E 31AH

Report 46

Some Insurance Law Problems

May 1998
Wellington, New Zealand

The Law Commission is an independent, publicly funded, central advisory body established by statute to undertake the systematic review, reform and development of the law of New Zealand. Its purpose is to help achieve law that is just, principled, and accessible, and that reflects the heritage and aspirations of the peoples of New Zealand.

The Commissioners are:

The Honourable Justice Baragwanath – President
Joanne Morris OBE
Judge Margaret Lee
DF Dugdale
Denese Henare ONZM
Timothy Brewer ED

The office of the Law Commission is at 89 The Terrace, Wellington
Postal address: PO Box 2590, Wellington 6001, New Zealand
Document Exchange Number: SP 23534
Telephone: (04) 473–3453, Facsimile: (04) 471–0959
E-mail: com@lawcom.govt.nz

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Dear Minister

I am pleased to submit to you Report 46 of the Law Commission, *Some Insurance Law Problems*.

The great majority of adult New Zealanders enter into insurance contracts of one sort or another. It is important to get the law governing such contracts right. This report deals with five separate problem areas.

The first area deals with the rule of disclosure of relevant facts. It is a sensible rule and one consistent with the duty of utmost good faith that a person seeking insurance cover should have to disclose relevant facts to the insurance company. It is sensible that if you want to insure your life you should have to disclose the fact that your doctor has told you that you have only 6 months to live. Those are obvious examples; less obvious examples abound where it is not as clear what matters the insured must tell the insurance company. Moreover, the consequences for the insured may be drastic if he or she gets it wrong. Judges and others have been saying for many years that the law needs fixing. While there is no perfect answer, we believe that our proposal holds a fair balance between insurer and insured. It should prevent unjust situations where people are denied insurance claim payouts for not disclosing some fact that the insurance company says should have originally been disclosed.

The Insurance Law Reform Act 1977 prevented, among other things, the unfair use by insurers of provisions requiring notification of claims within certain time limits, and of provisions excluding liability in certain circumstances where the risk of loss is increased. Although the Act has worked well it is clear that in certain respects it needs adjusting to avoid odd results. Chapters 2 and 3 deal with these issues.

The Fires Prevention (Metropolis) Act s 83 was enacted in 1774 (in the reign of George III) and is still part of New Zealand law. It is not needed. Part of our job is to concern ourselves with keeping the law tidy so it seemed sensible while we were dealing with insurance problems to get rid of this old statute as a matter of housekeeping.

The fifth situation with which our report is concerned is this: X, who may be an individual or a company, is insured against liability to third parties. X becomes liable to a third party but before the third party's claim is finalised X dies or disappears, or (being a

company) goes into liquidation or is dissolved. What then is the third party's position? Parliament's answer has been to allow the third party to step into the shoes of the insured. The earliest relevant statute was enacted in 1900 but that applied only to workers' compensation claims. The remedy was extended to motor vehicle claims in 1928 and in 1936 to all liability insurance. Under all the New Zealand statutes including that of 1936 (still in force) the mechanism used was to give the third party a charge over the insurance moneys. Over the intervening 60 years or so (or nearly 100 if you calculate from 1900) it has become apparent that there are defects in this machinery, and our proposal is for a modern equivalent.

Of course, where the departure from the scene of X is because X has become insolvent, the theoretical effect of the present legislation and of our proposals is to give the third party a preference over other creditors. In practice, however, it is much more likely than not that in the absence of some such provision as the one under discussion there is no incentive to pursue the insurer, so that while the provision does give the third party an advantage it is unlikely to be at the expense of other creditors. The enactment simply avoids the situation where the insurer escapes having to meet the contractual obligation to pay up. I mention this aspect because although the question of preferential entitlement is expected to be reviewed as part of the Ministry of Commerce's examination of insolvency law that fact should not be allowed to hold up the adoption of our present proposals.

Yours sincerely

The Hon Justice Baragwanath
President

The Hon Douglas Graham MP
Minister of Justice
Parliament House
Wellington

Preface

In May 1997 the Commission sent a written inquiry to industry organisations, legal practitioners active in the field and interested academic lawyers seeking expressions of opinion as to whether any, and if so which, areas of insurance law were in need of reform. By that process we identified the five discrete topics that are the subject of this report. Of all these topics it can be said that aspects of the existing law make the law unjust or inefficient and that in each case the problem is soluble by legislation. Where relevant, each chapter concludes with legislation that we propose be enacted as the Insurance Law Reform Amendment Act. The entire draft Act, with commentary, is set out at pages 59–81; throughout the text of the report and commentary we refer to draft provisions in full and in italic to distinguish them from references to current legislation.

The process then followed by the Commission was to circulate a draft report among those who had responded to its initial inquiry and certain interested government departments and agencies. In addition there were references to the draft and its availability in the Commission's quarterly newsletter, *Te Aka Kōrero*, and in the New Zealand Law Society's newsletter, *LawTalk*, which resulted in copies of the draft report being distributed to a number of further inquirers. That this was an effective method of consulting interested parties is we think clear from the list in appendix A of those who helped with responses to our initial inquiry or with submissions on our draft. This report has been greatly assisted by the help so readily given.

1
Non-disclosure of material circumstances

THE EXISTING LAW

1 Section 18 of the Marine Insurance Act 1908 reads as follows:

18 Disclosure by assured

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

(2) Every circumstance is material which would influence the judgment of a prudent insurer in fixing the premium or determining whether he will take the risk.

(3) In the absence of inquiry the following circumstances need not be disclosed, namely:
  (a) Any circumstance which diminishes the risk:
  (b) Any circumstance known or presumed to be known to the insurer. The insurer is presumed to know matters of common notoriety or knowledge, and matters which an insurer in the ordinary course of his business, as such, ought to know:
  (c) Any circumstance as to which information is waived by the insurer:
  (d) Any circumstance which it is superfluous to disclose by reason of an express or implied warranty.

(4) Whether any particular circumstance which is not disclosed is material or not is in each case a question of fact.

(5) The term **circumstance** includes any communication made to or information received by the assured.

2 While the 1908 Act applies only to marine insurance, it is well settled that, except for the reference in subsection (1) to constructive knowledge, s 18 states correctly the law applicable to all insurance contracts (see, for example, *Pan Atlantic Insurance Co Ltd v Pine Top Insurance Co Ltd* [1995] 1 AC 501, 518, 554).

3 The disclosure rule has its origin in the reciprocal duty of utmost good faith (*uberrimae fidei*) owed by and to each party to a contract of insurance. The business of an insurance underwriter is the assessment of risk. If there are circumstances affecting that assessment known to the insured, then the insured must disclose them. This is true in every case, but the reason for the rule becomes particularly plain when the insurer is not in a position to discover the circumstances affecting the risk. The ship the insurer is asked to insure may be on the high seas and unavailable for inspection, or the circumstance may be one that by its nature will not be known to the insurer – as, for example, where an insured seeks life cover after receiving a death threat. There can be no sensible quarrel with the basic fairness of an insured's duty to disclose material circumstances.

Problems with the existing law

What the insured must disclose is uncertain

4 The first problem with the existing law concerns what must be disclosed. The test of materiality is whether the circumstance is one which would influence the judgment of a prudent insurer in determining whether to accept a risk and if so on what terms. How can the ordinary consumer be expected to know what circumstances would influence the judgment of a prudent insurer? Doubtless there are plain cases where the insured should be expected to use common sense. An insured told recently by a doctor that he or she has only 12 months to live who seeks to obtain life insurance can reasonably be expected to know that an insurer would be interested to learn this prognosis. But there is much room for genuine misunderstanding, particularly in relation to what is known as "moral hazard", a term used to describe the risks flowing from the insured's lack of moral integrity. It will not always be apparent to a person seeking insurance cover that he or she is under a duty to disclose criminal convictions.

Ignorance no excuse for breach of duty to disclose

5 The insured will usually be totally ignorant of the niceties of insurance law. The second problem is that the insured's disclosure duty is unaffected by the fact that he or she did not know and was not warned by the insurer of the nature or extent of the duty.

Specific questions do not relieve the insured of the duty

6 The third problem is allied to the second. An insurer is likely in a proposal form to ask specific questions of the prospective insured

– about, for example, claims history, or health if the insured is seeking life or sickness cover or insurance in respect of medical costs. The law is quite clear that where an insurer chooses to ask the insured some questions the insured is not excused from volunteering matters that he or she is under a legal duty to disclose but that are outside the scope of the insurer's questions (see, for example, *Roselodge v Castle* [1966] 2 Lloyd's Rep 113; *Quinby Enterprises Ltd (in liq) v General Accident Ltd* [1995] 1 NZLR 736; *Benjamin v State Insurance Ltd* (unreported, HC, Auckland, 13 May 1997, CP 536/95)).

Breach of the duty may have disproportionately harsh results for an insured

7 The fourth problem is that breach of the duty may have disproportionately harsh consequences for an insured. An insured's failure to disclose a material circumstance allows an insurer to treat the contract of insurance as void from the start. So a person who took steps to insure against a loss which he or she then suffers may find that an insurer relies on non-disclosure of a material circumstance to cancel the contract with retrospective effect. Instead of being able to claim under the policy, the insured usually receives at most only a refund of the premiums paid under it. For example, in *Quinby Enterprises Ltd (in liq) v General Accident Ltd* [1995] 1 NZLR 736, the failure to disclose Mr Quinby's criminal convictions and precarious financial position prevented his company recovering anything under a fire policy following a fire probably caused by an electrical fault. A non-disclosure allows an insurer to act this way even if disclosure of the material circumstance would not have induced the insurer to refuse outright to accept the risk (See, for example, *Pan Atlantic Insurance Ltd v Pine Top Ltd* [1995] 1 AC 501, 528–529). It is all or nothing.

Calls for the reform of the existing law

8 In a letter dated 11 June 1997 from the Insurance and Savings Ombudsman Commission (ISOC) we were told that "non-disclosure complaints represent one of the largest single reasons for consumer dissatisfaction and complaint to the Insurance Ombudsman". The letter also stated that between the office's opening in January 1995 and April 1997 it had 129 resolved or pending complaints based on or involving non-disclosure, and knew of approximately 160 further disputes (not yet complaints). (See further the Annual Reports of the Insurance and Savings Ombudsman: (1995), paras 4.5 and 4.7; (1996), 7; (1997), 8–9; see

also "Insurers urged to act openly", *National Business Review*, 19 September 1997.) ISOC notes that as the law stands

> there is an assumption that consumers know how insurance works, but in reality there seldom appears to be an appreciation that the information required goes beyond questions asked at inception and renewal.

ISOC also said that the Ombudsman notes a consistent theme in comments from insureds along the lines of: If they had wanted to know about that, why didn't they just ask? ISOC provided the following example:

> The Ombudsman has upheld a complaint where there was no question asked about the insured's criminal history. The insurance product in question was targeted at a low socio-economic group and there was a broad statement in the declaration section which said:
>
> "I/We declare that and warrant that:
>
> 1 No information has been withheld which is likely to affect the acceptance of this insurance."
>
> No specific questions about criminal convictions were asked. Although the proposal asked for disclosure of information likely to affect the acceptance of the insurance, without further amplification the insured in these circumstances did not appreciate that his convictions were relevant. The policy document was no more specific.

9 There have been calls for reform from New Zealand judges. In *State Insurance v McHale* [1992] 2 NZLR 399, Cooke P said that that case had

> shown that the law of this country is in far from a clear or satisfactory state. In 1957 the Law Reform Committee in England recommended legislation as to disclosure adopting the test of what would have been considered material by a reasonable insured. The late Sir Brian Mac-Kenna in *Lambert* [*v Co-operative Insurance Society Ltd* [1975] 2 Lloyd's Rep 485] at 491 expressed his personal regret that the recommendation had not been implemented. Legislation on those lines has since been introduced in Australia. In effect I follow him in suggesting that it appears to be time that New Zealand did the same. (404)

Richardson and Hardie Boys JJ ended their judgment in *McHale* by noting

> that the law in New Zealand as to materiality and the duty of disclosure is not satisfactory. It can lead to uncertainty and injustice. It is unfortunate that it was not addressed when the 1977 reforms were enacted. The test of the reasonable assured has much to commend it. The Australian legislation adopting that test, which we have already mentioned, could well be followed in this country. (415)

More recently, in *Quinby Enterprises Ltd (in liq) v General Accident Ltd*, Barker J observed that

> [u]ncertainty and possible injustice may be caused by the current state of the law in New Zealand as enunciated. Legislation along the lines of the Australian Commonwealth legislation on the point was commended by Richardson and Hardie Boys JJ at the conclusion of their joint judgment in *McHale's* case; no action has been taken by the New Zealand legislature. Therefore one must accept that, despite its potential harshness, the law in New Zealand on the insured's duty of disclosure is generally as stated above. (740)

10 It was common ground shared by most if not all who made submissions on our draft report that the present law is defective in the respects referred to. Unfortunately there unanimity ceased. There is alas no agreement among law reformers who have considered this issue or among those who assisted us with submissions as to how to solve the problem. The available devices include:

- The amendment of the requirement of what is to be disclosed either by a redefinition of what is material or by excusing insured from some types of non-disclosure, perhaps non-disclosure that is neither fraudulent nor the consequence of some degree of carelessness.
- Warning the insured as to the need for information to be volunteered candidly and of the consequences of a failure to do so.
- Requiring insurers to define exhaustively the information they seek by means of questions in proposal forms. It is of course plain that under the existing law a false answer to a specific question entitles the insurer (subject always to the terms of the contract and to the provisions of the Insurance Law Reform Act 1977 ss 4–7) to avoid the contract, though only prospectively.
- Limiting the remedies for non-disclosure available to insurers by one of the following options:
  - modify or abolish the right to cancel the cover retrospectively, or
  - substitute for such right a right to abate the indemnity payment to which the insured would otherwise have been entitled to reflect the non-disclosure (in some cases this would reduce the indemnity payment to nothing).

  In other words, substitute a right to claim damages from the insured (not available at common law: Legh-Jones, 1997, para 17.27) for the right to rescind the contract.
- Abolishing the disclosure obligation altogether.

Although a perfect solution is likely to elude the reformer it is possible to devise a rule that holds the balance fairly between insurer and insured. This rule should avoid both excessive interference with existing commercial practices and the introduction of avoidable uncertainty.

PROPOSALS BY THE LAW COMMISSION (ENGLAND AND WALES)

11 The Law Commission (England and Wales) issued a working paper in 1979 and a final report in 1980: *Insurance Law: Non-disclosure and Breach of Warranty*. The report represented a marked shift away from the working paper proposals in a direction more acceptable to the insurance industry. It has not been followed by legislation. The principal proposals of the working paper were:

> (d) Where there is no proposal form the insured should be under a duty to disclose those facts which a reasonable man in his circumstances would consider to be material in the sense that they would influence the judgment of a prudent insurer in accepting the risk or fixing the premium. The insured should however only be under a duty to disclose facts which he either knows or which a reasonable man in his circumstances ought to know.
>
> (e) Where a proposal form has been completed by the insured the insurer should, subject to (i) below, be taken to have waived the insured's duty in regard to any fact outside the scope of the questions asked.
>
> (i) A residual duty should be imposed on the insured not deliberately to conceal facts which he knows to be material and of which he has actual knowledge even if they are outside the ambit of all the questions asked in the proposal form. In the event of a breach of this duty by the insured the insurer should be entitled to repudiate the policy and reject any claim that has arisen. The insurer should be required to give clear and prominent notice of this duty in the proposal form and to warn the insured of the consequences of breach.
>
> (j) Insurers should not be entitled to ask a "general question" such as "Are there any other facts which you, as a reasonable insured, consider would influence the judgment of a prudent insurer in fixing the premium or accepting the risk?" An insured should be entitled to ignore any such question and insurers should be deprived of any remedy in respect of false information supplied in answer to any such question. However, insurers should be entitled to ask specific questions on any topics which they regard as material. (198–201)

12 In the report the recommendations were as follows. In lieu of (d) in the working paper the Commission proposed:

> 10.9 The duty of disclosure should be retained but it should be modified along the lines suggested in the Fifth Report of the Law Reform Committee [*Conditions and Exceptions in Insurance Policies* (1957), Cmnd 62]. A fact should be disclosed to the insurer by an applicant if:—
>
> (a) it is material in the sense that it would influence a prudent insurer in deciding whether to offer cover against the proposed risk and, if so, at what premium and on what terms; and
>
> (b) it is either known to the applicant or it is one which he can be assumed to know; for this purpose he should be assumed to know a material fact if it would have been ascertainable by reasonable enquiry and if a reasonable man applying for the insurance in question would have ascertained it; and
>
> (c) it is one which a reasonable man in the position of the applicant would disclose to his insurers, having regard to the nature and extent of the insurance cover which is sought and the circumstances in which it is sought.

In lieu of (e) and (i) the Commission proposed:

> 10.13 The duty to volunteer information in addition to answering the questions in the proposal form should be retained. The duty would be the same as the duty of disclosure when there is no proposal form.
>
> 10.14 All proposal forms should contain certain clear and explicit warnings to the insured, presented in a prominent manner. The insured should be warned about the standard of answer to the questions that is required of him, and of the existence and extent of his duty to volunteer information, apart from answering the questions, and of the consequences of the failure to fulfil either of these obligations.

There was no equivalent provision to (j).

13 We disagree with the proposals of the final paper which seem to us to fall short of comprehensively correcting the problems of the existing law.

14 Founding the duty of disclosure upon what a reasonable applicant would disclose is not a workable answer to the problems discussed in paras 4–7 as to an insured's ignorance of the obligation. The heavy reliance in 10.9(b) and (c) on tests of reasonableness seem to introduce unnecessary uncertainty. The problem of the disproportionally harsh penalty is also not addressed.

THE AUSTRALIAN REFORM

15 The Australian Law Reform Commission issued a working paper in 1978 and a final report in 1982: *Insurance Contracts*. The discussion paper proposed that innocent non-disclosure not be a ground for avoidance of a policy, and instead that insurers' remedies should be confined to cases of an insured wilfully concealing material facts. But this proposal was criticised for the reason that a concealment test might be difficult to prove and so might make dishonesty more difficult to detect. A commentator suggested that the test of the innocence of a non-disclosure should be what a reasonable insured would have done in the circumstances. Despite considering that the difficulty of proving concealment could be exaggerated (because concealment could often be readily inferred from the nature of the undisclosed circumstances), the Commission ultimately rejected the concealment test.

16 The 1982 report also considered modifying the duty of disclosure so that the test of materiality depended on the judgment not of the prudent insurer but of the reasonable insured. The Commission considered, however, that the duty of utmost good faith was in any case owed by the particular insured rather than a hypothetical reasonable insured. Consequently, a "reasonable insured" test would in some cases be too stringent, and in other cases too lenient. By contrast, if the test became too subjective in nature, an insurer's remedies would be restricted unfairly.

17 The Commission concluded that the insured's duty should be retained but modified. An insurer should, before a contract is concluded, be obliged to warn an insured of the duty of disclosure. An insurer who did not comply with this recommended duty would be unable to rely on non-disclosure for a remedy unless that non-disclosure was fraudulent. An insured should be required to disclose facts which he or she knew, or which a reasonable person *in the insured's circumstances* would have known, to be relevant to the particular insurer's decision whether or not to accept a risk and if so on what terms. The Commission considered that this formulation of the duty was more consistent with the limits of the insured's duty to exercise utmost good faith. The Commission also considered that (like the test in the English Commission's working paper) the formulation would achieve a fairer balance between insured and insurer than would the more objective test recommended in the English Commission's report. Finally, the Commission recommended that an insurer should be deemed to have waived disclosure in relation to matters that they questioned an insured on in proposal forms that the insured failed to answer or gave an obviously incomplete or irrelevant answer to.

Remedies for breach

18 The Commission considered that an insurer's right to avoid from the start a contract of insurance was disproportionate to the harm caused by an insured's non-fraudulent non-disclosure and so should be limited. The Commission suggested that a more proportionate response to non-fraudulent non-disclosure would result if insurers' right to avoid a contract for non-disclosure was replaced by a right to damages. The Commission considered that assessing such damages could, however, be difficult.

19 The 1982 report considers and evaluates four ways of assessing damages for non-disclosure. Two methods (one English, the other European Union–French) were based on the notion of "proportionality", under which the insured would bear the loss resulting from the greater cost to the insurer of the increase in risk caused by the non-fraudulent non-disclosure. The Commission indicated that these two approaches had been criticised as creating hypothetical calculations that were difficult to quantify and in some cases unrealistic. For example, an insurer might have responded to the disclosure of a matter by imposing a condition or excess rather than merely increasing a premium payable.

20 The third method of assessment required a "causal connection" between non-disclosure and the insurer's loss, so that the insured could recover under a policy only where, and to the extent that, a non-disclosure caused a loss. The Commission identified two difficulties with such a method of assessing damages for non-disclosure. The first was that an insured's duty is to disclose circumstances existing *before a contract is concluded*, and that these circumstances may not persist and cause a later loss. The second difficulty was that the causal connection test did not deal with cases where the undisclosed circumstances would simply have caused the insurer to decline to accept a risk.

21 The Commission ultimately recommended the fourth "common law" method used to assess damages for misrepresentation: damages for a breach of the duty would simply depend on what the insurer would have done had it known the true facts. The Commission considered that an insurer acting in utmost good faith could rely on a non-fraudulent non-disclosure to recover only the loss which it actually suffered as a result of the non-disclosure. Consequently, an insurer's right to cancel retrospectively a contract of insurance for non-fraudulent non-disclosure should be abolished. The Commission recommended that an insurer's right to cancel a policy from the start should, however, remain in cases of fraudulent non-disclosure. The insurer's other remedies (if any) should depend on

the response it would have made if it had known the undisclosed material circumstances. In particular, if the insurer would have responded by:

- declining to accept the risk on any terms, then the insurer's loss is equivalent to the amount of the claim made against it; or
- accepting the risk only at a higher premium, then its loss is the difference between the actual and notional premiums; or
- accepting the risk on different terms (whether at the same premium or not), then its loss is the difference between its liabilities under the actual and notional contracts.

Insurance Contracts Act 1984 (Aust)

22 The Insurance Contracts Act 1984 (Aust) received Royal Assent on 25 June 1984, and most of its provisions came into operation on 1 January 1986. With one exception the Australian Federal Parliament appears have enacted, without material alteration, the provisions of the draft Act recommended in the 1982 report. The Federal Parliament departed from the Commission's recommendations by adopting, in s 21(1)(b) of the Act (which concerns matters an insured is deemed to have known and should therefore have disclosed), a more objective test. The Commission's draft s 21(1)(b) required an insured to disclose matters that "a person in the circumstances of the insured" could be expected to know were relevant to the insurer's decisions. By contrast, the enacted s 21(1)(b) refers to matters that "a *reasonable* person in the circumstances" could be expected to know were relevant to the insurer's decisions. The relevant sections of the Australian statute are set out in appendix C.

Criticism of the Australian Act

23 Provisions like those in the Australian Act are simpler than those proposed in England and would help solve some of the problems of the existing law. But we would prefer not to adopt unaltered the Australian provisions because:

- their formulation still results in avoidable uncertainty about the precise extent of an insured's duty of disclosure (eg, when is a non-disclosure fraudulent?); and
- while they would modify the unfairness to an insured of an insurer's current all or nothing remedy, they would also introduce the need to make and prove difficult hypothetical and retrospective assessments of an insurer's likely response to an insured having disclosed a matter (Pickering, 1989), a process

sardonically referred to in some of the Australian literature as retrospective underwriting.

CANADA

24 In all provinces and territories, except Quebec, non-disclosure may be relied on to avoid a fire policy only if it is fraudulent (ie, if the insured knew the facts that ought to have been disclosed and had actual knowledge that they were relevant to the underwriter's decision). Comparable provisions apply in all provinces and territories in the context of automobile insurance (Brown, 1997, 112–118).

LIMIT THE DUTY RATHER THAN ABOLISH

25 We have considered whether an insured's duty of disclosure should be abolished. Without the duty an insurer could by questions or inquiries (in proposal forms or otherwise) identify, and obtain from an insured, information necessary to assess accurately the risk to be accepted. As Kirby P observed in *Barclay Holdings (Australia) Pty Ltd v British National Insurance Co Ltd* (1987) 8 NSWLR 514:

> In the real world of insurance cover, it is more appropriate to require insurers, who control such matters, to pay more attention to the language of their proposal forms than to extend the scope of the obligation of insureds to volunteer the whole history of their insurance-related past, lest some item in it might play a part, however minor, in the decision-making process of an insurance officer, however junior. (518–519)

In *Gate v Sun Alliance* (1995) 8 ANZ Ins Cas 75.806 Richardson J observed of the existing law that

> good faith obligations apply to insurers as well as insured. It is at least arguable that . . . those insurers concerned about moral risk should put their cards on the table and signal that fair and accurate answers to all questions in the proposal may not discharge the proponent's disclosure obligations. (75.817)

Does not the insurer's duty of good faith therefore require an insurer – by asking appropriate questions of an insured – to notify the insured of the information required to assess accurately a risk to be accepted? Equally, does not an insured's reciprocal duty of good faith require the insured to answer correctly an insurer's questions? If these limits to the duty of good faith are accepted then the law could more simply provide an insurer with a remedy only for any incorrect responses which could constitute misrepresentations.

26 In the report of the Law Commission (England and Wales), *Insurance Law: Non-disclosure and Breach of Warranty* (paras 4.32–4.40), the Commission rejected *abolition*, though not *limitation*, of the insured's duty of disclosure, with insurers relying instead on posing questions because

- insurers would be compelled to use more numerous and detailed questions which even then could not always identify and elicit the information insurers need;
- higher premiums would result for all insureds to compensate for "sharp practice" on the part of the relatively rare defaulters; and
- insureds would in practice often need insurers to grant at least provisional cover (eg, cover agreed upon over the telephone before a vehicle is driven out of a supplier's premises) before the insureds could properly answer all questions.

A fourth argument against abolition might be added – that self-regulation deals or could deal adequately with the problems of the existing law of non-disclosure.

27 We reject the first argument against abolition – that it would be impossible to draft questions covering all risks. An example often given is that it would be unrealistic for an insurer to ask a person seeking to insure his or her life whether or not he or she had received a death threat. The Law Commission in its 1980 report posed the question:

> Suppose that prospective life insured's life has been threatened. If there were no duty of disclosure he could then apply for life insurance, knowing this fact and knowing it to be material, and could say nothing about it unless it was asked, which would be unlikely to be the case. (para 4.32)

But this example would be met by a question to the insured such as "Do you know of any reason particular to you why you may not attain your normal life expectancy?"

28 We doubt too the second argument – that more numerous and detailed questions would impose costs on insurers and require higher premiums on all insureds for no better purpose than protection against a few defaulters. Disputes resulting from insurers declining to indemnify on the grounds of non-disclosure may well increase premiums as much as (if not more than) would more detailed and complex preliminary inquiries of insureds. The Australian Law Reform Commission observed in its *Insurance Contracts* report over 15 years ago that

> [m]arketing methods are adopted which increase the risk of non-disclosure. Where intermediaries are not involved, there is no-one to

bring the insured's obligation to his attention. For reasons of cost and competition, proposal forms are often kept to a minimum. Relevant questions concerning the moral risk are not asked in case they should embarrass a prospective insured. The adoption of direct marketing techniques has increased pressure for brevity and simplicity. Within the foreseeable future, insurance, like many goods and services, may be purchased by means of computer-based communications systems. All these developments increase the risk of occasional innocent non-disclosure by an unsuspecting member of the public. (ALRC 20, para 183)

29 We accept, however, the third argument – that in effect substituting an obligation to answer questions correctly for an obligation to disclose would interfere unduly with existing commercial practices under which an insurer agrees to go on risk either immediately or sufficiently early after cover is sought to make impractical obtaining answers to questions asked. Our recommendation is tailored to meet this difficulty.

30 Considering the fourth argument, we note and commend as impressive the initiative and efficacy of the Insurance and Savings Ombudsman Scheme.[1] We note that the Fair Insurance Codes (periodically revised) and Ombudsman's jurisdiction provide real help to an insured, especially a private consumer. The relevant portion of the current code reads:

Duty of disclosure

Members will:

- advise customers of the need to provide complete and accurate material information when completing proposals, confirming renewals or providing claims information.

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[1] The first Insurance and Savings Ombudsman was until his recent resignation Mr Terry Weir. He was appointed in December 1994. A Ministry of Consumer Affairs *Survey of Insurance Practices* (which identified non-disclosure as a major theme of complaints about insurance) had in 1993 reviewed existing means of redress provided by individual and associated insurers. The self-regulating initiative of individual and associated insurers led to calls for and the creation of an Insurance and Savings Ombudsman Scheme. Similar schemes had earlier been established in Australia and the United Kingdom. On 1 January 1995 the scheme began to provide an impartial, free, fair, accessible, effective, and publicly accountable insurance and savings dispute resolution service. The Ombudsman is appointed by, and reports publicly to, a commission whose members include nominees of the Minister of Consumer Affairs. The Ombudsman works within terms of reference (dated 13 May 1994), and is funded by levies, both of which are set by the third part of the scheme: an Industry Board. The scheme applies only to insurance products that participating insurers elect to submit to the Ombudsman's jurisdiction. For more detail see Rogers, 1996.

- advise customers that they must disclose all material facts. This may include giving information that has not been asked for directly in the proposal form questions.

  "a material fact is one which may influence a prudent insurer in deciding whether or not to insure you, and if so, at what terms and conditions and for what premium."

- advise customers that if they are in doubt about which facts are considered material, then they should discuss these with their insurer. If facts are considered material, they will be recorded.

- advise customers that if they do not disclose all material facts their insurer may refuse to pay their claim or even cancel their insurance from the starting date of the policy.

- where the contract is completed over the telephone the insurer will upon request make available a copy of the information provided for the customer to confirm the information recorded. The onus rests with the customer to confirm that the information recorded is correct within the time specified by the insurer.

- upon request make available a copy of the proposal form where the contract is completed by means other than over the telephone.

But there is no real substitute for voluntary codes being underpinned by a sound legal system. First, the liquidator of an insurance company would be bound to reject all invalid claims whatever a fair insurance code might say. Secondly, the Ombudsman in any event makes it clear that disputes are reseolved in accordance with legal principles.[2] A survey of British experience suggested that in the area of non-disclosure the benefits of self-regulation may be more perceived than real: Hamilton, 1995; see also the conclusions of Clarke, 1996, that consumers' protection depends on code promulgators choosing to deliver benefits that codes promise (731). The 1996 Annual Report of the Australian self-regulator, General Insurance Inquiries and Complaints Ltd, criticised proposals drafted to rely heavily on an insured's general duty of disclosure (Insurance Contracts Act 1984 (Aust) s 21), and recommended that insurers ask in their proposals the questions to which they need answers, precisely what we recommend in this report.

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[2] "In considering what is fair and reasonable in any circumstances I may . . . have regard to relevant law", Insurance and Savings Ombudsman, Terms of Reference (13 May 1994), 7.

RECOMMENDATION

31 Any right that an insured's non-fraudulent non-disclosure gives the insurer to cancel the contract from its inception (that is with retrospective effect) should have a time limit. That time limit would mean the right was exercisable only within the period that begins with the risk first attaching and ends ten working days later. Any right that the non-disclosure gives the insurer to cancel a concluded contract prospectively is unaffected. The recommendation would be implemented by the draft section in para 32 (see pages 59–81 for our complete draft Insurance Law Reform Amendment Act and commentary). So that related provisions on misrepresentation and non-disclosure can be found easily together, and to avoid repeating some general provisions, the draft section has been prepared as a new *section 7A* of the Insurance Law Reform Act 1977 and uses language consistent with that statute. The following matters in the draft call for comment:

- *Subsection (6)* defines **risk first attaching** to exclude the attaching of a risk under a policy replacing interim cover, or on the reinstatement or renewal of a policy. This will prevent attempts to prolong indefinitely an insurer's right to cancel prospectively by continual renewals of short-term contracts of insurance. It is of course always open to an insurer to pose questions before agreeing to reinstate or renew. As such questions would be directed only to changes in circumstances increasing the risk we are not persuaded that such a requirement imposes undue practical difficulty.
- Any right an insurer might have to cancel a contract prospectively is unaffected by the proposed provision.
- Fraudulent non-disclosure is unaffected by the proposed section. The term employed to describe the conduct is *blameworthy*. For there to be blameworthy non-disclosure it is provided in *subsection (3)* that an insured must know (or the circumstances must be that a reasonable person could have been expected to know) both the undisclosed facts and that they would have influenced the judgment of a prudent insurer in accepting the risk, and if so on what terms.
- In theory, if a word or term is defined in a certain way within a statute, any words can be used. In practice it is more user-friendly if the ordinary meaning of the word coincides as closely as possible to the meaning defined in the statute. In the present case what might at first sight seem the more obvious adjective to use, *fraudulent*, is inappropriate because the conduct defined includes conduct that is only constructively fraudulent. The

word *culpable* is not appropriate outside a criminal context (Garner, 1995, 110), and the words *misleading* and *deceptive* carry inappropriate baggage from their use in the Fair Trading Act 1986. The most appropriate expression is *blameworthy*.

- The purpose of the reform is to shift the emphasis from an insured's duty to disclose to an insurer's duty to identify (by asking the insured appropriate questions) circumstances about which the insurer needs to be informed. It is important, however, that the reform should not be undone by an insurer being permitted to pose some such proposal question as "Are there any other circumstances material to the proposal?". It is for this reason that the expression employed in *subsection (2)* is "a specific question expressly put" and that those words are defined in *subsection (4)*.
- It is also important that the reform should not be undone by insurers stipulating for a warranty as to disclosure; *subsection (5)* is intended to guard against this.
- The 10-working-day time limit exception would ensure that there was no interference with existing commercial practices involving immediate acceptance of risk. The potential injustice (no greater than that under existing law) to insureds who suffer loss within the initial 10-working-day period seems a small price to pay for a solution cleaner and neater that those recommended or enacted in other jurisdictions. There are criticisms of the 10-working-day period on grounds that the non-disclosure may not come to light until long after the period ends. Those criticisms fail to take into account that the purpose of the time limit is not to enable the insurer to discover the non-disclosure but to allow the insurer time to pose appropriate questions to the insured before agreeing to the contract.
- There are circumstances in which a mis-statement in response to a proposal question will as a matter of theory allow the insurer a choice between conceptually different remedies. If the insurance contract (as it may be assumed it will) is appropriately framed then the insurer will be entitled to cancel the contract on the basis of such mis-statement. Cancellation is, of course, always subject to the provisions of the Insurance Law Reform Act 1977 ss 4–5 which require the statement to be *substantially incorrect* and *material* (both are defined in objective, prudent insurer terms in s 6). Alternatively, if *subsection (2)* applies, the time limit in *subsection (1)* will not apply and the insurer will be entitled to cancel the contract on the ground of the non-disclosure of the true facts, assuming them to be material. In

practice, however, it is unlikely that the insurer will choose the former alternative because, without agreement to the contrary, cancellation on that basis can only be prospective: Contractual Remedies Act 1979 s 8. If the contract did provide for cancellation from the start for misrepresentation the existence of the choice of remedy is unlikely to have practical consequences.

- The purpose of this section is to switch the emphasis from the duty of the insured to disclose to the right of the insurer to seek information. It follows that one effect of *subsection 2(b)* is to draw a distinction between a mis-statement amounting to a non-disclosure in response to a question, and one that is volunteered. This confers on the insurer a stronger remedy (that of retrospective cancellation) in the former case than is available in the absence of fraud in the latter.
- Our draft section does not prohibit contracting out as that is provided for in s 15 of the 1977 Act. We do not propose repealing or amending s 15.
- Because in contracts of reinsurance the insured may be taken to be adequately informed of the insured's disclosure obligation, such contracts are excluded from the proposed new section.

32 The new *section 7A* that we recommend is as follows (see pages 59–81 for our complete draft Insurance Law Reform Amendment Act and commentary):

> **7A Non-disclosure**
>
> (1) Any right of an insurer to cancel a contract of insurance by reason of the failure of an insured to disclose a fact to the insurer before the contract is concluded may only be exercised, if the cancellation is to take effect from a date earlier than the date on which it is notified to the insured, within 10 working days of the risk first attaching.
>
> (2) This section does not apply
>
> (a) to contracts of reinsurance; or
>
> (b) if the failure to disclose a fact is blameworthy; or
>
> (c) if, before the contract is concluded, the insured answers a specific question expressly put by the insurer in a way that is substantially incorrect because of the failure to disclose a fact.
>
> (3) A failure to disclose a fact is not blameworthy unless the insured knew, or in the circumstances a reasonable person could have been expected to know, both the undisclosed fact and that disclosure of the undisclosed fact would have influenced the judgment of a prudent insurer in accepting the risk or the terms of such acceptance.

(4) For the purposes of subsection (2)(c),

(a) a question is not a specific question expressly put by the insurer if, in order to answer it, the insured must decide whether a fact is or might be relevant to the decision of the insurer to accept the risk or the terms of such acceptance; and

(b) an insured's answer to a question is substantially incorrect only if the difference between what is stated and what is actually correct would have been considered material by a prudent insurer.

(5) This section has effect despite any warranty by the insured that the insured's disclosure obligation has been complied with.

(6) For the purposes of subsection (1),

(a) a reference to a **risk first attaching** does not include the attaching of a risk on the issue of a policy replacing interim cover or on the reinstatement or renewal of a policy; and

(b) **working day** means a day of the week other than

(i) a Saturday, a Sunday, Waitangi Day, Good Friday, Easter Monday, Anzac Day, the Sovereign's birthday, and Labour Day; and

(ii) a day in the period commencing with 25 December in a year and ending with 2 January in the following year; and

(iii) if 1 January falls on a Friday, the following Monday; and

(iv) if 1 January falls on a Saturday or a Sunday, the following Monday and Tuesday.

2
Section 9 of the Insurance Law Reform Act 1977 and claims made policies

33 Section 9 of the Insurance Law Reform Act 1977 reads as follows:

9 Time limits on claims under contracts of insurance

(1) A provision of a contract of insurance prescribing any manner in which or any limit of time within which notice of any claim by the insured under such contract must be given or prescribing any limit of time within which any suit or action by the insured must be brought shall

(a) If that contract of insurance is embodied in a life policy and the claim, suit, or action relates to the death of the insured, not bind the insured; and

(b) In any other case, bind the insured only if in the opinion of the arbitrator or Court determining the claim the insurer has in the particular circumstances been so prejudiced by the failure of the insured to comply with such provision that it would be inequitable if such provision were not to bind the insured.

(2) Where

(a) The insured under any contract of insurance to which subsection (1) (b) of this section applies fails to give notice of any claim in any manner or within any limit of time prescribed by the contract; and

(b) The cost of repairing, replacing, or reinstating any property when it falls to be met is greater than that which would have applied if the notice had been given in the manner or within the time so prescribed,

that greater cost shall not constitute prejudice to the insurer for the purposes of subsection (1)(b) of this section, but the insurer shall not be obliged to apply or pay in repairing, replacing, or reinstating the property a greater sum than that for which he would have been liable if the notice of claim had been given in the manner or within the time so prescribed.

34 Section 9 was enacted on the recommendation of the Contracts and Commercial Law Reform Committee (*Aspects of Insurance Law*,

1975, para 21). It is based on s 27 of the Instruments Act 1958 (Victoria). It overrides contractual time-bars in all policies of life insurance and in other policies where the insurer suffers no prejudice as a result of the delay.

35 In general, we consider that s 9 has been operating satisfactorily. However, recent decisions of the Court of Appeal and High Court have revealed problems in applying s 9 to "claims made" insurance policies. This chapter discusses these problems and recommends reform of s 9 in order to resolve them.

Claims made policies

36 Claims made policies are typically used for professional indemnity and company directors' and officers' indemnity insurance. These policies provide indemnity to the insured in respect of claims made against the insured by third parties during the currency of the policy. The insured may therefore be covered for claims arising from errors or omissions which occurred before the policy came into force, as it is the claim of the third party, rather than the error or omission of the insured, which must fall within the period of time covered by the policy. Some policies require not only that the claim be made by the third party against the insured during the policy period but also that the insurer be notified of the claim within that period. Such policies are known as "claims made and notified" policies. It is common for both claims made and claims made and notified policies to contain a provision which gives cover in situations where the insured notifies the insurer of potential claims during the currency of the policy, even if the third party claim is not actually made until after the policy expires. Such a provision is variously described as a "deeming clause" or a "circumstances notification clause" or an "extension provision".

37 A typical deeming or circumstances notification clause would read as follows:

> If during the term of the policy the insured becomes aware of any circumstance which may subsequently give rise to a claim against the insured and shall during the term of the policy give written notice to the insurer of the circumstance, then any such claim which may subsequently be made against the insured arising out of such circumstances shall be deemed to have been made during the term of this policy.

This kind of provision is intended to protect the insured whose policy expires after the insured becomes aware that a third party is likely to make a claim, but before any claim is received. Without such a provision the insured may fall between two stools: the

insured is not covered under the earlier policy but is obliged to disclose the possibility of a claim to the insurer under the later policy. That insurer may or may not be prepared to accept the risk of indemnifying against such a claim if it eventuates (Legh-Jones, 1997, para 28.69).

38 The promise of the insurer under a claims made or claims made and notified policy does not extend to liability to indemnify for errors or omissions of the insured which, even if they occurred during the currency of the policy, only become apparent after the policy expired. Where indemnity is provided for errors or omissions of the insured during the currency of the policy ("occurrence policies"), rather than in respect of claims made against the insured during such currency, the insurer's contractual liability under the policy continues until such time as all possible claims are time-barred. In this context it should be kept in mind that the Limitation Act 1950 may not bar claims based on breach of fiduciary duties. For this reason, occurrence policies are said to have a "long tail" and are consequently less attractive to underwriters. The Supreme Court of Michigan explained the position lucidly in the 1984 case of *Stine v Continental Casualty Company* 349 NW 2d 127 (Mich 1984) 127:

> There is greater public familiarity with the "occurrence" type of policy than with the "claims made" type, largely because automobile insurance liability policies are "occurrence" policies, although other perils are covered in such policies as well. Coverage in an "occurrence" policy is provided no matter when the claim is made, subject, of course, to contractual and statutory notice and limitations of actions provisions, providing the act complained of occurred during the policy period. Because the insurer's liability in such policies ordinarily relates to a definite, easily identifiable and notorious event such as an automobile accident, a fire, a slip and fall injury, or a ship collision, the insurer is ordinarily able to conduct a prompt investigation of the incident and make an early assessment of related injuries and damages with the result that actuarial considerations permit relative certainty in estimating loss ratios, establishing reserves, and fixing premium rates.
>
> "Claims made", or "discovery" policies, on the other hand, are of relatively recent origin and were developed primarily to deal with situations in which the error, omission, or negligent act is difficult to pinpoint and may have occurred over an extended period of time. In the case of a "claims made" policy written to cover professional liability, the error or omission may be a discrete act or failure to act, or it may consist of a lengthy process and remain latent and undiscoverable for a number of years. Examples include a physician's mis-diagnosis, an attorney's fraudulent concealment, or an architect's defective design. From an underwriting perspective, occurrence policies are unrealistic

> for such risks because of the long or open "tail" exposure which results. When the "event" intended to be covered cannot easily be fixed and the liability for the consequent injury extends long into the future, often well after expiration of the policy, considerations of inflation, upward spiralling jury awards, and legislative and judicial adoption of newly developing concepts of tort law mean that actuarial factors, including fixing premium rates and establishing adequate reserves, are highly speculative. The result, logically, is the establishment of a premium rate schedule sufficiently high to accommodate "worst scenario" jury verdicts returned years after the error, omission, or negligent act.
>
> "Claims made" policies meet such difficulties by enabling the insurer to underwrite the risk, compute the premiums, and establish reserves with greater accuracy, safe in the assumption that liability will be limited to claims actually made during the term of the policy for which the premium is computed. When the policy term expires, the insurer knows exactly what its exposure is, at least in terms of the nature and number of "claims made". As a result, the insurer is better able to predict the limits of its exposure and more accurately estimate the premium rate schedule necessary to accommodate the risk undertaken. (131)

The problem

39 In *Sinclair Horder O'Malley & Co v National Insurance Co of NZ Ltd* [1995] 2 NZLR 257 the Court of Appeal applied s 9 to an extension provision in a claims made policy. The consequence was that the insurer could therefore avoid liability only if it could demonstrate that it had been prejudiced by the failure to give notice. Although three judgments were given, each based on different reasons, the court was unanimous in deciding that the case be remitted to the High Court for a further hearing to determine whether the insurer had in fact been prejudiced by the delay. *Sinclair Horder* has subsequently been applied to a claims made and notified policy: *Bradley West Clarke List v Keeman* (1997) 9 ANZ Ins Cas 76,742.

40 The legal effect of *Sinclair Horder* is to change in a fundamental way the promise made by the insurer to the insured. The insurer's purpose of knowing where it stands at the end of the period of cover is defeated because of the possibility of future claims that the insurer can resist only if it can establish prejudice (for discussion see Campbell, 1997, 104).

RECOMMENDATION

41 The Law Commission considers that this is an unsatisfactory outcome and one that changes the bargain in a way that is unfair to insurers. Accordingly, we recommend that s 9 of the Insurance Law Reform Act 1977 should be amended by the addition of these new *subsections (3)* and *(4)* (see pages 59–81 for our complete draft Insurance Law Reform Amendment Act and commentary):

> (3) Subsection (1)(b) does not apply to a provision of a claims made policy that defines the period within which claims made against the insured or claims arising out of circumstances notified to the insurer are within the risk accepted by the insurer under the policy.
>
> (4) In this section **claims made policy** means a contract of insurance in which the period during which liability for claims against the insured is within the risk accepted by the insurer is defined by reference to the time when such claims are made or claims or circumstances which may give rise to a claim are notified to the insurer.

Note that the proposed *subsection (3)* is by its terms carefully confined to the definition of the risk. It will still be possible for an insured to invoke s 9 in respect of a delay in notifying within the period of cover. In some United States jurisdictions the courts themselves have evolved a "notice prejudice" rule which has roughly the same effect as s 9. Commencing with the 1989 decision in *Burns v International Insurance Company* (ND Cal 1989) 709 F Supp 187, there have been a number of cases in which it has been held that the notice prejudice rule should not apply to claims made policies (see Chamberlain, 1992).

3
Section 11 of the Insurance Law Reform Act 1977

42 Section 11 of the Insurance Law Reform Act 1977 reads as follows:

> **11 Certain exclusions forbidden**
> Where
> (a) By the provisions of a contract of insurance the circumstances in which the insurer is bound to indemnify the insured against loss are so defined as to exclude or limit the liability of the insurer to indemnify the insured on the happening of certain events or on the existence of certain circumstances; and
> (b) In the view of the Court or arbitrator determining the claim of the insured the liability of the insurer has been so defined because the happening of such events or the existence of such circumstances was in the view of the insurer likely to increase the risk of such loss occurring,
> the insured shall not be disentitled to be indemnified by the insurer by reason only of such provisions of the contract of insurance if the insured proves on the balance of probability that the loss in respect of which the insured seeks to be indemnified was not caused or contributed to by the happening of such events or the existence of such circumstances.

The section was recommended by the Contracts and Commercial Law Reform Committee (*Aspects of Insurance Law*, 1975, paras 28–30). Exclusions are justifiable if they define circumstances where there may be an increase in risk. The purpose of s 11 is to prevent exclusions being used to exclude liability where the circumstances, and so the increase in risk, exist but the loss is not attributable to that increase. The recommendation was triggered by two cases, then recent, in which the word "whilst" used in the definition of an exclusion was held to have a temporal and not a causative meaning: *Parsons v Farmers Mutual Insurance Association* [1972] NZLR 966; *State Insurance v Harray* [1973] 1 NZLR 276. The example given by the Contracts and Commercial Law Reform Committee of the wrong to be remedied 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. (15)

The problem

43 The underwriter's art is (theoretically at least) that of determining whether to accept a risk and on what terms, having regard to the likelihood of the loss occurring. The problem with s 11 as it has been interpreted is that it takes no account of the extent to which an exclusion may be framed with that statistical likelihood in mind. It is reasonable, for example, for an insurer to charge different rates of premium for vehicles used commercially and vehicles used privately because of the greater risk of accident (eg, a taxicab is more likely to be involved in an accident than the same vehicle confined to private use). But s 11 has been interpreted in a way that prevents insurers from declining liability to indemnify for losses to equipment during commercial use when the cover by its terms is confined to private use: *New Zealand Insurance Co Ltd v Harris* [1990] 1 NZLR 10. It has also been interpreted in a situation where the insured paid a lesser premium in return for motor vehicle cover on the basis that it was confined to a named driver but the insurer was required to indemnify for loss caused when the vehicle was in the control of a different driver: *State Insurance Ltd v Lam* (unreported, 10 October 1996, CA 159/96). Both these cases are decisions by the Court of Appeal. The approach has comparable implications for exclusions relating to a requirement that a driver be licensed and not be in breach of the terms of a licence and to higher deductibles imposed in respect of drivers under a certain age: *Daly v Electronic Navigation Ltd* [1992] DCR 379; *Flight v State Insurance Office* [1972] DLR 781; *State Insurance Ltd v Electronic Navigation Ltd* (1992) 7 ANZ Ins Cas 77,542; *Allied Mutual Ltd v Crofts* (1992) 7 ANZ Ins Cas 77,711. For a general discussion of the problem, see Kelly and Ball, 1991, paras 6.151–6.153.) This seems to the Commission to be unfair to insurers.

The English response

44 In its report, *Insurance Law: Non-disclosure and Breach of Warranty*, the Law Commission (England and Wales) sought to achieve the same policy objective as that underlying s 11 (para 6.22). Clause 10(5) of the draft statute in the report included the following:

> [T]he insurer shall be liable to meet the claim if the insured proves either
> (a) that the warranty concerned was intended to safeguard against, or was otherwise related to, the risk of the occurrence of the

events of a description which does not include the event which gave rise to the claim; or

(b) that the breach of warranty could not have increased the risk that the event which gave rise to the claim would occur in the way in which it did in fact occur.

This recommendation has not to date been implemented.

The Australian response

45 The difficulty in translating the policy objective into statutory form is illustrated by the Australian experience. The Australian Law Reform Commission rejected s 11 as a model precisely because of its failure to take into account the statistical likelihood factor (*Insurance Contracts*, ALRC 20, para 228). Its proposal was enacted as the Insurance Contracts Act 1984 (Aust) s 54. It reads:

54 Insurer may not refuse to pay claims in certain circumstances

(1) Subject to this section, where the effect of a contract of insurance would, but for this section, be that the insurer may refuse to pay a claim, either in whole or in part, by reason of some act of the insured or of some other person, being an act that occurred after the contract was entered into but not being an act in respect of which subsection (2) applies, the insurer may not refuse to pay the claim by reason only of that act but his liability in respect of the claim is reduced by the amount that fairly represents the extent to which the insurer's interests were prejudiced as a result of that act.

(2) Subject to the succeeding provisions of this section, where the act could reasonably be regarded as being capable of causing or contributing to a loss in respect of which insurance cover is provided by the contract, the insurer may refuse to pay the claim.

(3) Where the insured proves that no part of the loss that gave rise to the claim was caused by the act, the insurer may not refuse to pay the claim, so far as it concerns that part of the loss, by reason only of the act.

(4) Where the insured proves that some part of the loss that gave rise to the claim was not caused by the act, the insurer may not refuse to pay the claim, so far as it concerns that part of the loss, by reason only of the act.

(5) Where:

(a) the act was necessary to protect the safety of a person or to preserve property; or

(b) it was not reasonably possible for the insured or other person not to do the act;

the insurer may not refuse to pay the claim by reason only of that act.

(6) A reference in this section to an act includes a reference to:
  (a) an omission; and
  (b) an act or omission that has the effect of altering the state or condition of the subject-matter of the contract or of allowing the state or condition of that subject-matter to alter.

46 We have given careful consideration as to whether this model should be followed in New Zealand. It divides into two classes all acts and omissions after the contract is concluded that would under the contract entitle the insurer to decline liability to indemnify. If the act or omission has a loss-causing potential, then the insurer may rely on it except to the extent that the insured proves that the loss was not caused by the act or omission. In this respect s 54 follows the New Zealand s 11 but with provision for proportional recovery rather than the all-or-nothing approach of the New Zealand provision. If the act or omission does not have a loss-causing potential, then the insurer may rely on it only to the extent that the insurer's interests were prejudiced. In our view there are a number of reasons why s 54 should not be adopted in New Zealand:

- The basic entitlement of parties to an insurance or any other contract is to determine their bargain for themselves. While we believe that it is appropriate for the legislature to interfere with contractual freedom if it corrects specific perceived injustices (eg, in the various remedial provisions of the 1977 statute), in our view this does not justify so sweeping and unfocussed a provision as s 54.

- A broadly-expressed provision that runs counter both to the interests of insurers and to the ingrained habits of lawyers experienced in the field will inevitably cause litigation and will not necessarily, in the end, be found to be judge-proof. This proposition seems to us to be well enough illustrated by the Australian experience (see Horsely, 1996; also *Antico v Heath Fielding Australia Pty Ltd* (1997) 188 CLR 652).

- The application of the notion of proportionality in s 11 circumstances can only be a matter of guesswork. In *New Zealand Insurance Co Ltd v Harris* equipment insured only in respect of non-commercial use was vandalised while being used on a job outside that category. In this case it can be argued on the one hand that, but for the non-private use, the equipment would not have been where it was and the loss would not have occurred; on the other hand, as the Court of Appeal held, it can be argued that the commercial use was not causative. In such circumstances it seems impossible to calculate an apportionment in any intellectually justifiable manner.

- It has been suggested to us that the extent of the insurer's prejudice is readily calculable in such circumstances as those existing in *New Zealand Insurance Co Ltd v Harris* and *State Insurance Ltd v Lam*. The extent of that prejudice is simply the additional premium that the insured would have had to pay had the cover extended to the circumstances which in fact occurred. But that is surely to present the insured with a double-headed penny. Why should anyone bear the expense of insuring at the higher premium rate required for commercial use if, in the absence of fraud or misrepresentation, the only penalty for preferring the lower rate applicable to private use is (if a claim has to be made for loss suffered while the vehicle or equipment is being used commercially) to pay the difference between the two premiums?

RECOMMENDATION

47 Section 11 has been the subject of useful judicial exegesis and except in respect of the point under discussion is working well enough (see Dugdale, 1992). The solution recommended is the retention of the substance of s 11 in a replacement section that includes as *subsection (3)* a provision dealing with the precise areas of difficulty. While it may be fairly said that this solution falls short of perfect elegance, in our view it will provide a practical answer to the problems that have arisen. Our draft *subsection (3)* has been criticised for undue specificity and we gave thought to a provision (drafted with an eye to the precedent afforded by the Human Rights Act 1993 s 48) along the following lines:

> A provision is not an increased risk exclusion for the purposes of this section if it is based on actuarial or statistical data establishing an increased risk of loss occurring in the circumstances in which the insurer's liability is excluded or limited.

But it is important that any exclusion should not be so wide as to wipe out the original reform and for this and other reasons the proposal set out below seemed to us preferable.

48 We recommend that Parliament replace s 11 by enacting the following (see pages 59–81 for our complete draft Insurance Law Reform Amendment Act and commentary):

> **11 Increased risk exclusions**
>
> (1) An insured is not bound by an increased risk exclusion if the insured proves on the balance of probability that the loss in respect of which the insured seeks 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.

(2) For the purposes of this section, an increased risk exclusion is a provision in a contract of insurance that

(a) defines the circumstances in which the insurer is bound to indemnify the insured against loss so as to exclude or limit the liability of the insurer to indemnify the insured on the happening of certain events or on the existence of certain circumstances; and

(b) so defined the liability of the insurer, in the view of the court or arbitrator determining the claim of the insured, because the happening of such events or the existence of such circumstances was in the view of the insurer likely to increase the risk of loss occurring.

(3) A provision is not an increased risk exclusion for the purposes of this section that

(a) defines the age, identity, qualifications or experience of a driver of a vehicle, a pilot of an aircraft, or an operator of a chattel; or

(b) defines the geographical area in which a loss must occur if the insurer is to be liable to indemnify the insured; or

(c) excludes loss that occurs while a vehicle, aircraft, or other chattel is being used for commercial purposes other than those permitted by the contract of insurance.

4
Section 83 of the Fires Prevention (Metropolis) Act 1774 (Imp)

49 The long title to the Fires Prevention (Metropolis) Act 1774 (Imp) describes the Act as:

> An Act . . . for the more effectually preventing Mischiefs by Fire within the Cities of London and Westminster the Liberties thereof, and other the Parishes Precincts and Places within the Weekly Bills of Mortality,[3] the Parishes of St Mary–le–bon, Paddington, St Pancras and St Luke at Chelsea, in the county of Middlesex.

Despite what would appear to be the clear intention demonstrated by these words the section has been held to apply generally in England and Wales and in former colonies including New Zealand: *Cleland v South British Insurance Co* (1890) 9 NZLR 177; *Searl v South British Insurance Co Ltd* [1916] NZLR 137; *Auckland City Corporation v Mercantile and General Insurance Co Ltd* [1930] NZLR 809. It was carefully preserved by the Imperial Laws Application Act 1988 s 3(1) and the first schedule. It reads as follows:

> **83 Money insured on houses burnt; how to be applied**
> In order to deter and hinder ill-minded persons from wilfully setting their house or houses or other buildings on fire with a view of gaining to themselves the insurance money, whereby the lives and fortunes of many families may be lost or endangered: . . . It shall and may be lawful to and for the respective governors or directors of the several insurance offices for insuring houses or other buildings against loss by fire, and they are hereby authorised and required, upon the request of any person or persons interested in or entitled unto any house or houses or other buildings which may hereafter be burnt down, demolished or damaged by fire, or upon any grounds of suspicion that the owner or owners, occupier or occupiers, or other person or persons

[3] The Bills of Mortality is of course the area within which before the Births and Deaths Regulation Act 1836 (6 and 7 Will 4, c 86) provision was made for the recording of deaths in London.

> who shall have insured such house or houses or other buildings have been guilty of fraud, or of wilfully setting their house or houses or other buildings on fire, to cause the insurance money to be laid out and expended, as far as the same will go, towards rebuilding, reinstating or repairing such house or houses or other buildings so burnt down, demolished or damaged by fire, unless the party or parties claiming such insurance money shall, within 60 days next after his, her or their claim is adjusted, give a sufficient security to the governors or directors of the insurance office where such house or houses or other buildings are insured, that the same insurance money shall be laid out and expended as aforesaid, or unless the said insurance money shall be in that time settled and disposed of to and amongst all the contending parties, to the satisfaction and approbation of such governors or directors of such insurance office respectively.

The purpose of the section

50 It is evident that the section is intended to deter the wilful burning down of buildings by persons with a partial interest in claiming the insurance money. The section endeavours to achieve this deterrent purpose by:

- entitling interested parties to require that insurance money be applied in reinstatement rather than paid out in cash; and
- authorising insurers if they suspect fraud to elect to reinstate rather than paying out in cash.

51 The second of these points is of little practical significance because:

- a right to the insurer to elect to reinstate can be and commonly is included in the insurance contract; and
- if the insured has only a limited interest an insurer is unlikely to elect to reinstate as the cost of reinstatement is likely to exceed the indemnity the insured is entitled to in respect of that limited interest: *British Traders Insurance Company Ltd v Manson* (1964) 111 CLR 86, 96.

52 On the first point, persons held entitled to compel reinstatement include owners, mortgagors and mortgagees, tenants for life and remaindermen and lessors and lessees (see 25 *Halsbury's Laws of England*, 1994, para 639). The purpose of the provision is to protect the indemnifiers from fraud by removing the incentive for persons with limited interests in premises to burn them down to get the insurance proceeds. The purpose is not to alter the rights between the insured and other persons. Although it is not certain, a mortgagor, for example, would presumably not be permitted to invoke s 83 and override such provisions as those implied by cl 6 of the fourth schedule to the Property Law Act 1952 and in the meaning given to the expression "will insure" by cl 4 of the fifth

schedule to the Chattels Transfer Act 1924.[4] But a stranger to the mortgage contract such as a lessee or subsequent encumbrancer has, by virtue of s 83, a clear right to compel reinstatement. It is difficult to see how the sole reason for the existence of the section, namely to discourage fraud by owners of limited interests, is promoted by the existence of such a power.

The application of the section

53 The section is limited in its application. It does not apply to insurance

- against risks other than fire, or
- with Lloyd's underwriters,[5] or
- of contents.

Abolition in Australia

54 There has been no corresponding provision in New South Wales since 1879, a position which the Australian Capital Territory inherited and has not changed. The absence of such a provision has led to no discernible mischief. (Other Australian states have retained either the original s 83 or a re-enactment in contemporary language.) The Australian Law Reform Commission concluded that the section should be repealed and not replaced and this recommendation was adopted in the Insurance Contracts Act 1984 (Aust) s 3(1) (see *Insurance Contracts*, 1982, ALRC 20, paras 128–129).

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[4] This provision entitles the secured creditor to compel the application of insurance proceeds in reduction of the secured liability, though this is uncertain. For a discussion of the position in England (where, however, the corresponding provision is preceded by the words "[w]ithout prejudice to any obligation to the contrary imposed by law": Law of Property Act 1925 s 108(4)), see Law Commission (England and Wales), *Land Mortgages* (Working Paper 99, 1986), para 3.28. In the context of landlord and tenant see *Searl v South British Insurance Co Ltd* [1916] NZLR 137, 144, Sim J: "Now the Statute in question was not passed for altering the contractual rights and obligations of parties."

[5] Because of the reference to "governors or directors of the several insurance offices": *Portavon Cinema Co Ltd v Price and Century Insurance Co Ltd* [1939] 4 All ER 601, 607.

RECOMMENDATION

55 In our view this section is anachronistic and unnecessary and so should be removed from the New Zealand statute book.[6] None of those who commented on our draft report indicated a serious contrary view (see pages 59–81 for our complete draft Insurance Law Reform Amendment Act and commentary).[7]

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[6] Compare Contracts and Commercial Law Reform Committee, 1984, paras 4.1–4.4. The question whether the only other section of that statute surviving in New Zealand (s 86) should remain is outside the scope of this report and must await New Zealand developments following such decisions as *Cambridge Water Co v Eastern Counties Leather plc* [1994] 2 AC 264 and *Burnie Port Authority v General Jones Pty Ltd* (1994) 179 CLR 520. (See the discussion by Chambers in Todd (ed), 1997, chapter 10). When that decision is made the observations of McKenna J in *Mason v Levy Auto Parts of England Ltd* [1967] 2 QB 530, 543 should not be overlooked:

> For my part, I find it . . . deplorable that liability should depend, in the matter of fire, on what a draftsman meant in Queen Anne's day by "accidental fires". (The Act of 1774 re-enacted with amendment 6 Anne c 31 s 6.) It is proof of our love of old things, rather than a tribute to his drafting skill, that we – and more surprisingly our kinsmen in the antipodes . . . – are still governed by his phrase.

[7] The view expressed in *MacGillivray on Insurance Law*, 1997, para 21.25 is that "[s]ection 83 should now be repealed and replaced by a short statute requiring any insurer to use the insurance money for reinstatement if he is requested to do so by any person interested in the property."

5
Part III of the Law Reform Act 1936

INTRODUCTION

56 UNDER A CONTRACT OF LIABILITY INSURANCE a person (the insured) is entitled to be indemnified by another person (the insurer) for damages or compensation that, because events specified in the contract occurred, the insured has become liable to pay to a third party. Under Part III of the Law Reform Act 1936 (reproduced in appendix B) such an injured third party may be entitled to a charge over the insurance money payable from insurer to insured. The third party's charge over the insurance money arises on the insured's insolvency (s 9) or death where no one is granted administration of the insured's estate (s 9A). Section 10, which repeals earlier provisions, is the third and last section of Part III.

57 After considering the origins and development of Part III, and comparable overseas provisions, this chapter addresses the questions:

- Should the s 9 priority continue? If so, how should it be achieved?
- Should s 9A be retained? If so, should it also be modified or extended?
- If Part III is retained, how can it be made more workable in practice?

We conclude with draft provisions to replace Part III (see para 112).

ORIGINS AND DEVELOPMENT OF PART III

Three cases illustrating the mischief section 9 addresses

IN RE HARRINGTON MOTOR COMPANY LTD, EX PARTE CHAPLIN [1928] 1 CH 105

58 At first instance Eve J held that the proceeds of an insurance policy taken out by the insured company (by then in liquidation) were to

be distributed among the creditors of the insured company with equal priority (*pari passu*). Chaplin, the injured third party in the accident that gave rise to indemnification, was therefore left to prove in the liquidation in competition with other creditors of the insured. Eve J expressed sympathy with the plight of Chaplin (110). On appeal the Court of Appeal affirmed Eve J's initial judgment. Lord Hanworth MR added that it was

> perhaps unfortunate that one should have to give a judgment which would, at first sight, appear to run counter to what I might call the common-sense view of the proceedings. Nonetheless it is necessary for us to administer the law as it stands and if any alteration is to be made in it that must be made by the proper authorities and by proper means. (111)

Atkin LJ expressed the view "that the applicant has a real grievance, and if it were possible to decide for him I should very willingly do so" (116). Lawrence LJ added his sympathy but noted that "we cannot allow that sympathy to lead us astray, or do otherwise than administer the law as it exists" (124).

HOOD'S TRUSTEES V SOUTHERN UNION GENERAL INSURANCE CO OF AUSTRALASIA LTD [1928] 1 CH 793

59 The injured third party, Caddy, fared even worse than had Chaplin, the injured third party in *Harrington*. Despite it having been held that the proceeds of the insurance policy passed to the trustee in bankruptcy, Caddy was refused the right to participate with equal priority with other creditors of the bankrupt/insured because he had not established his claim by a judgment obtained before the bankruptcy.[8] Although Caddy pursued Hood and obtained a second order of adjudication in bankruptcy, both Tomlin J and the Court of Appeal (applying *Harrington*) held that the insurance moneys passed to the trustee of the first bankruptcy. This meant that the

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[8] In 1928 in both the United Kingdom and in New Zealand a claim in tort, to be provable in a bankruptcy or winding up, was required to be a liquidated sum. An exception was a claim that arose from a tortious act committed in a New Zealand workplace, which from the coming into force of the Workers' Compensation Act 1922 (NZ) s 53 was allowed to be proved in a bankruptcy even if not a liquidated sum. Section 87 of the Insolvency Act 1967 read with the definitions of "debt provable in bankruptcy" and "provable debt" in s 2 of the 1967 Act made all unliquidated claims in tort provable on a bankruptcy. Before the Companies Act 1903 (NZ) s 246 was enacted all claims were admissible to proof against a company (see Companies Act 1882 (NZ) s 219). But after the 1903 Act bankruptcy rules applied to debts provable in company liquidations: Companies Act 1908 s 246; Companies Act 1933 s 256; Companies Act 1955 s 307; Companies Act 1993 ss 302–313.

creditors of Hood's first bankruptcy shared in the financial fruits of Caddy's injuries to his exclusion. Tomlin J described the result (802) as "a very remarkable position", and added that in *Harrington*

> Atkin LJ said that he thought that the appellant had a real grievance; but the general rule of law was too strong to allow the Court to make any exception, however the Court might sympathise with the appellant. The position in law was quite clear, and it was that the appellant had no right or claim against the insurance company or against money paid by the insurance company. The assured had a direct right of recourse against the insurance company, but a third party had no such right, because there was no privity between him and the insurance company, and it was difficult to see how a special right could be said to exist against the insurance company, or any right to claim money paid over by the insurance company, merely because the assured happened to be in financial difficulties. (802–803)

SMITH V HORLOR [1930] NZLR 537

60 In this case Reed J applied the pre-existing law in *Harrington* and *Hood's Trustees*, and held that the proceeds of an insurance policy passed to a trustee under an assignment, by the insured, of "all real and personal estate" for the benefit of his creditors before the time at which the third-party obtained judgment against the insured. Like the English judges, Reed J came to this conclusion with regret, saying that

> [i]t is undeniably a hard case. So also were the two English cases, in which similar regret was expressed and in which suggestions were made that legislation should be introduced to meet a similar situation should it arise. It has been done in New Zealand by the Motor Vehicles Insurance [(Third-party Risks)] Act 1928 which, however, was not passed in time to affect this case. (544)

The Motor Vehicles Insurance (Third-party Risks) Act 1928 (NZ) section 10

61 The Motor Vehicles Insurance (Third-party Risks) Act 1928 (NZ) s 10 came into force on 9 October 1928. Speaking on the introduction of the Bill enacted as the 1928 Act, the Attorney-General explained to members that the Bill was meant to deal with motor vehicle accidents where victims were injured or killed. The long title to the Act described it as an Act to "require the Owners of Motor-vehicles to insure against Liability to pay Damages on account of Deaths or Bodily Injuries caused by the Use of . . . Motor-vehicles." In the late 1920s the use of motor vehicles on New Zealand roads was increasing, although motor vehicles were

relatively new to New Zealand at the time. Proceedings for damages for personal injury by accident could then still be taken – the bar on proceedings for damages for personal injury would of course not be introduced until the Accident Compensation Act 1972. The 1928 Bill was meant especially, the Attorney-General's speech introducing it advised members, to address the dangers that the increasing use of motor vehicles caused to New Zealanders' *persons*:

> it appears to be the function of the State primarily to protect the lives and ensure the safety of the people, but so far as property is concerned, that is a function which individuals can look after themselves. In dealing with this matter we have in this Bill dealt only with the questions of accidents and injuries to persons. ((1928) 219 NZPD 589, 590)

62 The Attorney-General referred to the growing death toll on the roads, and to an increase in numbers of convictions for dangerous driving (from 4259 in 1926 to 5171 in 1927).[9] Responding to these trends, the 1928 Act introduced a compulsory insurance regime. Added to that regime were provisions to avoid the consequences of *Harrington* and *Hood's Trustees*.

63 To ensure that the injured third party did not have to share the insurance money with other creditors of the insured, the 1928 New Zealand Act used a "charge" no doubt because since 1900 there had been a comparable provision in the workers' compensation legislation.[10]

64 Section 10 of the 1928 Act allowed an injured third party to stand outside the insolvency regime. It applied "after the happening of an accident giving rise to a claim for damages" where the owner of the car was indemnified for liability to the third party under a contract of insurance taken out under the 1928 Act and the insured

- died insolvent, or
- made a composition or arrangement with his or her creditors, or
- was a body corporate subjected to winding up proceedings.

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[9] While not comparable, the fact that in 1995 there were 64 247 convictions for traffic offences is an indication of the increase since 1928 in the use of motor vehicles in New Zealand: Ministry of Justice, 1996, 88.

[10] Workers' Compensation for Accidents Act 1900 s 17, Workers' Compensation for Accidents Act 1908 s 19, Workers' Compensation Act 1908 s 42, and Workers' Compensation Act 1922 s 48. Both the 1908 and 1922 statutes expressly made compensation claims provable in bankruptcy (s 47, s 53 respectively).

In such cases the Act gave the third party a charge over the insurance money payable whether the insured was bankrupt at the time of the accident or later became bankrupt, and whether or not the insured's liability to the third party was determinate: s 10(1).

65 Because s 10 could apply to charge the same insurance money with more than one liability to a third party, it also provided for the relative priority of multiple charges. If insufficient money was available to pay two or more claims by third parties, claims would be met in the same order as accidents had occurred (but by reference only to dates, and not times within the same date): s 10(2).

66 Third parties could enforce a charge under the Act by an action against the insurer. Section 10(3) provided that a third party may bring such proceedings "in the same way as if brought by the insured" – presumably to avoid any privity argument based on a third party not being a party to the contract of insurance (eg, see para 59: *Hood's Trustees* [1928] 1 Ch 793, 802–803, per Tomlin J). An action to enforce the charge could be brought even though proceedings had already been issued (and a judgment obtained and enforced) against the insured: s 10(4).

67 Section 10 was intended to apply only to insolvent entities, so if a company went into liquidation voluntarily (for the purposes of reconstruction, or to amalgamate with another body corporate) then the charge would not attach: s 10(5).

68 Finally, s 10 included two provisions protecting an insurer. First, any payment made by an insurer without actual notice of the existence of the statutory charge continued to be an effective discharge of the insurer's contractual (and, over-riding statutory) duties, despite the insurer having actually paid the insurance money to the wrong person: s 10(6). Secondly, where an insured's rights were enforceable as a charge by a third party, s 10(7) provided clearly that the insurer would not be liable beyond the limits of the contract of insurance. The purpose of s 10(7) seems to have been to ensure that in an action a third party brought to enforce the charge an insurer had the same defences as it would have had if the insured had been the defendant. But this consequence was not provided for explicitly.

Jorgensen v Findlater

69 Considering s 10(1) of the 1928 Act in *Jorgensen v Findlater* [1931] GLR 403, Myers CJ held that because the insured's liability to pay damages ended with his death in the accident, the insurance company could not be held liable to the third party because it was not

liable to the insured.[11] The Chief Justice said that the purpose of s 10(1) was

> to create a charge in respect of any existing liability that there may be and to prevent the injustice that was shown to exist in such cases as *In re Harrington Motor Company Ltd, ex parte Chaplin*, and not (as I think) to create a new liability on the part of either the owner of a motor vehicle or the insurance company except of course to the extent of covering the extended liability under s 3(1). (407)

The "extended liability under s 3(1)" refers to the Act applying to insurance cover for liability arising from a person other than an owner driving a motor vehicle.

How Part III (section 9) extended the 1928 Act

70 The Law Reform Act 1936 kept the 1928 Act technique of the charge, but departed from the 1928 Act in:

- *Applying to indemnity policies for any damage*: The 1936 Act applied not only to contracts of insurance dealing with third party risks under a motor vehicle policy (as the 1928 Act had), but also to contracts of insurance to indemnify an insured against "liability to pay any damages or compensation": s 9(1). Introducing to the House of Representatives the 1936 Bill that would enact Part III, the Attorney-General, the Hon Mr Mason, said:

  > Part III simply consolidates some existing provisions, which provide that where there is wrong perpetrated by a person who is insured the injured person can have a lien on the insurance-moneys. That already exists in the law in respect of the Workers' Compensation Act, and also there are provisions in the Motor-vehicles Insurance (Third-party Risks) Act in relation to the matter. There was a provision of that sort in regard to the Deaths by Accidents Compensation Act, and *instead of making a third provision the Law Draftsman thought it better to consolidate them all and make a general rule, which he has done in Part III to cover all cases of that description*. ((1936) 247 NZPD 237, emphasis added)

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[11] Only with the enactment of the Law Reform Act 1936 ss 3(1)–(2) was the law in New Zealand changed so that a deceased insured's cause of action against an insurer could survive the insured's death and so be maintained by an administrator of the deceased insured's estate. Where the insurer's liability arose under a policy of insurance taken out before 1 June 1937 under the Motor-vehicles Insurance (Third-party Risks) Act 1928, special time limits applied: s 3(7). It seems likely that this part of the 1936 New Zealand Act was modelled on the virtually identical change to the law in the United Kingdom made by the Law Reform (Miscellaneous Provisions) Act 1934 s 1(1). See para 75 for comments by Sir William Jowitt.

The words in italic suggest that s 9 in Part III extended inadvertently the 1928 Act provisions.

- *Attaching the charge not on the accident but on the "event giving rise to claim"*: Section 9(1) provides that the charge attaches "on the happening of the event giving rise to the claim for damages or compensation," rather than as s 10(1) of the 1928 Act provided "after the happening of the accident." The new wording is problematic in its application to policies under which the insured's indemnity becomes payable neither on the accident occurring nor on the injured third party making the claim for damages or compensation. Under so-called "claims made policies" (see paras 36–38) the insured is indemnified only if the third party makes the claim during a specified period. Questions arise especially about whether or not a s 9 charge attaches to an indemnity paid under a claims made policy that an insured took out only after the event in which the third party was injured.
- *Clarifying that insured affected even where insolvency arose only after liability*: If the insured was subjected to bankruptcy or winding up only after the date of the event giving rise to the insured's liability, s 9(2) deemed the insolvency administration to have commenced not later than the "happening of the event giving rise to" the claim of the injured third party.
- *Priority of charges*: The new Act clarified that if events giving rise to rights under a contract of insurance arose on the same day, then charges based on the rights rank equally as between themselves: s 9(3).
- *Requirement of leave for third party to enforce charge*: A proviso to s 9(4) added this requirement for cases where the bankruptcy or winding up was not in effect at the date of the event giving rise to the claim (see further para 106).

1957 Amendment to supply defendant if insured died solvent with no administrator

71 Neither s 10 of the 1928 Act nor s 9 of the 1936 Act included a provision to give an injured third party someone to claim against where the insured died solvent and no one had sought a grant of administration of his or her estate. Only from 24 October 1957, when the Law Reform Amendment Act 1957 was given the Royal Assent and came into force, was an injured third party guaranteed someone to claim against. Attorney-General the Hon Mr Marshall

described to members the purpose of the 1957 Amendment Act provisions as being

> to avoid a procedural difficulty that arises where a person desires to claim damages or compensation the liability for which is covered by insurance, but the person who would be primarily liable is deceased and there is no person willing to take out administration in his estate. In those circumstances there is no one whom the claimant can sue so he has a right without a remedy, and it is a principle of the law that no person who has a right should be without a remedy. The clause [enacted as s 9A of the 1936 Act] provides that a person so placed may pursue his claim by this procedure, in that he may give notice to the insurer requiring the insurer to nominate a defendant, that is a person against whom a claim may be taken and if the insurer fails within fourteen days to nominate a person the claimant can apply to the Court to appoint the Public Trustee to act in that capacity. ((1957) 314 NZPD 3047; committal of Statutes Amendment Bill 15 October 1957)

OVERSEAS LEGISLATION

The Third Parties (Rights Against Insurers) Act 1930 (UK)

72 The Third Parties (Rights Against Insurers) Act 1930 (UK) came into force on 10 July 1930. The long title to the Act describes it as an "Act to confer on third parties rights against insurers of third-party risks in the event of the insured becoming insolvent, and in certain other events." It differed from New Zealand's 1928 Act by applying to policies of insurance covering injuries to property as well as to persons,[12] and by using the technique of assignment rather than attachment of a charge. The assignment gives the third party the insured's rights against the insurer under the contract of insurance outside any insolvency regime to which the insured is subject.

73 Section 1(1) assigns to an injured third party an insured's cause of action against an insurer (so that the third party stands outside the insolvency regime) if before or after the event giving rise to the right of indemnity the insured

- became bankrupt or made a composition with his or her creditors, or
- was a company – other than a company in liquidation for re-construction or amalgamation (s 1(6)) – that was wound up or

[12] Section 1(1) of the Act refers, generally, to "any contract of insurance [whereby] a person . . . is insured against liabilities to third parties which he may incur."

made subject to a receivership (or, after the Insolvency Act 1986 (UK) was enacted, was made subject to administration orders or voluntary arrangements).

74 The cause of action is also assigned where a person's estate is sequestrated in Scotland: s 1(2). There is no right to contract out of the Act: s 1(3). The insurer's liability to the third party will never be greater than it would have been to the insured: s 1(4)(a). Where there is a shortfall to a third party, the third party retains the right to sue the insured or to prove with other creditors for that shortfall: s 1(4)(b). Third parties are also given rights to receive all information necessary to bring claims directly: s 2. Finally, agreements between insurer and insured to settle a claim are not valid if made after the commencement of the insolvency regime: s 3.

75 The UK Act concerns only insolvency. Claims against an insured who has died solvent were purposely excluded because under the then law the death extinguished the third party's claim. Introducing the Bill enacting the 1930 Act, Sir William Jowitt reminded the Commons that the Bill had nothing "to do with the effect of death on the [insurance] contract because hon. Members will know that as a rule personal actions come to an end by the death of either of the parties concerned": (1929–1930) 231 HC 128. The quotation also suggests that the application of the 1930 Act to insurance for all forms of liability to third parties may have been unintended. Certainly the case of *Harrington* was mentioned in convincing members of the need for the Bill (128–130).

76 So the 1930 UK Act does not apply if an insured dies solvent. A third party in such a case must pursue a personal representative of the insured who, representing the insured's estate, will be entitled to be paid the insurance money by the insurer. The 1930 UK Act is currently under joint review by the Law Commission (England and Wales) and the Scottish Law Commission – a joint consultation paper defining certain issues was published in 1998: *Third Parties (Rights Against Insurers) Act 1930: A joint consultation paper*.

Australian legislation

77 Australian provisions that – like s 9 of the 1936 New Zealand Act – attach to insurance money a charge in favour of an injured third party include:

- Law Reform (Miscellaneous Provisions) Act 1946 s 6 (NSW)
- Law Reform (Miscellaneous Provisions) Act 1955 (ACT) ss 25–28

- Bankruptcy Act 1966 (Aust) s 117 and Corporations Act 1989 (Aust) s 562 (compare the former Companies Act 1981 (Aust) s 447)[13]
- Law Reform (Miscellaneous Provisions) Act 1992 (NT) ss 26–29.

78 Before 1 January 1986, when s 51 of the Insurance Contracts Act 1984 (Aust) came into force, in cases where the insured had died the third party usually had to bring an action against the estate of the insured. This requirement could prejudice the third party if no one had been granted administration of the insured's estate. In such a case, to obtain a defendant, the third party had to have appointed an administrator *ad litem*.

79 An exception was the limited area of compulsory third party motor vehicle insurance, where state legislation (eg, Motor Vehicles Act 1959 (SA) s 113(1)) might give the third party a right to proceed directly against the insurer in cases where the insured driver was dead or could not be found. In cases where the insured could not be found insurers had been known to defeat claims by third parties by insisting that proceedings be served on or judgments enforced against insureds who would be difficult or impossible to locate.

80 To prevent such prejudice to injured third parties, the Australian Law Reform Commission recommended in *Insurance Contracts* (paras 338–340) that the exception become the rule. Legislation giving third parties a right to proceed directly against insurers where an insured was dead or could not be found should be extended to insurance generally. From 1 January 1986 s 51 of the Insurance Contracts Act 1984 (Aust) has given third parties the entitlement recommended.

SECTION 9

81 Section 9 of the Law Reform Act 1936 raises two main questions:
- Is it proper that a third party continue in effect to be granted priority over other creditors in the insured's insolvency? (for background see Affleck, 1995, 439–445)
- If a third party should be granted an effective priority, then by what general technique should this purpose be achieved?

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[13] On which see Australian Law Reform Commission, 1982, paras 338–340, and 1988, paras 759–764.

Should injured third parties' priority over other creditors of the insured continue?

82 Section 10 of the 1928 Act, and its successor s 9 of the 1936 Act (applying to policies indemnifying for any liability and not only liability for personal injury) were both designed to place insurance moneys outside bankruptcy and winding up legislation. In enacting these provisions the New Zealand Parliament accorded the claims of injured third parties a greater priority in the insured's insolvency than that accorded to the claims of other creditors. In his introductory speech the Attorney-General described the effect of the provision enacted as s 9 by saying that if the insured "happened to become bankrupt the insurance moneys will necessarily go to the injured party, and not to the Official Assignee": (1928) 219 NZPD 589, 601. Notably, over 60 years later in *FAI (NZ) General Insurance Co Ltd v Blundell & Brown Ltd* [1994] 1 NZLR 11, 15, 18, 26, the members of the Court of Appeal noted this priority without question.

83 Affleck argues that s 9 is inconsistent with existing insolvency legislation because on the insured's insolvency a third party's claim for damages or compensation for injury is satisfied before the claim of any other unsecured creditor (on preferences generally, see Heath, 1996; and Cantlie in Ziegel, 1994, 413). Affleck would accord no preference to the third party's claim because:

- The introduction in 1972 of a universal accident compensation scheme means that actions today are usually those for property damage or economic loss, and not to compensate for personal injury (a main purpose of the original 1928 Act).
- A third party with a claim in tort is no different in practice from any other involuntary creditor (eg, an unpaid supplier of goods not protected by a retention of title clause, or the Crown claiming for unpaid revenue). The Report of the Insolvency Law Review Committee (chaired by Sir Kenneth Cork GBE) on *Insolvency Law and Practice* concluded that involuntary creditors in an insolvency should receive no priority over other unsecured creditors (chapters 32–33).
- The third party's priority seems unprincipled because it depends upon whether the insured has taken out liability insurance for liability for the particular kind of injury the third party suffers. The insured is under no duty to insure against third party risks.[14]

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[14] Motor vehicle owners' duty to insure against liability for injuring the person of a third party in s 3 of the Motor Vehicles Insurance (Third Party Risks) Act 1928 was re-enacted in s 67 of the Transport Act 1949 and in s 79 of the Transport Act 1962, repealed as from 1 April 1974 (SR 1973/167/2) by s 22(1) of the Transport Amendment Act 1972. The last provision requiring employers

- The insurance was taken out and paid for by the insolvent for the benefit of the insolvent. As Affleck says "[i]t is unrealistic to think the insured obtains insurance to protect third parties in the event of the insured's insolvency" (Affleck, 441). Consequently the benefit of the insurance moneys should be enjoyed by all unsecured creditors of the insolvent, and not only by the injured third party who, after all, was not a party to the contract of insurance.

84 Affleck would, however, accord an injured third party's claim priority over that of other unsecured creditors if the liability of the insured arose after the insured became insolvent, in order to prevent the insurer receiving a windfall (441). The reason for this is because either:

- the official assignee or liquidator would, because of cost or uncertainty of success, not pursue a claim against the insurer; or
- a term of the contract of insurance would purport to avoid the insurer's liability on the insolvency of the insured.

85 It might also be argued that if the priority of an injured third party was removed, other unsecured creditors of the insolvent would be unjustly enriched, because they would receive insurance money meant to pay *only* for the cost of compensating the third party for his or her injury. The possible perversity of the law before the 1928 Act was illustrated in *Harrington Motor Co* [1928] 1 Ch 105 when Atkin LJ said that

> it would appear as though a person who is insured against risks and who has general creditors whom he is unable to satisfy, has only to go out in the street and to find the most expensive motor car or the most wealthy man he can to run down, and he will at once be provided with assets which will enable him to pay his creditors quite a substantial dividend! (124)

86 To similar effect is the statement in the Australian Law Reform Commission *General Insolvency Inquiry* report that

> the rationale for this priority [for the injured third party] would appear to be that an individual who would have been entitled to the proceeds of an insurance claim could be very adversely affected if insurance money which has been generated because of their claim is pooled on behalf of all creditors. (para 759)

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to insure against liability to pay compensation appears to have been s 82 of the Workers' Compensation Act 1956, repealed from 1 July 1992 by s 179(1) of the Accident Rehabilitation and Compensation Insurance Act 1992. However, there is still on the books a requirement for air carriers to insure against specified consequences: see Carriage by Air Act 1967 ss 22 and 29.

87 Although the cost of pursuing a claim is a factor which is equally relevant in a pre- or post-insolvency setting and not unique to insurance contracts, when coupled with the widespread community expectation that a third party's loss will be met from insurance moneys available to the insured, it becomes arguable that the de facto priority should remain.

88 Review of corporate insolvency law cannot be deferred indefinitely. Whether an injured third party's s 9 priority should remain is a question which should be considered in a comprehensive review of corporate and personal insolvency. On 24 June 1997 the Hon John Luxton MP, Minister of Commerce, responded to a question for written answer of the Rt Hon Mike Moore MP by saying:

> The primary legislation in relation to receiverships is the Receiverships Act 1993, which was enacted as part of the 1993 company law reform package, and codified the common law relating to the conduct of receiverships. The Ministry of Commerce will review the Receiverships Act as part of a comprehensive review of insolvency law. That review will be commenced with the release, by the end of 1997, of a discussion paper on the framework for insolvency law. The insolvency review will be a long term project, and is likely to take at least three years to complete. This will allow, among other things, for monitoring of the impact of the Receiverships Act 1993. No substantial legislative changes to the Act are proposed before the review is completed. (House of Representatives, *Replies Supplement 97.18* (24 June 1997), 65–66, Q10245)

89 Parliament removed another form of priority when it repealed as from 1 July 1988 the Wages Protection and Contractors' Liens Act 1939.[15] Depending on the weight to be properly attributed to the factors mentioned above, a complete review of insolvency law might conclude either that s 9 is:

- inconsistent with the principles underlying the insolvency legislation and should therefore be repealed, or
- a justifiable exception to the "with equal priority" (*pari passu*) rule that should be retained.

90 In determining whether, at this stage, to make any amendments to s 9 it is important to bear in mind:

- that s 9 applies in other than insolvency situations;
- that there are existing practical problems (particularised in para 98) that should be attended to without delay;

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[15] Wages Protection and Contractors' Liens Act Repeal Act 1988. See too the dissenting judgment of Williamson J in *Attorney-General v McMillan & Lockwood Ltd* [1991] 1 NZLR 53, 67–68.

- there is likely to be a community expectation that a third party's loss will be met from insurance moneys available to the insured (to which we refer in para 87); and
- although there is a priority, it is not at the expense of other creditors if the consequence of the lack of an efficient protection is that a liquidator or official assignee is disinclined to pursue the indemnifier.

The latter two points suggest that there is sufficient reason to justify amending s 9 at this time.

By what general technique should the section 9 priority be achieved?

91 The current s 9 priority for the injured third party might be achieved by:

- "Assigning" the insured's rights against the insurer
  - to the third party – as in s 1 of the Third Party (Rights Against Insurers) Act 1930 (UK), or
  - to the official assignee or liquidator also subjected to a personal duty to pay the injured third party – as in the Bankruptcy Act 1966 (Aust) s 117 and Corporations Act 1989 (Aust) s 562);
- "Impressing with a trust" the insurance money payable by the insurer to the insured;
- "Fixing a charge" in favour of the third party over the insurance money payable by the insurer to the insured – as in the Law Reform Act 1936 s 9 (NZ) and the Law Reform (Miscellaneous Provisions) Act 1946 s 6 (NSW); or
- "Extending privity" to the third party so that he or she may sue the insurer for a benefit that the insurance contract between insurer and insured confers – as provided generally by the Contracts (Privity) Act 1982 (NZ) s 4,[16] and for insurance by the Insurance Contracts Act 1984 (Aust) s 48.

92 Charges would provide the necessary protection, but only with complicating property connotations. In *Grimson v Aviation and General (Underwriting) Agents Pty. Ltd* (1991) 25 NSWLR 422, 428, Meagher JA said of the New South Wales section attaching a charge to insurance moneys payable: "It is, on any account, a somewhat curious section because it purports to grant a charge or

[16] For a discussion of the difficulties a third party injured faces in using the 1982 Act to enforce an insurance contract for his or her benefit, see Brian, 1996.

security but not over any property." Using a trust would require complex and changing definitions of the property subject to the trust, the trustee, and the beneficiary. Using a charge may leave undesirable uncertainty, because such a charge may (at least theoretically, if not to date in practice) be open to attack under either the voidable preference or transaction provisions in ss 56–57 of the Insolvency Act 1967, or the voidable security/charge provisions in ss 292–293 of the Companies Act 1993. Assignments introduce the possibility of confusion given the general statutory assignment of property on bankruptcy (see Insolvency Act 1967 s 42(2)). Use of the charge, assignment, or trust also raises the question whether the insurer may raise – as a defence to the third party's action to enforce the charge, assignment, or trust – any defence it would have had to an action by the insured to enforce the contract of insurance.[17]

93 Extending privity would therefore seem to be the most apt technique for protecting the injured third party. It would address most directly the original mischief. In *Hood's Trustees v Southern Union General Insurance Co of Australasia Ltd* [1928] 1 Ch 793, 802–803 Tomlin J attributed the injured third party's difficulty to his or her lack of privity of contract with the insurer (see para 59). While both the insured and the third party may expect the insurer to pay the third party's loss, the insurer's contractual duty to indemnify is owed only to the insured.

94 Section 4 of the Contracts (Privity) Act 1982 ameliorates "the rigours of the privity doctrine" for contracts generally.[18] We recommend that s 9 be replaced by a new provision deeming the benefit of the contract of liability insurance to be one that is recoverable by the third party under s 4 of the Contracts (Privity) Act 1982.

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[17] Affleck notes that s 9 does not answer this question as the proviso to s 6(4) of the Law Reform (Miscellaneous Provisions) Act 1946 does by providing that courts shall not grant the leave usually required to enforce the charge if satisfied that the insurer is entitled under the contract to disclaim liability (1996, 634). However, Affleck adds that the decision in *Lissenden v Yorkville Nominees Pty Ltd (in liq) and Ors* (1984) 3 ANZ Ins Cas 60-597 clarifies that the reference in s 9(1) of the New Zealand Act to insurance money "that is or may become payable" entitles an insurer to deny liability for breach of a condition precedent to liability before the event giving rise to liability.

[18] Todd, 1993, 217, citing the Report to the Minister of Justice of the Contracts and Commercial Law Reform Committee, *Privity of Contract* (1981). Compare Law Commission (England and Wales), 1996; the legislation the report recommends has apparently not yet been enacted in the United Kingdom.

SHOULD SECTION 9A BE RETAINED, MODIFIED OR EXTENDED?

95 We know of no reason why a provision like s 9A should not be retained. In cases where no one has been granted probate or letters of administration of the estate it supplies an essential practical benefit to the injured third party: a defendant. Indeed, we are of the view that there are two circumstances which justify its extension.

96 First, for the reasons identified by the Australian Law Reform Commission (see para 80), we recommend s 9A should be modified and extended to the like case where an insured is not dead but merely cannot reasonably be found.

97 Secondly, we recommend that a corporate insured which has been removed from the register of companies under s 317 Companies Act 1993 or has otherwise been dissolved or ceased to exist (where not a company subject to the 1993 Act), should be treated analogously to a deceased individual so that the third party may retain the benefits of the policy.

HOW CAN PART III BE MADE MORE WORKABLE IN PRACTICE?

98 Pending the review of corporate insolvency law mentioned in para 88, problems Part III has shown in practice might be remedied by new provisions answering the following questions:

- What time limits should apply to a third party's claim?
- Should "claims made" policies be included?
- What insolvency regimes should be affected?
- Must the third party get an empty judgment or put the insured into an insolvency?
- In what cases should third parties require leave to sue an insurer directly?
- In what circumstances should leave be granted?
- What insurance policy terms should be of no effect?
- How should two or more third party claims abate where the insurance money is insufficient to satisfy fully each claim?
- What payments should be a valid discharge of an insurer's liability?
- Should there be duties to disclose information third parties need in order to claim?

WHAT TIME LIMITS SHOULD APPLY TO A THIRD PARTY'S CLAIM?

99 New Zealand and New South Wales judges have expressed different views on whether a third party's proceedings to enforce a charge

against an insurer must be brought

- *only* within the time for proceedings by the third party against the insured, or
- *also* within the time for proceedings by the insured against the insurer.

100 The wording of s 9(4) and its New South Wales equivalent affect this question. As Baragwanath J stated in *UEB Packaging Ltd v QBE Insurance (International) Ltd* [1996] 2 NZLR 467, 481:

> Unless the statutory cause of action by the [injured third party] plaintiff against the insurer shadows the cause of action against the insured, the clear language of s 9(4) "the same rights and liabilities" is departed from.[19]

101 Disregarding the meanings that may reasonably be given to the words of the current provisions, what limitation period should apply? Given the purpose of granting a third party direct access to the insurer where the insured is insolvent or has disappeared or died, there seems to be no reason why if the third party has brought proceedings against the insured within time, the third party must also bring further separate proceedings against the insurer within the time the insured has to proceed against the insurer. It is likely that an insured will notify its indemnifier if a third party issues proceedings against it in time and, if it does not, the insurer may have other defences against the insured which would also prevail over the third party. No prejudice is apparent to the insurer if another set of proceedings is not issued within the limitation period as against the insured. However, much prejudice may result to the third party whose right to recompense may be lost. It also seems wrong for a third party who has prosecuted diligently a claim against an insured to be met by a limitation defence where the insured has (from the third party's perspective) been unexpectedly placed into an insolvency regime after expiration of the limitation period as against the insurer. We therefore recommend that new provisions to replace s 9 clarify:

- that time ceases to run against the third party once proceedings are issued against the insured, and

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[19] Affirmed without a decision on this point being necessary *UEB Packaging Ltd v QBE Insurance (International) Ltd* (unreported, 19 December 1997, CA 169/96). See too Meagher JA's words on the corresponding New South Wales provision: "The basic reason why the plaintiff must fail is that s 6(4) expressly provides that the plaintiff in a statutory action 'shall . . . have the same rights and liabilities . . . as if the action were against the insured' ": (1991) 25 NSWLR 422, 428.

- despite the clarification above, that an insurer's liability to a third party is not to exceed the insurer's contractual liability to the insured.

SHOULD CLAIMS MADE POLICIES BE INCLUDED?

102 Paragraphs 35 and 39–40 mention that the way s 9 is worded – particulary subs (1) – has led to different views about whether it applies to claims made policies (defined in paras 36–38) (see discussion in Affleck, 1996, 647–649). As Robertson J noted in *FAI (NZ) General Insurance v Blundell* [1994] 1 NZLR 11, 25, in 1936 the New Zealand Parliament may not have contemplated these policies. Affleck suggests that liability insurance was not commonly available in 1936 and that claims made policies may have been first discussed by textbooks only in the 1960s (Affleck, 647). The problem is most acute in cases where the claims made policy does not even exist at the critical time under s 9(1): "on the happening of the event giving rise to the claim for damages or compensation." The s 9(1) references to a person who has "entered into a contract of insurance" and "[insurance moneys] that are or may become payable" in respect of liability under such a contract may well mean that for a charge to attach to insurance money, an insurance contract must exist when the event occurs that gives rise to a third party's claim. For clarity we recommend that new provisions apply to all insurance policies, which includes claims made policies.

WHAT INSOLVENCY REGIMES SHOULD BE AFFECTED?

103 Ways by which an insured might be subjected to an insolvency regime include:

- administrative means (eg, a receiver appointed by a debenture holder);
- judicial order (eg, bankruptcy, some liquidations, and proposals under Part XV of the Insolvency Act 1967); or
- voluntary action (eg, some forms of liquidation, and some compromises under Part XIV of the Companies Act 1993).

Any statutory list of insureds able to be subjected to insolvency regimes would be cumbersome and require careful ongoing monitoring for accuracy and completeness (for entities that can be subjected to insolvency regimes, see *Laws NZ*, Insolvency, para 3). However, not referring to particular regimes may impose on third parties the greater costs of seeking leave to proceed despite the form of insolvency regime to which the insured has been subjected being no different in kind from a bankruptcy or liquidation. Provisions to replace s 9 should allow a third party as of

right (that is, without the leave of the court) to proceed directly against an insurer where an insured:

- is subject to a statutory or contractual regime under which the assets of the insured have been, or will be, realised for the benefit of its secured or unsecured creditors; or
- has died and his or her estate is being administered under Part XVII of the Insolvency Act 1967.

MUST THE THIRD PARTY GET AN EMPTY JUDGMENT OR PUT THE INSURED INTO AN INSOLVENCY?

104 Should a third party, before being able to sue an insurer directly, be required to go to the cost of seeking, obtaining, and trying in vain to enforce an empty judgment against an insured known to be insolvent? As Richardson J said succinctly in *FAI (NZ) General Insurance v Blundell* [1994] 1 NZLR 11:

> If the insured is apparently impecunious there can be no justification for postponing recourse against the insurer and expecting the claimant to bear the cost and effort of pursuing other possible defendants. (15)

Similarly we can see no reason to force a third party to put the insured into an insolvency regime so that the third party might then exercise rights outside the insolvency regime.

IN WHAT CASES SHOULD THIRD PARTIES REQUIRE LEAVE TO SUE AN INSURER DIRECTLY?

105 We also recommend that a third party be allowed to proceed directly against an insurer if the third party proves to the satisfaction of the court that the insured:

- would be unable to pay from his or her own money the debts provable on bankruptcy or liquidation as they fall due; or
- has died and more than 60 days have elapsed without appointment of an administrator of the insured's estate;
- cannot, after reasonable inquiry, be found; or
- being a corporation, has been removed from the New Zealand register under s 317 of the Companies Act 1933 or has otherwise been dissolved or ceased to exist.

IN WHAT CIRCUMSTANCES SHOULD LEAVE BE GRANTED?

106 In *Campbell v Mutual Life and Citizens Fire and General Insurance Company (New Zealand) Ltd* [1971] NZLR 240, 243 Roper J stated that leave should be refused only where a "perfectly good common law defendant" was available to the third party. In *FAI (NZ) General Insurance v Blundell* [1994] 1 NZLR 11, 15, 19, 22, Richard-

son, Hardie Boys and Robertson JJ adopted Roper J's test and put at a relatively low level the threshold for granting leave to the third party. The Court of Appeal accepted that an insolvent insured is not the "perfectly good common law defendant" that the test requires. It also considered that, given the purpose of s 9, the existence of other defendants was not a bar to granting leave. The Court concluded that an arguable or prima facie case against the insurer was all that was required for leave to be granted. To clarify the law we recommend that leave be granted to any third party who satisfies the preconditions and shows a prima facie case against an insurer.

WHAT INSURANCE POLICY TERMS SHOULD BE OF NO EFFECT?

107 Because they might undermine or avoid the achievement of the purpose of provisions to replace s 9, we recommend that two types of policy terms be made of no effect. First, it may be a term of a liability insurance policy that the insured's right to be indemnified arises only if a third party obtains judgment against the insured (see, for example, *Post Office v Norwich Union Fire Insurance Society Ltd* [1967] 2 QB 367, approved in *Bradley v Eagle Star Insurance Co Ltd* [1989] AC 957). This will not be so under the provisions we recommend which treat the contract of insurance as one for the benefit of the third party. Secondly, new provisions should also state that a term of an insurance contract is of no effect if that term

- seeks to prevent an insured disclosing to a third party that the insured has liability insurance cover or the terms of that cover, and/or
- allows the insurer to avoid the contract of liability insurance if the insured discloses this kind of information.

This recommendation is consistent with the duties we recommend in para 111.

MULTIPLE CLAIMS TO INSUFFICIENT INSURANCE MONEY

108 Section 9(1) charges currently rank in the order of the events that gave rise to the insured's rights under the contract of insurance: s 9(3). But the 1936 Act introduced an exception: if the events giving rise to the insured's rights arose on the same day, then charges arising out of those events rank equally with each other.[20] We

[20] Both provisions are in marked contrast to the "first in first served" effect of the English statute: see *Cox v Bankside Members Agency* [1995] 2 Lloyds' Reports 437.

consider the approach of the exception to be more equitable than that of the rule, which makes the rights of third parties depend on the order in which events giving rise to liability chance to happen, rather than on the nature of the injury or on any diligent prosecution of action by a third party who has suffered loss. We therefore recommend that the exception displace the rule entirely: where the insurance money is insufficient to satisfy fully two or more third party claims, each claim should abate proportionately.

WHAT PAYMENTS SHOULD BE A VALID DISCHARGE OF AN INSURER'S LIABILITY?

109 Any payment that an insurer, before having received notice that the insured is insolvent, makes to an insured should be a valid discharge of the insurer's duty to both the insured and the third party. New provisions should also provide that an insurer's payments to an administrator of an insolvent insured's estate or property are not a valid discharge of the insurer's duties. In this case the insurer must know that the insured is insolvent.

110 It is desirable, however, that insurers be entitled to rely on settlements entered into before the proposed legislation comes into force. We therefore recommend that nothing in our proposed legislation affect any discharge of an insurer's liability under a contract of insurance when the discharge was concluded before the date on which the new legislation comes into force.

SHOULD THERE BE DUTIES TO DISCLOSE INFORMATION THIRD PARTIES NEED IN ORDER TO CLAIM?

111 To help third parties exercise their rights responsibly and quickly, s 2 of the Third Parties (Rights Against Insurers) Act 1930 (UK) obliges insurers and others to supply to third parties information they need to make their claims. Provisions to replace ss 9 and 9A should provide similarly that:

- the insured, or insurer or any personal representative or insolvency administrator of the insured, must provide information relevant to a third party claim against an insurer; and
- apart from any duty to make discovery on an application before a proceeding, these persons must disclose for inspection and copying by a third party information relevant to the third party's claim against the insurer.

Third parties should be able have these duties enforced by originating applications to the High Court or a District Court.

RECOMMENDATION

112 We therefore recommend that Parliament replace Part III by enacting the following provisions which we recommend be inserted in the Insurance Law Reform Act 1977 as sections 11A to 11E (see pages 59–81 for our complete draft Insurance Law Reform Amendment Act and commentary).

11A Application of sections 11B to 11E

Sections 11B to 11E apply in respect of any contract of insurance entered into before or after the commencement of those sections under which the insurer promises to indemnify the insured in respect of the insured's liability to pay damages or compensation to another person ("the third party"), but do not affect a discharge of an insurer's liability under a contract of insurance which discharge was concluded before the commencement of those sections.

11B Insolvency or death of insured before payment

(1) The benefit of an insurer's promise under a contract of insurance to which sections 11B to 11E apply to indemnify the insured in respect of the insured's liability to pay damages or compensation to a third party is deemed to be a benefit conferred on the third party which is enforceable against the insurer by the third party under section 4 of the *Contracts (Privity) Act 1982* as if it were a promise by the insurer to pay such damages or compensation to the third party if, before payment is made by the insurer to indemnify the insured,

(a) the insured has become insolvent or, if the insured is deceased, the insured's estate is being administered under Part XVII of the *Insolvency Act 1967*; or

(b) the insured has been deceased for not less than 60 days and no administrator of the deceased's estate has been appointed in New Zealand; or

(c) the insured, being a corporation, has been removed from the New Zealand register under section 317 of the *Companies Act 1993* (if a company), or has otherwise been dissolved or ceased to exist; or

(d) the insured cannot, after reasonable inquiry, be found.

(2) An insured is insolvent for the purposes of this Act if the insured

(a) is subject to a statutory or contractual regime under which the assets of the insured have been or are to be realised for the benefit of secured or unsecured creditors; or

(b) is unable to pay the insured's debts that would be provable in bankruptcy or on a liquidation as they fall due and from the insured's own money.

11C Extent of insurer's liability in actions by third parties

(1) An insurer is not liable to a third party in an action brought under section 11B for any amount in excess of the amount of the insurer's liability provided for under the contract of insurance.

(2) If the amounts payable in respect of claims made against an insurer by one or more actions under section 11B exceed the amount for which the insurer is liable under the contract of insurance, those claims are to abate proportionately to their amounts.

(3) A payment made under the contract of insurance by the insurer to one third party without actual notice of a possible claim by any other third party constitutes, to the extent of that payment, a valid discharge to the insurer in respect of the claim of such other third party or third parties.

(4) A payment made under the contract of insurance by the insurer to the insured without actual notice that the insured is insolvent constitutes, to the extent of that payment, a valid discharge to the insurer in respect of the insured's liability to the third party.

(5) Nothing in this Act prevents the variation or discharge of an insurer's obligation under a contract of insurance at any time before the insurer has actual notice that the insured is insolvent.

(6) A payment made under the contract of insurance by the insurer to an insolvency administrator who has been appointed in respect of the insured's property or estate does not constitute a valid discharge to the insurer in respect of the insured's liability to the third party.

11D Duty to give necessary information to third parties

(1) Every insurer and every insured and any receiver, manager, trustee, liquidator, personal representative or other person in possession of the estate or property of the insured must, at the request of the third party, give to the third party such information as the third party may reasonably require to ascertain whether any promise of the insurer to indemnify the insured is one to which section 11B applies.

(2) The duty to give information under this section includes a duty to allow all contracts of insurance, receipts for premiums, and other relevant documents in the possession or power of the person on whom the duty is imposed to be inspected and copies of them to be taken.

(3) An application to enforce a duty imposed by this section may be made by originating application either in the High Court or in a District Court.

(4) A provision of a contract of insurance is of no effect if it purports, directly or indirectly,
   (a) to prohibit or prevent the giving of any information required to be given by this section; or
   (b) to avoid the contract or to alter the rights of the parties under it upon the giving of any such information.

11E Actions by third parties against insurers

(1) A third party may bring an action against an insurer under section 11B although judgment has already been entered against the insured for damages or compensation in respect of the same matter.

(2) Before commencing an action against an insurer under section 11B, a third party must obtain the leave of the court in which the action is to be commenced unless
   (a) the insured is subject to a statutory or contractual regime under which the assets of the insured have been or are to be realised for the benefit of secured or unsecured creditors; or
   (b) the insured's estate is being administered under Part XVII of the *Insolvency Act 1967*; or
   (c) the insured, being a corporation, has been removed from the New Zealand register under section 317 of the *Companies Act 1993* (if a company) or has otherwise been dissolved or ceased to exist.

(3) On an application by a third party for leave to bring an action against an insurer, the court must grant leave if it is satisfied that the third party has established a prima facie entitlement to bring such an action.

(4) If an action for damages or compensation is commenced by a third party against an insured within the time allowed by section 4 of the *Limitation Act 1950* and subsequently the third party commences an action under section 11B of this Act against the insured in respect of the same matter, section 4 of the *Limitation Act 1950* does not apply to that action against the insurer.

DRAFT INSURANCE LAW REFORM AMENDMENT ACT 199–

CONTENTS

1 Title
This Act is the *Insurance Law Reform Amendment Act 199–* and is part of the *Insurance Law Reform Act 1977* ("the principal Act").

2 Commencement
This Act comes into force at the end of 3 months beginning on the day on which this Act receives the Royal Assent.

COMMENTARY

Section 2

C1 Because in particular the new provisions as to non-disclosure are likely to necessitate a review by insurers of their proposal forms a lapse of 3 months following the Royal Assent is provided for.

3 New section inserted

The principal Act is amended by inserting after section 7 the following section:

"**7A Non-disclosure**

(1) Any right of an insurer to cancel a contract of insurance by reason of the failure of an insured to disclose a fact to the insurer before the contract is concluded may only be exercised, if the cancellation is to take effect from a date earlier than the date on which it is notified to the insured, within 10 working days of the risk first attaching.

(2) This section does not apply

(a) to contracts of reinsurance; or

(b) if the failure to disclose a fact is blameworthy; or

(c) if, before the contract is concluded, the insured answers a specific question expressly put by the insurer in a way that is substantially incorrect because of the failure to disclose a fact.

(3) A failure to disclose a fact is not blameworthy unless the insured knew, or in the circumstances a reasonable person could have been expected to know, both the undisclosed fact and that disclosure of the undisclosed fact would have influenced the judgment of a prudent insurer in accepting the risk or the terms of such acceptance.

Section 3 continues overleaf

Section 3

C2 This section inserts into the Insurance Law Reform Act 1977 a new s 7A intended to reform the law as to non-disclosure. Its placement in the 1977 statute positions it immediately following four sections (ss 4–7) concerned with mis-statement.

C3 The only remedy presently available to an insurer in the event of non-disclosure is to cancel the contract *ab initio*, that is, retrospectively from the start of the contract. *Subsection (1)* provides that that remedy may be exercised only within 10 working days of the risk first attaching.

C4 *Subsection (2)* provides exceptions to the rule set out in *subsection (1)*. The section will not apply and the right to cancel *ab initio* will survive in three circumstances only, namely:

- in the case of reinsurance contracts,
- if the non-disclosure is blameworthy, or
- if an answer to a specific question put by the insurer (usually, it may be expected, as part of a proposal form) is answered in a way that by reason of non-disclosure is substantially incorrect.

C5 *Subsection (3)* defines when non-disclosure is *blameworthy*. It is necessary that the insured should know both the undisclosed fact and that the failure to disclose it would have influenced the judgment of the underwriter. To make unnecessary the process of drawing inferences as to the extent of the knowledge of the particular insured, the subsection provides that it is enough if in the circumstances a reasonable person could have been expected to know those facts.

(4) For the purposes of subsection (2)(c),

(a) a question is not a specific question expressly put by the insurer if, in order to answer it, the insured must decide whether a fact is or might be relevant to the decision of the insurer to accept the risk or the terms of such acceptance; and

(b) an insured's answer to a question is substantially incorrect only if the difference between what is stated and what is actually correct would have been considered material by a prudent insurer.

(5) This section has effect despite any warranty by the insured that the insured's disclosure obligation has been complied with.

(6) For the purposes of subsection (1),

(a) a reference to a **risk first attaching** does not include the attaching of a risk on the issue of a policy replacing interim cover or on the reinstatement or renewal of a policy; and

(b) **working day** means a day of the week other than

(i) a Saturday, a Sunday, Waitangi Day, Good Friday, Easter Monday, Anzac Day, the Sovereign's birthday, and Labour Day; and

(ii) a day in the period commencing with 25 December in a year and ending with 2 January in the following year; and

(iii) if 1 January falls on a Friday, the following Monday; and

(iv) if 1 January falls on a Saturday or a Sunday, the following Monday and Tuesday."

Section 3 commentary continued

C6 *Subsection (4)(a)* is designed to avoid the reform being defeated by insurers posing such questions as "Are there any other facts material to the assessment of risk?" The specific question expressly put, as required by *subsection (2)(b)*, may not be one that leaves it to the insured to determine the issue of materiality. *Subsection (4)(b)* defines when an answer is substantially incorrect in terms analogous to s 6(1) of the 1977 Act.

C7 *Subsection (5)* is designed to avoid the reform being defeated by insurers stipulating for a warranty as to disclosure.

C8 *Subsection (6)(a)* defines **risk first attaching** used in *subsection (1)*. *Subsection (6)(b)* defines **working day**. *Subsection (6)(b)* copies the definition of working day contained in the Interpretation Bill now before Parliament; *subsection (6)(b)* will be unnecessary if that Bill is enacted.

4 Time limits on claims under contracts of insurance

Section 9 of the Principal Act is amended by adding the following subsections:

"(3) Subsection (1)(b) does not apply to a provision of a claims made policy that defines the period within which claims made against the insured or claims arising out of circumstances notified to the insurer are within the risk accepted by the insurer under the policy.

(4) In this section **claims made policy** means a contract of insurance in which the period during which liability for claims against the insured is within the risk accepted by the insurer is defined by reference to the time when such claims are made or claims or circumstances which may give rise to a claim are notified to the insurer."

Section 4

C9 This section adds two new subsections to the Insurance Law Reform Act 1977 s 9. That section provides that an insurer may never rely on time bars in an insurance contract limiting the time for making claims in the case of life policies and may rely on time bars in the case of other policies only if the insurer has been prejudiced. This provision causes difficulties where the time provision is not just procedural but as in claims made policies defines the risk that the insured has agreed to accept. *Section 4* adds two new subsections to the existing s 9 to make it clear that s 9 does not apply to provisions of claims made policies defining the risk.

5 New section substituted

The principal Act is amended by repealing section 11 and substituting the following section:

"**11 Increased risk exclusions**

(1) An insured is not bound by an increased risk exclusion if the insured proves on the balance of probability that the loss in respect of which the insured seeks 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.

(2) For the purposes of this section, an increased risk exclusion is a provision in a contract of insurance that

(a) defines the circumstances in which the insurer is bound to indemnify the insured against loss so as to exclude or limit the liability of the insurer to indemnify the insured on the happening of certain events or on the existence of certain circumstances; and

(b) so defined the liability of the insurer, in the view of the court or arbitrator determining the claim of the insured, because the happening of such events or the existence of such circumstances was in the view of the insurer likely to increase the risk of loss occurring.

(3) A provision is not an increased risk exclusion for the purposes of this section that

(a) defines the age, identity, qualifications or experience of a driver of a vehicle, a pilot of an aircraft, or an operator of a chattel; or

(b) defines the geographical area in which a loss must occur if the insurer is to be liable to indemnify the insured; or

(c) excludes loss that occurs while a vehicle, aircraft, or other chattel is being used for commercial purposes other than those permitted by the contract of insurance."

Section 5

C10 *Subsections (1)* and *(2)* of this section re-enact in modified form s 11 of the 1977 statute. That section prevents insurers relying on provisions excluding cover in situations of increased risk where the increased risk did not in fact cause the loss. It is unfair to insurers, however, to prevent their relying on such provisions where the excluded situation is one where loss becomes statistically more likely. *Subsection (3)* excludes from the operation of the section situations within that category.

6 New sections inserted

The principal Act is amended by inserting after section 11 the following headings and sections:

"

Insolvency or death of insured

11A Application of sections 11B to 11E

Sections 11B to 11E apply in respect of any contract of insurance entered into before or after the commencement of those sections under which the insurer promises to indemnify the insured in respect of the insured's liability to pay damages or compensation to another person ("the third party"), but do not affect a discharge of an insurer's liability under a contract of insurance which discharge was concluded before the commencement of those sections.

Section 6 continues overleaf

Section 6

C11 This section inserts into the Insurance Law Reform Act 1977 new *sections 11A–11E* which replace the Law Reform Act 1936 Part III.

C12 The new *section 11A* applies the new provisions to existing as well as future contracts but leaves unaffected any release of the insurer pre-dating the commencement of the sections.

11B Insolvency or death of insured before payment

(1) The benefit of an insurer's promise under a contract of insurance to which sections 11B to 11E apply to indemnify the insured in respect of the insured's liability to pay damages or compensation to a third party is deemed to be a benefit conferred on the third party which is enforceable against the insurer by the third party under section 4 of the *Contracts (Privity) Act 1982* as if it were a promise by the insurer to pay such damages or compensation to the third party if, before payment is made by the insurer to indemnify the insured,

(a) the insured has become insolvent or, if the insured is deceased, the insured's estate is being administered under Part XVII of the *Insolvency Act 1967*; or

(b) the insured has been deceased for not less than 60 days and no administrator of the deceased's estate has been appointed in New Zealand; or

(c) the insured, being a corporation, has been removed from the New Zealand register under section 317 of the *Companies Act 1993* (if a company), or has otherwise been dissolved or ceased to exist; or

(d) the insured cannot, after reasonable inquiry, be found.

(2) An insured is insolvent for the purposes of this Act if the insured

(a) is subject to a statutory or contractual regime under which the assets of the insured have been or are to be realised for the benefit of secured or unsecured creditors; or

(b) is unable to pay the insured's debts that would be provable in bankruptcy or on a liquidation as they fall due and from the insured's own money.

Section 6 continues overleaf

C13 The new *section 11B* provides that liability cover is to be treated as enforceable as against the insurer under the Contracts (Privity) Act 1982 by a party entitled to redress from the insured if:

- the insured has become insolvent; or
- if an individual has died and after 60 days no administrator of the deceased's estate has been appointed; or
- being a corporation, it has ceased to exist; or
- if the insured cannot, after reasonable inquiry, be found.

Subsection (2) defines the word **insolvent** used in *subsection (1)*. One consequence of this section is to override the cases referred to in para 107 requiring the third party to obtain judgment against the insured before proceeding against the insurer.

11C Extent of insurer's liability in actions by third parties

(1) An insurer is not liable to a third party in an action brought under section 11B for any amount in excess of the amount of the insurer's liability provided for under the contract of insurance.

(2) If the amounts payable in respect of claims made against an insurer by one or more actions under section 11B exceed the amount for which the insurer is liable under the contract of insurance, those claims are to abate proportionately to their amounts.

(3) A payment made under the contract of insurance by the insurer to one third party without actual notice of a possible claim by any other third party constitutes, to the extent of that payment, a valid discharge to the insurer in respect of the claim of such other third party or third parties.

(4) A payment made under the contract of insurance by the insurer to the insured without actual notice that the insured is insolvent constitutes, to the extent of that payment, a valid discharge to the insurer in respect of the insured's liability to the third party.

(5) Nothing in this Act prevents the variation or discharge of an insurer's obligation under a contract of insurance at any time before the insurer has actual notice that the insured is insolvent.

(6) A payment made under the contract of insurance by the insurer to an insolvency administrator who has been appointed in respect of the insured's property or estate does not constitute a valid discharge to the insurer in respect of the insured's liability to the third party.

Section 6 continues overleaf

Section 6 commentary continued

C14 *Section 11C(1)* makes it clear that the insurer's contractual liability may not be exceeded. This is the existing law. "The claimant cannot be in a better position viz a viz the insurer under s 9 than was the insured": Tipping J for the Court of Appeal in *UEB Packaging Ltd v QBE Insurance (International) Ltd* (unreported, 19 December 1997, CA 169/96). *Subsection (2)* provides for abatement if there are a number of claims exceeding in total the available fund. *Subsection (3)* protects an insurer who pays one claimant unaware of the existence of others. *Subsection (4)* protects an insurer in the event of a payment without actual notice of an insolvency. *Subsection (5)* makes it clear that insurer and insured may vary their contract at any time before the insurer has notice of an insolvency. *Subsection (6)* makes it clear that an insurer is not discharged by a payment to an insolvency administrator.

11D Duty to give necessary information to third parties

(1) Every insurer and every insured and any receiver, manager, trustee, liquidator, personal representative or other person in possession of the estate or property of the insured must, at the request of the third party, give to the third party such information as the third party may reasonably require to ascertain whether any promise of the insurer to indemnify the insured is one to which section 11B applies.

(2) The duty to give information under this section includes a duty to allow all contracts of insurance, receipts for premiums, and other relevant documents in the possession or power of the person on whom the duty is imposed to be inspected and copies of them to be taken.

(3) An application to enforce a duty imposed by this section may be made by originating application either in the High Court or in a District Court.

(4) A provision of a contract of insurance is of no effect if it purports, directly or indirectly,

(a) to prohibit or prevent the giving of any information required to be given by this section; or

(b) to avoid the contract or to alter the rights of the parties under it upon the giving of any such information.

Section 6 continues overleaf

Section 6 commentary continued

C15 *Section 11D(1)* and *(2)* spell out the duty of various parties to disclose to the third party information relevant to the insurance cover. *Subsection (3)* gives a right to apply to a court to enforce that duty. *Subsection (4)* invalidates provisions inhibiting such disclosure of information.

11E Actions by third parties against insurers

(1) A third party may bring an action against an insurer under section 11B although judgment has already been entered against the insured for damages or compensation in respect of the same matter.

(2) Before commencing an action against an insurer under section 11B, a third party must obtain the leave of the court in which the action is to be commenced unless

(a) the insured is subject to a statutory or contractual regime under which the assets of the insured have been or are to be realised for the benefit of secured or unsecured creditors; or

(b) the insured's estate is being administered under Part XVII of the *Insolvency Act 1967*; or

(c) the insured, being a corporation, has been removed from the New Zealand register under section 317 of the *Companies Act 1993* (if a company) or has otherwise been dissolved or ceased to exist.

(3) On an application by a third party for leave to bring an action against an insurer, the court must grant leave if it is satisfied that the third party has established a prima facie entitlement to bring such an action.

(4) If an action for damages or compensation is commenced by a third party against an insured within the time allowed by section 4 of the *Limitation Act 1950* and subsequently the third party commences an action under section 11B of this Act against the insured in respect of the same matter, section 4 of the *Limitation Act 1950* does not apply to that action against the insurer."

Section 6 commentary continued

C16 *Section 11E(1)* makes it clear that a third party's right to sue the insurer directly is not affected by the existence of a judgment against the insured in respect of the same matter. *Subsection (2)* provides that the prior leave of the court is necessary before suing the insurer directly unless there is a liquidation, a receivership, a statutory management, an administration under the Insolvency Act 1967 Part XVII or a dissolution. *Subsection (3)* provides for a corporation that leave must be granted if the third party establishes a prima facie case. *Subsection (4)* provides that the Limitation Act 1950 does not apply as between third party and insurer if proceedings against the insured have been commenced within the time limited by that statute.

Miscellaneous provisions

7 Application of Act

Section 13 of the principal Act is amended by adding the following subsection:

"(3) Subsections (1) and (2) have effect in relation to the application of the amendments of this Act enacted by sections 3 to 5 of the *Insurance Law Reform Amendment Act 199–* as if the references in those subsections to "the commencement of this Act" were references to the commencement of the *Insurance Law Reform Amendment Act 199–*."

8 Repeals and amendments

Section 16 of the principal Act is amended by adding, as subsection (2) and (3), the following subsections:

"(2) Part III of the *Law Reform Act 1936** is repealed.

(1936, No. 31, R.S. Vol. 3, p. 187)

(3) The *Imperial Laws Application Act 1988** is amended in the item in the First Schedule relating to *The Fires Prevention (Metropolis) Act 1774* by omitting the following:

"section 83, and".

(R.S. Vol. 30 p. 1)"

Section 7

C17 Section 13 of the 1977 statute applies that statute to all life policies whether entered into before or after that Act's commencement, subject to certain qualifications preserving rights, and to all other policies whether entered into before or after that Act's commencement without those qualifications. *Section 7* adds a subsection to s 13 that applies those provisions *mutatis mutandis* to *sections 3–5* of this draft Act.

Section 8

C18 *Section 8* repeals Part III of the Law Reform Act 1936 and, in its application to New Zealand, the Fires Prevention (Metropolis) Act 1774 s 83.

APPENDIX A
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APPENDIX B
Law Reform Act 1936 Part III

CHARGES ON INSURANCE MONEY PAYABLE AS INDEMNITY FOR LIABILITY TO PAY DAMAGES OR COMPENSATION

9 Amount of liability to be charge on insurance money payable against that liability

(1) If any person (hereinafter in this Part of this Act referred to as the insured) has, whether before or after the passing of this Act, entered into a contract of insurance by which he is indemnified against liability to pay any damages or compensation, the amount of his liability shall, on the happening of the event giving rise to the claim for damages or compensation, and notwithstanding that the amount of such liability may not then have been determined, be a charge on all insurance money that is or may become payable in respect of that liability.

(2) If, on the happening of the event giving rise to any claim for damages or compensation as aforesaid, the insured has died insolvent or is bankrupt or, in the case of a corporation, is being wound up, or if any subsequent bankruptcy or winding up of the insured is deemed to have commenced not later than the happening of that event, the provisions of the last preceding subsection shall apply notwithstanding the insolvency, bankruptcy, or winding up of the insured.

(3) Every charge created by this section shall have priority over all other charges affecting the said insurance money, and where the same insurance money is subject to 2 or more charges by virtue of this Part of this Act 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.

(4) Every such charge as aforesaid shall be enforceable by way of an action against the insurer in the same way and in the same Court as if the action were an action to recover damages or compensation from the insured; and in respect of any such action and of the judgment given therein the parties shall, to the extent of the charge,

have the same rights and liabilities, and the Court shall have the same powers, as if the action were against the insured:
Provided that, except where the provisions of subsection (2) of this section apply, no such action shall be commenced in any Court except with the leave of that Court.

(5) Such an action may be brought although judgment has been already recovered against the insured for damages or compensation in respect of the same matter.

(6) Any payment made by an insurer under the contract of insurance without actual notice of the existence of any such charge shall to the extent of that payment be a valid discharge to the insurer, notwithstanding anything in this Part of this Act contained.

(7) No insurer shall be liable under this Part of this Act for any sum beyond the limits fixed by the contract of insurance between himself and the insured.

9A Claims for damages or compensation against estate of deceased owner where no administrator

(1) Where
(a) Any person desires to claim damages or compensation on account of any event, whether happening before or after the commencement of this section, in respect of which a contract of insurance was in force at the time of the happening of the event indemnifying the insured from liability in respect of those damages or that compensation; and
(b) The insured is deceased and there is in New Zealand no administrator within the meaning of [[*the Administration Act 1969*]] of the estate of the insured,
the person desiring to claim those damages or that compensation may give notice in writing to the insurer requiring the insurer to nominate some person to be the defendant in place of the insured in any action proposed to be brought in any Court claiming those damages or that compensation.

(2) Within 14 days after the service on the insurer of such a notice, the insurer may, by notice in writing served on the claimant, nominate some person (with his consent) to be the defendant in the proposed action, and thereupon the claimant may sue the defendant so nominated, describing him as the administrator *ad litem* of the estate of the insured.

(3) If within the said period of 14 days the insurer does not nominate a defendant as aforesaid, the Court in which an action claiming those damages or that compensation is intended to be commenced may, on the application of the claimant, appoint the Public Trustee to be the administrator *ad litem* of the estate of the insured for the purposes of the intended action, and it shall be the duty of the Public Trustee to act as such.

(4) Where any such appointment is made, the claimant may sue the Public Trustee, describing him as the administrator *ad litem* of the estate of the insured.

(5) The person nominated as the defendant by the insurer or, as the case may be, the Public Trustee shall be indemnified by the insurer in respect of any judgment against him (including the costs of the action and any costs awarded under subsection (6) of this section), and also in respect of all costs and expenses reasonably incurred by him in or in connection with the action irrespective of the result of the action, and, in the case of the Public Trustee, shall be entitled to recover from the insurer reasonable remuneration for his services: Provided that, where in any such action the plaintiff obtains judgment against the administrator *ad litem*, the judgment shall not be enforceable against the administrator *ad litem* by execution or otherwise except to the extent to which the insured was entitled to be indemnified by the insurer under the contract of insurance, and, to the extent to which the judgment is not so enforceable, the amount thereof shall be deemed to be a liability of the estate (if any) of the insured, and shall be enforceable accordingly against that estate.

(6) Where in any action against the Public Trustee as administrator *ad litem* the plaintiff recovers judgment, the Court may award the plaintiff his costs of and incidental to the order appointing the Public Trustee as such administrator.

(7) No appointment or nomination of an administrator *ad litem* under this section shall confer any rights or impose any obligations on the Public Trustee or on the person so nominated in respect of any other assets of the estate of the insured or any liabilities in connection with that estate.

Origins: *Law Reform Amendment Act 1957* s 2

10 Consequential repeals

Section 48 of the *Workers' Compensation Act 1922* and section 10 of the *Motor Vehicles Insurance (Third Party Risks) Act 1928* are hereby consequentially repealed:

Provided that where the event giving rise to a claim for damages or compensation happens before the passing of this Act all rights under those sections, whether accrued on the passing of this Act or subsequently accruing, shall subsist for the benefit of the person having the claim.

APPENDIX C
Excerpts from the Insurance Contracts Act (Aust) 1984

11 Interpretation

(1) In this Act, unless the contrary intention appears:
"avoid", in relation to a contract of insurance, means avoid from its inception;

. . .

21 The insured's duty of disclosure

(1) Subject to this Act, an insured has a duty to disclose to the insurer, before the relevant contract of insurance is entered into, every matter that is known to the insured, being a matter that:
   (a) the insured 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) The duty of disclosure does not require the disclosure of a matter:
   (a) that diminishes the risk;
   (b) that is of common knowledge;
   (c) that the insurer knows or in the ordinary course of his business as an insurer ought to know; or
   (d) as to which compliance with the duty of disclosure is waived by the insurer.

(3) 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.

28 General Insurance

(1) This section applies where the person who became the insured under a contract of general insurance upon the contract being entered into:
   (a) failed to comply with the duty of disclosure; or
   (b) made a misrepresentation to the insurer before the contract was entered into;

but does not apply where the insurer would have entered into the contract, for the same premium and on the same terms and conditions, even if the insured had not failed to comply with the duty of disclosure or had not made the misrepresentation before the contract was entered into.

(2) If the failure was fraudulent or the misrepresentation was made fraudulently, the insurer may avoid the contract.

(3) If the insurer is not entitled to avoid the contract or, being entitled to avoid the contract (whether under subsection (2) or otherwise) has not done so, the liability of the insurer in respect of a claim is reduced to the amount that would place him in a position in which he would have been if the failure had not occurred or the misrepresentation had not been made.

29 Life Insurance

(1) This section applies where the person who became the insured under a contract of life insurance upon the contract being entered into:

(a) failed to comply with the duty of disclosure; or

(b) made a representation to the insurer before the contract was entered into;

but does not apply where:

(c) the insurer would have entered into the contract even if the insured had not failed to comply with the duty of disclosure or had not made the misrepresentation before the contract was entered into; or

(d) the failure or misrepresentation was in respect of the date of birth of one or more of the life insureds.

(2) If the failure was fraudulent or the misrepresentation was made fraudulently, the insurer may avoid the contract.

(3) If the insurer would not have been prepared to enter into a contract of life insurance with the insured on any terms if the duty of disclosure had been complied with or the misrepresentation had not been made, the insurer may, within 3 years after the contract was entered into, avoid the contract.

(4) If the insurer has not avoided the contract, whether under subsection (2) or (3) or otherwise, he may, by notice in writing given to the insured before the expiration of 3 years after the contract was entered into, vary the contract by substituting for the sum insured (including any bonuses) a sum that is not less than the sum ascertained in accordance with the formula $\frac{SP}{Q}$, where:

S is the number of dollars that is equal to the sum insured (including any bonuses);

P is the number of dollars that is equal to the premium that has, or to the sum of the premiums that have, become payable under the contract; and

Q is the number of dollars that is equal to the premium, or to the sum of the premiums, that the insurer would have been likely to have charged if the duty of disclosure had been complied with or the misrepresentation had not been made.

(5) In the application of subsection (4) in relation to a contract that provides for periodic payments, "the sum insured" means each such payment (including any bonuses).

(6) A variation of a contract under subsection (4) has effect from the time when the contract was entered into.

30 Misstatements of age

(1) In this section, "the standard formula", in relation to a contract of life insurance means the formula $\frac{SP}{Q}$, where:

S is the number of dollars that is equal to the sum insured (including any bonuses);

P is the number of dollars that is equal to the premium that has, or to the sum of the premiums that have, become payable under the contract; and

Q is the number of dollars that is equal to the premium, or to the sum of the premiums, that would have become payable under the contract if it or they had been ascertained on the basis of the correct date of birth or dates of birth.

(2) If the date of birth of one or more of the life insureds under a contract of life insurance was not correctly stated to the insurer at the time when the contract was entered into:

(a) where the sum insured (including any bonuses) exceeds the amount in dollars ascertained in accordance with the standard formula — the insurer may at any time vary the contract by substituting for the sum insured (including any bonuses) an amount that is not less than the amount in dollars so ascertained; and

(b) where the sum insured (including any bonuses) is less than the amount so ascertained, the insurer shall either:

(i) reduce, as from the date on which the contract was entered into, the premium payable to the amount that would have been payable if the contract had been based on the correct date of birth or correct dates of birth and repay the amount of overpayments of premium (less any amount that has been paid as the cash value of bonuses in excess of the cash value that would have been paid if the contract had been based on the correct date of birth or correct dates of birth) together with interest on that amount at the prescribed rate computed from the date on which the contract was entered into; or

(ii) vary the contract by substituting for the sum insured (including any bonuses) the amount in dollars so ascertained.

(3) In the application of subsection (2) in relation to a contract that provides for periodic payments, "the sum insured" means each such payment (including any bonuses).

(4) A variation of a contract under subsection (2) has effect from the time when the contract was entered into.

31 Court may disregard avoidance in certain circumstances

(1) In any proceedings by the insured in respect of a contract of insurance that has been avoided on the ground of fraudulent failure to comply with the duty of disclosure or fraudulent misrepresentation, the court may, if it would be harsh and unfair not to do so, but subject to this section, disregard the avoidance and, if it does so, shall allow the insured 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.

(2) The power conferred by subsection (1) may be exercised only where the court is of the opinion that, in respect of the loss that is the subject of the proceedings before the court, 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.

(3) In exercising the power conferred by subsection (1) the court:
(a) shall have regard to the need to deter fraudulent conduct in relation to insurance; and
(b) shall weigh the extent of the culpability of the insured in the fraudulent conduct against the magnitude of the loss that would be suffered by the insured if the avoidance were not disregarded;
but may also have regard to any other relevant matter.

(4) The power conferred by subsection (1) applies only in relation to the loss that is the subject of the proceedings before the court, and any disregard by the court of the avoidance does not otherwise operate to reinstate the contract.

33 No other remedies

The provisions of this Division are exclusive of any right that the insurer has otherwise than under this Act in respect of a failure by the insured to disclose a matter to the insurer before the contract was entered into and in respect of a misrepresentation or incorrect statement.

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