencies are intended to improve the regulatory oversight of financial services, (including insurance), and to provide for an inexpensive dispute resolution mechanism for consumers and small businesses.⁸⁰

⁷⁵ Australian Law Reform Commission *Report on Insurance Contracts* (Report No. 20,1982).

⁷⁶ The Law Commission of England and Wales and the Scottish Law Commission began their joint project on insurance contract law in 2006. The Commissions have, since 2006, published ten Issues Papers, three Consultation Papers and two Reports related to the project. The two Reports are *Consumer Insurance Law: Pre-contract Disclosure and Misrepresentation* (Law Com No.319/Scot Law Com No.219, 2009), which led to the *Consumer Insurance (Disclosure and Representations) Act 2012*, and *Insurance Contract Law: Business Disclosure; Warranties; Insurers' Remedies for Fraudulent Claims; and Late Payment* (Law Com No.353/Scot Law Com No.238, 2014), which led to the *Insurance Act 2015*. A third Report, which will include final recommendations on insurable interest and which will complete the Commissions' joint project, is at the time of writing (June 2015) in preparation.

⁷⁷ *Final Report of the Commission Expert Group on European Insurance Contract Law* (EU Commission, 2014).

⁷⁸ The *Central Bank Reform Act 2010* created a single body, the Central Bank of Ireland, which is responsible for both central banking and financial regulation, and which also incorporated the functions previously divided between the Central Bank and the Irish Financial Services Regulatory Authority ("IFSRA").

⁷⁹ Under the *Central Bank and Financial Services Authority of Ireland Act 2004*, which inserted a new Part VIIB into the *Central Bank Act 1942*. The FSO was not affected by the changes made by the *Central Bank Reform Act 2010*.

⁸⁰ The "principles only" ("light touch") approach to supervision by the Irish Financial Services Regulatory Authority (IFSRA) between 2004 and 2008 has been subject to extensive criticism in the wider context of the debate on the impact this may have had on the virtual collapse of the banking system in Ireland in 2008. The Commission does not propose to discuss this wider debate in this Report, since it ranges well beyond the insurance contract area. Nonetheless, the Commission notes that the Central Bank of Ireland

The Commission also notes below the relevance of data protection legislation, and relevant codes, to insurance contract law

(1) Central Bank of Ireland and the Consumer Protection Code

C.46 The Central Bank of Ireland is the principal regulator in the State for financial services, including banking and insurance services.⁸¹ As already noted, the primary focus of the regulatory regime in insurance, which applies throughout the EU, is prudential and solvency regulation rather than the specifics of insurance contracts.⁸²

C.47 The Central Bank has issued a number of statutory codes regarding compliance with regulatory requirements including, for example, the *Corporate Governance Code for Credit Institutions and Insurance Undertakings*, the *Minimum Competency Code*⁸³ and of particular relevance to this Report, the *Consumer Protection Code 2012*.

C.48 The Central Bank undertakes reviews and investigations into the insurance industry in order to ensure compliance with legislation, consumer protection codes and good practice.⁸⁴ It has several enforcement powers intended to ensure compliance with its regulatory provisions.

These include: pre-approval fitness and probity requirements for senior management positions; entry and search powers; administrative sanctions, including licence suspension or removal; civil financial sanctions; summary criminal prosecution; and referrals to other law enforcement agencies. These powers have been considerably strengthened by the *Central Bank (Supervision and Enforcement) Act 2013* which, for example, doubled the maximum civil financial sanction to €1m for an individual and €10m for an undertaking.

C.49 The Central Bank, through its consumer protection and enforcements directorates, is the most important regulatory body governing insurers and the writing of insurance contracts in Ireland. Its commitment to a “more vigorous enforcement effort”⁸⁵ and its adoption of the *Consumer Protection*

(the successor to IFSRA) has, since 2009, adopted a more robust “principles and rules” approach to regulation. Similarly, the reorganisation of the general regulatory system for financial services, in particular through the enactment of the *Central Bank Reform Act 2010* and the *Central Bank (Supervision and Enforcement) Act 2013*, suggests that this more robust approach will continue for the foreseeable future.

⁸¹ The *Central Bank Reform Act 2010* transferred to the Central Bank the power under section 61 of the *Insurance Act 1989* (previously conferred on the Minister for Jobs, Enterprise and Innovation and, later, on the Minister for Finance) to publish codes of conduct for insurers concerning the duty of disclosure and warranties.

⁸² The Central Bank has eight High Level Goals, as follows: (1) Eurosystem effectiveness and price stability, (2) Stability of the financial system, (3) Proper and effective regulation of financial institutions and markets, (4) Resolution of financial difficulties in credit institutions, (5) Protection of consumers of financial services, (6) Independent economic advice and high quality financial statistics, (7) Efficient and effective payment and settlement systems and currency services and (8) Operational efficiency and cost effectiveness. A detailed explanation of these high level goals can be found in the *Central Bank of Ireland’s Strategic Plan 2013-2015*. The Central Bank publishes an *Annual Performance Statement* setting out the progress they are making in delivering their strategy. In 2015, the Central Bank published the *Consumer Protection Outlook Report*, which outlines the wider consumer protection themes on which it will focus in the context of its strategy and the risks it sees to its consumer protection objectives under its “5 Cs Framework” (Consumer, Culture, Confidence, Challenge, Compliance).

⁸³ A comprehensive list of codes and related guidance notes is available on the Central Bank website, centralbank.ie.

⁸⁴ For example see Central Bank of Ireland *Summary Report of the Payment Protection Insurance Review* (2014).

⁸⁵ Central Bank of Ireland *Enforcement Strategy 2011-2012*.

Code 2012 indicates that consumer protection and the enforcement of regulatory provisions will have an increasingly significant role to play in the regulation of Irish insurance practices.

C.50 The provisions of the *Consumer Protection Code 2012*⁸⁶ are binding on regulated entities (for example, insurers), and must be complied with when providing financial services; consequently, insurance practice in Ireland is greatly influenced by its requirements.⁸⁷

The Code sets out enforceable general standards, and in many respects is a statutory restatement of some key contractual obligations. It has been effective in providing consumers with protective measures and remedies and in regulating the marketing and sale by insurers of their contracts and other products.

The Central Bank has the power to administer sanctions for a contravention of the Code under Part IIIC of the *Central Bank Act 1942*.

While there is no mechanism for individual consumer enforcement of the Code, in *Irish Life and Permanent plc v Financial Services Ombudsman*,⁸⁸ the High Court (Hogan J) - noting that in *Stepstone Mortgage Funding Ltd v Fitzell*,⁸⁹ the High Court (Laffoy J) had refused to make an order for possession of a family home where the lender was in breach of the Central Bank's comparable *Code for Mortgage Arrears* (2010) - held that the Consumer Protection Code could be taken into account in an individual case. Thus, the Court rejected the view that it was to be regarded as entirely a species of "soft" law, that is, not susceptible to legal enforcement.⁹⁰

(2) Role of the Financial Services Ombudsman

C.51 The Financial Services Ombudsman⁹¹ (FSO) is designed to independently and impartially investigate and resolve disputes between consumers and financial service providers, with insurance contract disputes accounting for half of all the complaints received.⁹²

⁸⁶ The Code was issued under the following statutory powers: (a) section 117 of the *Central Bank Act 1989*; (b) sections 23 and 37 of the *Investment Intermediaries Act 1995*; (c) section 8H of the *Consumer Credit Act 1995*; and (d) section 61 of the *Insurance Act 1989*.

⁸⁷ The Commission refers in detail to the provisions of the 2012 Code in the relevant Chapters of the Report, above.

⁸⁸ [2012] IEHC 367.

⁸⁹ [2012] IEHC 142; [2012] 2 IR 318.

⁹⁰ *Ibid* at paragraph 55. The Commission discusses the status of statutory and non-statutory codes in Chapter 1, above, and recommends that they be admissible in evidence where they provide practical guidance that would be relevant to an adjudication, including in litigation.

⁹¹ Established under Part VIIB (sections 57BA to 57CU) of the *Central Bank Act 1942*, as inserted by section 16 of the *Central Bank and Financial Services Authority of Ireland Act 2004*. Prior to the establishment of the FSO, complaints from consumers of insurance and credit institutions were handled by two voluntary ombudsman schemes: the Credit Institutions' Ombudsman and the Insurance Ombudsman of Ireland. The *Implementation Advisory Group on the Establishment of a Single Regulatory Authority for the Financial Services Sector* (PN. 7271 (1999), the McDowell Report) recommended the establishment of a single statutory ombudsman scheme for all financial services provided by regulated entities, to operate independently of the Single Regulatory Authority and to operate as a "one-stop-shop" for regulated entities and their customers. For a detailed background to the FSO see Donnelly "The Financial Services Ombudsman: Asking the 'Existential Question'" (2012) DULJ 229.

⁹² FSO Bi-Annual Review January to June 2013 (21 August 2013) at 4.

For the purposes of its jurisdiction a consumer is defined as⁹³ (a) a natural person when not acting in the course of, or in connection with, carrying on a business or (b) a person, or group of persons, of a class prescribed in Regulations⁹⁴ made by the Financial Services Ombudsman Council.⁹⁵

The envisaged extension, by Regulations, of the jurisdiction beyond an individual consumer was made in 2005⁹⁶ to include a person or group of persons (including limited companies and unincorporated bodies such as partnerships, charities, clubs, trusts and sole traders) having an annual turnover of €3 million or less in the financial year preceding the year in which a complaint is made to the FSO.

C.52 The FSO facilitates a decision-making process less expensive than litigation. Consumers are encouraged to engage firstly with the financial institution (the insurer) with which they are in dispute. Insurers must document their efforts to deal with complaints comprehensively and fairly before referring consumers to the FSO.

C.53 The FSO can engage in the mediation of disputes⁹⁷ and can suggest outcomes for consumers that depart from the precise requirements of the principles and rules of insurance contract law. This non-adversarial approach implicit in the FSO's mediation-type role is reinforced by the governing legislation which provides that the FSO:

“when dealing with a particular complaint, is required to act in an informal manner and according to equity, good conscience and the substantial merits of the complaint without regard to technicality or legal form.”⁹⁸

Even when engaged in more formal adjudicative decision-making the FSO may uphold a complaint on the basis that:

“although the conduct complained of was in accordance with a law or an established practice or regulatory standard, the law, practice or standard is, or may be, unreasonable, unjust, oppressive or improperly discriminatory in its application to the complainant.”⁹⁹

This statutory discretion acknowledges (as do the Insurance Ireland voluntary Codes of Practice) that these principles and rules do not reflect an appropriate calibration of the respective obligations and rights of consumers and insurers. The published decisions of the FSO indicate nonetheless that in many cases existing legal principles and rules have played a significant part in the determination of disputes concerning insurance contracts.

⁹³ Section 57BA of the *Central Bank Act 1942*, as inserted by section 16 of the *Central Bank and Financial Services Authority of Ireland Act 2004*.

⁹⁴ Section 57BF of the *Central Bank Act 1942*, as inserted by section 16 of the *Central Bank and Financial Services Authority of Ireland Act 2004*.

⁹⁵ Established under section 57BC of the *Central Bank Act 1942*, as inserted by section 16 of the *Central Bank and Financial Services Authority of Ireland Act 2004*.

⁹⁶ *Central Bank Act 1942 (Financial Services Ombudsman Council) Regulations 2005* (SI No.190 of 2005) as amended by the *Central Bank Act 1942 (Financial Services Ombudsman Council) (Amendment) Regulations 2014* (SI No.164 of 2014).

⁹⁷ Section 57BK(1) of the *Central Bank Act 1942* as inserted by section 16 of the *Central Bank and Financial Services Authority of Ireland Act 2004*.

⁹⁸ Section 57BK(4) of the *Central Bank Act 1942* as inserted by section 16 of the *Central Bank and Financial Services Authority of Ireland Act 2004*.

⁹⁹ Section 57CI(1)(c) of the *Central Bank Act 1942* as inserted by section 16 of the *Central Bank and Financial Services Authority of Ireland Act 2004*.

C.54 Where a consumer's complaint is upheld the FSO may order insurers to honour policies without regard to the value of the policy and, in addition to rectifying an insurance contract, the FSO may also make compensation awards up to a maximum of €250,000 which are binding on both parties subject to the right of appeal to the High Court.

C.55 There has been a significant increase in appeals from FSO decisions in recent years.¹⁰⁰ In the Annual Report 2012, the FSO advised that that the majority of appeals to High Court from FSO decisions have been grounded on the merits of particular decisions rather than on the type of alleged legal invalidity which would require judicial review.¹⁰¹

C.56 However the courts have shown significant deference to FSO decisions, overturning them on rare occasions, even where the relevant court might have reached a different conclusion on the facts. This approach to administrative decision-making bodies was explained by Hamilton CJ in the Supreme Court in *Henry Denny & Sons v Minister for Social Welfare*¹⁰² as follows:

"I believe it would be desirable to take this opportunity of expressing the view that the Courts should be slow to interfere with the decisions of expert administrative tribunals. Where conclusions are based upon an identifiable error of law or an unsustainable finding of fact by a tribunal, such conclusions must be corrected. Otherwise, it should be recognised that tribunals have been given statutory tasks to perform and exercise their functions, as is now usually the case, with a high degree of expertise and provide coherent and balanced judgements on the evidence and argument heard by them. It should not be necessary for the Courts to review their decisions by way of an appeal or judicial review."¹⁰³

C.57 In *Lyons and Murray v Financial Services Ombudsman*¹⁰⁴, the High Court (Hogan J), citing the constitutional right to fair procedures, upheld an appeal on grounds that the FSO had erred in law in rejecting the necessity for an oral hearing in order to determine certain factual issues between the parties.

C.58 Section 72 of the *Central Bank (Supervision and Enforcement) Act 2013* empowers the FSO to "name and shame" offending financial service providers (insurers) where not less than three complaints against them have been substantiated.¹⁰⁵ Insurance Ireland,¹⁰⁶ while supportive of section 72, has indicated concern that the:

"procedure should not give a false picture of the complaint-handling record of financial services firms... [T]he number of complaints upheld should be understood in proportion to the number of customers a particular insurance firm has."¹⁰⁷

C.59 It has been argued that the remedies provided by the FSO have prevented significant examination and judicial development of certain areas of insurance contract law.¹⁰⁸ In its submission

¹⁰⁰ As of 31 December 2012 there were 41 High Court appeals, one judicial review and four Supreme Court appeals pending. See Taplin "The FSO before the High Court" (2007) 14(11) CLP 235.

¹⁰¹ Financial Services Ombudsman *Annual Report 2012* at 22.

¹⁰² [1998] 1 IR 34.

¹⁰³ *Ibid*, at 39. See also *Ulster Bank v Financial Services Ombudsman* [2006] IEHC 323; and *FBD Insurance PLC v Financial Services Ombudsman* [2011] IEHC 315

¹⁰⁴ [2011] IEHC 454.

¹⁰⁵ Section 72(6)(a), which came into force on 1 September 2013.

¹⁰⁶ Formerly, the Irish Insurance Federation.

¹⁰⁷ Paul MacDonnell, Head of Policy & EU Affairs, Insurance Ireland, *The Irish Times*, 23 August 2013. The article was written in response to an editorial "Naming and Shaming Banks" *The Irish Times* 22 August 2013.

to the Law Commission of England and Wales and Scottish Law Commission in the context of their review of insurance contract law, the UK's Financial Ombudsman Service indicated that its own existence may have "stunted" the development of the law:¹⁰⁹

"We are concerned that the development of the common law has been impeded by our activities and by the very limited chance of success that any consumer may have in pursuing a non-disclosure case or misrepresentation issue in the courts."

The Law Commission of England and Wales and Scottish Law Commission concluded that while their Financial Ombudsman Service provides an "extremely valuable service"¹¹⁰ it was undesirable that it was "routinely obliged to replace the most fundamental principles of insurance contracts with its own approach."¹¹¹

C.60 The Commission believes that a lack of precedent creates uncertainty and may make the FSO less effective in encouraging insurers to alter their operations to conform to the standards of good practice, as identified by the FSO.

(3) Data Protection Acts and Code of Practice for Insurance

C.61 The nature of insurance contracts raises data protection and privacy considerations. In 2008, the Office of the Data Protection Commissioner published, under section 13(2) of the *Data Protection Act 1988*, a *Code of Practice on Data Protection for the Insurance Sector*.

C.62 In 2013, Insurance Ireland and the Data Protection Commissioner published a revised, jointly approved, *Code of Practice on Data Protection for the Insurance Sector*, under section 13(2) of the 1988 Act.¹¹²

The 2013 Code of Practice, like the 2008 Code, was built around the "eight rules" of data protection set out in the *Data Protection Acts 1988 and 2003*, which must be followed by any data controller engaged in the collection and use of personal data, whether that data is recorded on paper or some other format, for example, electronically. The eight rules require a data controller to:

- obtain and process information fairly;
- keep information only for one or more specified, explicit and lawful purposes;
- use and disclose the information only in ways compatible with those purposes;
- keep the information safe and secure;
- keep the information accurate, complete and up-to-date;
- ensure the information is adequate, relevant and not excessive;
- retain the information for no longer than is necessary for those purposes; and
- give the individual data subject a copy of their personal data, on request.

C.63 Section 13(3) of the 1988 Act provides that where a Code of Practice is laid before the Houses of the Oireachtas and approved by them "it shall have the force of law in accordance with its terms."

¹⁰⁸ Dockery (2012) 17(3) *Bar Review* 54.

¹⁰⁹ Law Commission of England and Wales and Scottish Law Commission *Issues Paper 1 on Misrepresentation and Non-Disclosure* (September 2006) paragraph 5.20.

¹¹⁰ *Ibid* paragraph 5.19.

¹¹¹ *Ibid* paragraph 5.22.

¹¹² Data Protection Commissioner *Code of Practice on Data Protection for the Insurance Sector* (June 2013), available at www.dataprotection.ie.

The 2013 Code of Practice was not laid before the Houses of the Oireachtas and thus does not have this formal legal effect, but in the Foreword to the 2013 Code the Data Protection Commissioner indicated an intention “to continue to work closely with Insurance Ireland to ensure that the guidance set out in the Code is followed in daily practice.”

C.64 The Data Protection Commissioner has used the enforcement powers in the 1988 Act in connection with insurance contracts and a number of case studies are recorded on the Commission’s website.¹¹³

In 2012 three insurers (Zurich Insurance Plc, FBD Insurance Plc and Travellers Insurance Co Ltd) were charged in the District Court with processing personal data contrary to section 19 of the 1988 Act, as amended. The defendants admitted possessing personal information of 15 consumers that had been obtained by a private detective in questionable circumstances.

On the facts of the case the District Court permitted each insurer to donate separate sums of €20,000 to a homeless charity¹¹⁴ and applied the *Probation of Offenders Act 1907*. In consequence, the defendant companies were not convicted.

C.65 Instances of breaches of data protection rights in insurance have also emerged in civil proceedings in the High Court. In *Murphy v ARB Underwriting and Ors*,¹¹⁵ the plaintiff instituted proceedings for a breach of his data protection rights, negligence, and defamation on the basis that the defendant insurer had repudiated his motor trade insurance policy after it had obtained information from An Garda Síochána in respect of his criminal record.

The plaintiff claimed that this information was inaccurate and also sought an order of *mandamus* against the insurer and the Garda Commissioner to correct the data in accordance with the 1988 and 2003 Acts. However, the High Court (MacMenamin J) refused the reliefs sought.

The Court held that the plaintiff had not made out a *prima facie* case that the information had been obtained or processed unfairly or in breach of the 1988 and 2003 Acts and added that, even if the plaintiff had established that there had been an unfair processing of data under the Acts, he had failed to establish any loss or damage.

In addition, the Court noted that he had not made any attempt to use the statutory remedy open to him under the 1988 and 2003 Acts to apply to the defendant, as a data controller, to seek correction of any inaccurate data; and that he had refused to respond to an invitation from the defendant to provide it with information which would rectify any inaccuracy.

C.66 In *Collins v FBD Insurance*,¹¹⁶ the plaintiff was a customer of FBD and having taken out insurance made a claim for the theft of an insured vehicle. FBD refused to pay on the basis that he had not disclosed a previous conviction and the plaintiff made a data protection request seeking a copy of his original insurance application form. The plaintiff argued that sections 2 and 4 of the *Data Protection Act 1988* had been breached.

Following an investigation, the Data Protection Commissioner held that FBD had breached section 4 of the 1988 Act by failing to disclose the relevant personal data within 40 days and failing to provide reasons for not so doing. It had also failed to advise the plaintiff of his right of recourse to the Data Protection Commissioner.

¹¹³ For example Case Study 2 of 1999; Case Study 1 of 2001; Case Study 8 of 2009; and Case Study 7 of 2011.

¹¹⁴ For an overview see the Data Protection Commissioner’s *Annual Report 2012* at 31. See also “Insurance firms at centre of data protection report”, *Irish Independent*, 19 August 2013.

¹¹⁵ High Court, 9 May 2012.

¹¹⁶ [2013] IEHC 137.

The Circuit Court awarded the plaintiff €15,000 damages. On appeal FBD argued that the plaintiff had failed to establish exactly what losses he suffered and accordingly damages should only be awarded in the normal manner and that no right to automatic compensation for a breach of data protection rights should follow.

The High Court (Feeney J) overturned the award of damages and held that section 7 of the 1988 Act does not provide for absolute liability or for the automatic payment of compensation.

The Court concluded that, consistent with general principles of the law of torts, in order to obtain compensation for a breach of duty of care under the 1988 Act the claimant must establish: (1) that there has been a breach of the 1988 Act; (2) that there has been damage suffered and (3) that the breach caused the damage. As the plaintiff had been unable to establish these matters, the Circuit Court award was overturned.

The Court noted that, unlike the position under the comparable UK 1988 Act, which allows damages for distress caused by a breach of data protection rights, the position in Ireland is that no matter how blatant the breach of the 1988 Act, the person affected by it can only receive damages on proof of loss or damage caused by the breach.

(4) *The status of statutory and non-statutory codes*

C.67 The Commission discusses the status of statutory and non-statutory codes in Chapter 1, above, and recommends that they be admissible in evidence where they provide practical guidance that would be relevant to an adjudication, including in litigation.



The Law Reform Commission is an independent statutory body established by the Law Reform Commission Act 1975. The Commission's principal role is to keep the law under review and to make proposals for reform, in particular by recommending the enactment of legislation to clarify and modernise the law.

The Commission's law reform role is carried out primarily under a Programme of Law Reform. Its Fourth Programme of Law Reform was prepared by the Commission following broad consultation and discussion. In accordance with the 1975 Act it was approved by the Government in October 2013 and placed before both Houses of the Oireachtas. The Commission also works on specific matters referred to it by the Attorney General under the 1975 Act.

The Commission's Access to Legislation project makes legislation more accessible online to the public. This includes the Legislation Directory (an electronically searchable index of amendments to Acts and statutory instruments), a selection of Revised Acts (Acts in their amended form rather than as enacted) and the Classified List of Legislation in Ireland (a list of Acts in force organised under 36 subject-matter headings).

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ADDRESS
35-39 Shelbourne Road Dublin 4 Ireland

TELEPHONE
+353 1 6377600

FAX
+353 1 6377601

EMAIL
info@lawreform.ie

WEBSITE
lawreform.ie

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