

**IMPORTANT ASPECTS OF THE PROPOSED  
REFORMS TO THE INSURANCE  
CONTRACTS ACT 1984 (CTH)**

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### **Introduction**

Some Acts stand the test of time. The *Sale of Goods Act 1896* (Qld) which has been adopted in its English form by all of the Australian States and which has remained essentially unchanged since its enactment in Queensland in 1896, is a good example. The amendments already made to the *Insurance Contracts Act 1984* (Cth) (ICA) suggest that the Act may not be in that league, but it must be remembered that, unlike the *Sale of Goods Act*, which largely codified established common law principle, the *Insurance Contracts Act* was a reforming Act and one in respect of which there was considerable controversy when it was enacted.

By and large the essential concepts in the Act have withstood the last 25 or so years.<sup>1</sup> The proposed changes are important but reflect for the most part an extension of existing concepts with some adjustment to the balance between insurers and insureds.

In this paper I will focus today on a number of the more significant reform proposals. These can be summarised as follows:

1. Section 54.
2. Duty of utmost good faith
3. The test for disclosure
4. Eligible contracts disclosure
5. New disclosure requirement for life insureds
6. Broader pre-contract notification requirements for insurers under s22
7. Greater court discretion to intervene in pre-contract remedies.
8. Electronic communication by insurer

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<sup>1</sup> The *Insurance Contracts Act 1984* (Cth) came into operation on 1 July 1986. The ICA was based on a report by the ALRC, *Report No 20, Insurance Contracts* (ALRC 20).

## **THE BACKGROUND TO THE REFORM PROCESS**

### **(i) Section 54 Reform**

On 6 August 2003, at the Ministerial Meeting on Insurance Issues (Commonwealth, State and Territories and the Australian Local Government Association), it was agreed that reform of the indemnity insurance market required a package of measures including professional standards legislation, proportionate liability, amendments to the *Trade Practices Act 1974* (Cth) and consideration of s54 of the ICA. This call for reform was at the height of the “insurance crisis” in the midst of a volatile and urgent environment. The timing of the commencement of this process is not without relevance: some aspects of the debate have settled a little since then.

The Review of the *Insurance Contracts Act 1984* (Cth) was announced on 10 September 2003. The first part of the Review focussed on s54 of the Act. Those conducting the review were given until the following month to provide their report. An Issues Paper on Section 54 was promptly produced which outlined how s54 had been applied by the courts and which sought to illustrate how this interpretation had affected the availability and pricing of insurance cover. The stated purpose of the issues paper was to guide submissions on possible options for reform. Following consultation with various stakeholders, the final s54 report was written. This report and subsequent submissions led to the drafting of proposed amendments to s40 and s54. There was further opportunity for submissions on these proposed sections. The sections were altered to reflect those submissions and we have now progressed to the draft Bill stage.

### **(ii) Provisions other than s54**

In relation to provisions other than s54, submissions “at large” concerning the operation of the Act were called for by 31 December 2003. An Issues Paper was released in March 2004. Following a consultation process, a Proposals Paper on provisions other than s54 was released in May 2004. Again, submissions on the

proposals outlined in the Paper were sought which culminated in a Final Report which was delivered in June 2004.

Many of the issues raised in the Final Report are now reflected in draft provisions in the *Insurance Contracts Amendment Bill 2007*. I will discuss some of the more important of these proposed changes.

## **1. SECTION 54**

The draft Bill considers proposals for the amendment of those provisions in the Act concerning post-contractual conduct. In particular, amendments are being considered which will narrow the operation of s54 in respect of claims made and notified policies.

Much of the litigation concerning s54 has addressed the nature of the contractual breach or omission which might attract the intervention of the section. The effect of the section, as now construed, might relevantly be summarised as follows (bearing in mind that the insurer may always reduce its liability to the extent that the insured's failure causes the insurer damage):

- s54 excuses a failure to notify within the policy period a claim, or where the policy provides, facts and circumstances giving rise to a claim: *FAI Insurance Co Ltd v Australian Hospital Care Pty Ltd* (2001) 204 CLR 641; *Greentree v FAI General Insurance Co Ltd* (1998) 158 ALR 592; *Permanent Trustee v FAI General Insurance Co Ltd* (1998) 44 NSWLR 186;
- the section does not apply to circumstances where, unbeknown to the insured, a third party has suffered a loss during the period of insurance but not informed the insured: *Greentree v FAI General Insurance Co Ltd* (1998) 158 ALR 592;
- a failure to exercise a right, choice or liberty is an omission for the purposes of s54: *Antico v Heath Fielding Australia Pty Ltd* (1997) 188 CLR 652; *FAI Insurance Co Ltd v Australian Hospital Care Pty Ltd* (2001) 204 CLR 641.

It is helpful to consider some practical instances of the application of s54 to date which in my view will remain unaffected by the proposed changes. These include:

- a failure by an insured to obtain the consent of the insurer prior to incurring defence costs: *Antico v Heath Fielding Australia Pty Ltd* (1997) 188 CLR 652.
- an insured's failure to comply with procedural obligations arising from the use of the subject matter of the insurance, for example, failure to register a mobile crane as a motor vehicle in breach of a term in the policy requiring notice to the insurer of a change in use: *Ferrcom Pty Ltd v Commercial Union Assurance Co of Aust Ltd* (1993) 176 CLR 332
- a failure by the insured to notify the insurers of a change of use of relevant premises: *Gibbs Holdings Pty Ltd v Mercantile Mutual Insurance (Australia) Ltd* [2000] QCA 524.
- where the insured modifies the insured vehicle without first obtaining the permission of the insurer as required by the policy: *Australian Associated Motor Insurers Ltd v Ellis* (1990) 54 SASR 61
- where the insured did not set an alarm in breach of the policy: *McNeill v O'Kane* [2004] QSC 144
- where the insured was drink-driving in breach of the policy: *Bunting v Australian Associated Motor Insurers Ltd* (1994) 19 MVR 37.

The Exposure Draft retains s54 more or less in its current form. It proposes three alternatives for reform of section 54. Option A, which is the recommendation of the Review Panel, is included in the draft Bill for discussion in the following terms:

**54A Exclusion of certain omissions from operation of section 54**

- (1) This section applies in relation to a contract of liability insurance to which section 40 applies.
- (2) Despite subsection 54(1), the insurer may refuse to pay a claim against the insured or any third party beneficiary under the contract if:

- (a) the insured or third party beneficiary became aware, during the period in which insurance cover was provided by the contract, of facts that might give rise to such a claim; and
  - (b) the insured or third party beneficiary did not give notice in writing to the insurer of those facts:
    - (i) during the period in which insurance cover was provided by the contract; or
    - (ii) within 28 days after that cover had expired.
- (3) The regulations may specify one or more classes of contract of liability insurance to which this section does not apply.

As drafted, it applies to contracts to which s40 applies, that is, contracts of liability insurance the effect of which is to exclude or limit liability if the claim is not made and notified within the policy period: “claims made and notified policies”. It is important to note that the proposed amendments are not intended to affect its application to “occurrence based policies”.

The effect of this proposal is to exclude from the operation of s54 circumstances where the insured becomes aware of facts which might give rise to a claim against it, but fails within the policy period (and the extended period of 28 days contemplated by the amending section) to notify the insurer of them. It is, in effect, a statutory reversal of *FAI Insurance Co Ltd v Australian Hospital Care Pty Ltd* (2001) 204 CLR 641.

In the draft regulation impact statement, two reasons are given for the proposal: the broad interpretation of s54 has forced insurers to have higher ongoing claims reserves, believed to have contributed to a reduction in the availability and affordability of liability insurance; and that because of the *Gosford* decision,<sup>2</sup> insurers are in any event removing clauses in policies which require an insured to notify of facts and circumstances within the policy period, such that it is rare nowadays to find them.<sup>3</sup>

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<sup>2</sup> *Gosford City Council v GIO General Limited* (2003) 56 NSWLR 542 held that s54 did not apply to cure a failure by an insured during the policy period to take advantage of the right conferred by s40(3) to notify facts that might give rise to a claim.

<sup>3</sup> *Insurance Contract Amendment Bill 2007*, Draft Regulation Impact Statement at 59

To those may be added a third, strong theme in the Report of the Review Panel: that s54 was not intended to alter the essential character of cover provided.

The Review Panel found, on the material available to them, that there had been a reduction in the affordability and availability of professional indemnity insurance in Australia<sup>4</sup> and that the judicial interpretation of s54 was one, although not the only, factor having an impact on the availability of professional indemnity insurance in Australia.

The amendments contemplate, in respect of this option, a requirement that the insurer notify of the consequences of a failure to notify facts and circumstances, and grant an extended period of twenty-eight days after the policy expires to do so.

Option B, set out in the draft regulation impact statement, but not in the draft exposure bill, involves amending the Act such that s54 does not extend to the late notification of a claim, nor to the failure to notify of facts and circumstances.

The third option involves no change at all.

One option that is not considered, but which in my view is worth considering, is the extension of s54 to the failure to notify of facts and circumstances which might give rise to a claim even where there is no term in the policy requiring the insured to do so (that is, the *Gosford* circumstances).

The philosophical basis for s54 was to make the effect of a post contractual breach by the insured proportional to the effect the breach had upon the insurer: the effect of the act or omission was not to be absolute, but was to reflect the damage suffered by the insurers as a consequence. Some might say “what is wrong with that?” It is consistent, for example, with principles which govern the assessment of damages for breach of contract, or a tort.

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<sup>4</sup> Report into the Operation of s54, 2007 at 7.

The contrary view, however, is that to assess the insurer's loss, and hence the reduction of the insured's claim, on the basis of demonstrable loss, did not tell the whole story.<sup>5</sup> It has been observed that prejudice to the insurer may be impossible to measure, and that it would be necessary to incorporate a notion of prejudice wider than mere damages; compensation for a loss of opportunity to investigate a claim: or for the need to maintain adequate reserves to meet claims in the future of which the insurer has no knowledge (see for example *FAI General Insurance Co Ltd v Australian Hospital Care Pty Ltd* (2001) 204 CLR 641 per Gleeson CJ). It is argued that the potential delay in the making of claims makes more difficult the actuarial task in forecasting loss, hence making necessary greater reserves and increasing costs to insureds. Some would say that this is not new. Insurers are in the business of assessing risk, the success of their business depends upon their ability to correctly estimate the nature and extent of claims. This can be difficult but does this mean that s54 should be amended to in effect reduce the cover afforded by liability insurance.<sup>6</sup>

In the upshot, the intention of the proposal is to limit the circumstances in which s54 may operate to circumstances where the omission is to notify of a "claim". In reality, such circumstances are likely to be relatively infrequent, and hence the ameliorative effect of s54 likely to be, relevantly, narrow.

It might be observed, at the outset, that the proposal has the effect of excusing the more culpable behaviour (failing to notify of a claim) while leaving no remedy where the less culpable conduct (failing to notify of circumstances) has occurred.

Some of the submissions called for a definition of "claim" in the legislation. This is not proposed.

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<sup>5</sup> In the United Kingdom, in the context of claims for damages for breach of policy terms, there being no equivalent of s54, the courts have not been convinced that insurers suffer prejudice as a result of late notification of claims: *K/S Merc-Skandia XXXXII v Lloyd's Underwriters* [2001] Lloyd's Rep IR 802; *Friends Provident v Sirius* [2006] Lloyd's Rep IR 45 cited in Professor R Merkin, "Reforming Insurance Law: Is there a case for Reverse Transportation?", A Report for the English and Scottish Law Commissions on the Australian Experience of Insurance Law Reform", April 2007, at 73.

<sup>6</sup> This view is supported by Goldring J in his submission to the Review dated 30 September 2003. The Honourable Desmond Derrington QC also expressed the view that there was no need to amend the section.

There remains, therefore, an issue about the meaning of “claim” in s54A, and the meaning of “facts that might give rise to such a claim”. As Professor Sutton points out: “The word “claim” is ambiguous for it may mean the occurrence of facts giving rise to a claim, that is, the right to make a claim, or the assertion of that right either by a formal demand or the initiation of proceedings: *ANZ Bank Ltd v Colonial & Eagle Wharves Ltd* [1960] 2 Lloyd’s Rep 241 at 255; *Mutual Acceptance (Insurance) Ltd v Nicol* (1987) 4 ANZInsCas 60-821 (NSWCA) at 75, 050; *Holts Corrosion Control Pty Ltd v CML Fire & General Insurance Co Ltd* (1983) 3 ANZInsCas 60-559 (SCQld) at 78, 371; *Bowman Industries Pty Ltd v Export Finance & Insurance Corp* (1990) 6 ANZInsCas 60-972 (SCNSW). There is also the intermediate step of an informal intimation that a demand will be made.”<sup>7</sup>

Section 54A, by its terms, applies to contracts of liability insurance as defined in s40. There is, at the threshold, an issue as to whether the policy is one to which s40(1) applies: is the effect of the policy that the insurer’s liability is excluded or limited by reason that notice of a claim is not given to the insurer before the expiration of the period of insurance cover. This involves construing the contract of insurance.

If it is determined that s54A applies, then whether or not the insured became aware of a claim, or of facts that might give rise to a claim, is in my view, a matter of assessing the facts against the proper construction of the section. That is, in my view, whether or not the insured has notice of a claim, or only of facts giving rise to a claim, ought to be construed independently of any contractual definition of those terms.

Bearing that in mind, “claim” would, in my view, include a legal proceeding. It may also extend to a letter of demand which identified an amount and demanded its payment under threat of legal proceedings. On the otherhand, a letter saying “our client may suffer loss as a consequence of your negligence”, and detailing the negligence would probably be “facts that might give rise to a claim”.

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<sup>7</sup> Sutton, *Insurance Law in Australia*, 3<sup>rd</sup> ed, LBC Information Services, at 1071.

In these examples, the insured will be arguing that a claim had been made against it; the insurer that the circumstances amounted only to facts that might give rise to a claim.<sup>8</sup>

There two further points I wish to make in respect of the reform provisions.

First, it is unclear from s54 how a co-assured is to be affected by an act or omission of his or her co-assured. This has always been a difficult issue and perhaps the section should be amended so as to make the position clear. At common law, it is accepted that a composite assured is not tainted by the wrongdoing of other policyholders.<sup>9</sup> However, this is not necessarily the case where the assureds are joint assureds.

Secondly, if the problem with s54 is that it has the potential to re-write the terms of cover, restricting its reform to claims made and notified policies is not a complete solution. There will be an inconsistency in legal principle between the broad and unfettered application of s54 to contractual options in general and its application to the option to notify circumstances so as to bring a claim that might otherwise fall outside the policy, within it. In a policy which provides an insured with a right to extend the operation of the policy and the insured fails to take up that option, s54 will still apply to permit the insured to argue that loss which occurred during the optional period which was not taken advantage of by the insured, would nonetheless be covered due to s54: the reasoning in *Kelly v New Zealand Insurance Co Ltd* (1996) 9 ANZInsCas 61-317 no longer applies following *Antico*.

## **2. DUTY OF GOOD FAITH**

The duty of utmost good faith is dealt with in s13. Section 13 currently provides:

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<sup>8</sup> In the comments of the Insurance Council of Australia on the Issues Paper, the author states: “insurers strongly fear that there will be a new round of litigation to determine what facts and circumstances do, and do not, fall within the coverage of proposed s54A” at p52.

<sup>9</sup> *P Samuel & Co Ltd v Dumas* [1924] AC 431 at 445; *Gaiform Pty Ltd v Suncorp Insurance & Finance* (1992) 7 ANZInsCas 61-143 at 77, 737; *McQuade v Sun Alliance Insurance Co* (1992) 7 ANZInsCas 61-136 at 77, 702 – 77, 703.

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

Utmost good faith is therefore an implied term of the insurance contract which applies to both parties to the contract. Although “party” would suggest that the obligation only applies to the conduct of the insurer and insured, it has been held to apply in respect of a third party in a number of cases: *Wyllie v National Mutual Life Association of Australasia Limited* (1997) 217 ALR 324; *Hannover Life Re of Australasia Limited v Sayseng* [2005] NSWCA 214; *Dumitrov v SC Johnson & Son Superannuation Pty Ltd* [2006] NSWSC 1372.

Under the proposed amendments, a breach of s13 would constitute not only a breach of a term in the policy but would also be a breach of the ICA: s13(2). This is significant because s55A of the ICA currently permits ASIC, the entity that administers the Act, to commence or continue a representative action on behalf of an insured against an insurer provided either the insured has suffered damage or is likely to suffer damage because the terms of the contract, or the conduct of the insurer *breaches the requirements of the ICA*. It also means that ASIC will be able to access other remedies under the *Corporations Act 2001 (Cth)* relating to an insurer’s license. These remedies include, for example, a banning order under s920A; suspension or cancellation of an insurer’s licence; or the imposition of conditions.

A banning order, if made, could prohibit the relevant insurer from providing all financial services, or one or more specified type of financial service. It may be permanent or for a specified period. The Explanatory Memorandum gives as an example of the conduct that could lead to such an order, a pattern of persistent contraventions that indicate systemic failures or a general lack of understanding of, and regard for, compliance. Isolated breaches it is said, would “not be expected to result in ASIC contemplating a banning order”.

The draft Bill complements s13(2) with a new s11F which provides that ASIC may intervene in any proceeding relating to a matter arising under this Act, in which case it is to be taken to be a party to the proceedings. The new s11F procedure is likely to be faster and easier than a full representative action, given that proceedings will already be on foot.

The new section also specifies that for the purposes of the good faith provision only, a third party is to be regarded as a party to the contract: s13(3). This has the effect that the duty of utmost faith will be owed to and by a third party. The extent of the duty is however limited in the case of a third party to the time after the contract is entered into: s13(4). The reason it is limited in this way is that it was considered impractical to apply the duty in respect of third parties pre-contractually and further because utmost good faith has most relevance for a third party at the claims stage. It is noted that s55A currently permits only a representative action by ASIC in relation to breaches of the Act which affect an insured. If, for example, there were repeated breaches of the duty of utmost good faith by an insurer of a superannuation trust fund in relation to its handling of claims by third party members, ASIC would arguably not have any power. Extension of the duty of good faith to third parties is not earth shattering in the sense that the courts had already held that such a duty was owed, despite the reference in s13 to “insured”: *Hannover Life Re of Australasia Limited v Sayseng* [2005] NSWCA 214; *Wyllie v National Mutual Life Association of Australasia Limited* (1997) 217 ALR 324; *Dumitrov v SC Johnson & Son Superannuation Pty Ltd* [2006] NSWSC 1372.

The primary motivation for the Review Recommendations leading to the proposed provisions was claims handling, in particular, the need to ensure that: insurers operate procedures under which claims handling is conducted in a fair, transparent and timely manner; assureds have the chance to respond to adverse findings by insurers and receive reasons for the denial of claims; employees and outsourced service providers involved in the claims handling process receive adequate training and supervision; insurers are liable for the conduct of outsourced providers involved in the claims handling process, and experts involved in the claims handling process are independent.

The only other inroads on the privity of contract doctrine, are in relation to the treatment of life insureds. Under the draft provisions, a life insured will be subject to a duty to disclose (s31A); a non-supply of information to the insurer by a life insured will be treated as a non-disclosure by the insured (s31A); an insurer will be required to notify an insured person of the general nature and effect of the duty of disclosure and the effect of proposed s31A; and that the duty of disclosure applies until the contract is entered: see proposed s22 (2).

### **3. CHANGES TO THE DISCLOSURE REGIME**

#### **Section 21(1)(b)**

The test for disclosure introduced by the ICA changed the focus of inquiry of an insured from disclosing what a prudent insurer would want to know to a much easier test of having to disclose what **he thought** an insurer would think was relevant. This was seen to be fairer because the average insured could not be expected to know what a prudent insurer would want to know. It was more reasonable to expect from an insured only that they disclose what the insured **thought** the insurer would think relevant.

The test as formulated has two limbs and is contained in s21. The section imposes a subjective test in 21(1)(a) and a “fallback test” in 21(1)(b). Section 21(1)(b) avoids difficulties of proof by requiring an insured to disclose what a reasonable person in the circumstances would consider relevant. The phrase “in the circumstances” has led to some difficulty in interpretation.

The issue is how far “in the circumstances” permits consideration of what would have been reasonable from the insured’s perspective. Does the term, for example permit a court to take into account the personal idiosyncracies of the insured or the assured’s position in life, mental condition and ability, education, literacy, knowledge, experience and cultural background<sup>10</sup> (ie intrinsic factors) or does it only permit the court to take into account external or extrinsic factors such as the nature of the policy

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<sup>10</sup> ALRC 20, para 183.

and the nature of the negotiations leading up to it. Obviously one interpretation was better for insureds – this was the one that allowed individual characteristics, such as education, literacy and cultural background, for example, of the insured to be considered. There has been a good deal of debate about this but the balance of authority favours the more restrictive view, that only extrinsic factors are relevant, in other words, that the insured remains the reasonable insured, albeit in the external or extrinsic circumstances of the insured: *Twenty-First Maylux Pty Ltd v Mercantile Mutual Insurance (Aust) Ltd* [1990] VR 919; *Dew v Suncorp Life and Superannuation Ltd* [2001] QSC 252. See, by way of illustration, *GIO General Ltd v Wallace* [2001] NSWCA 299.

The review considered whether s21(1)(b) imposed too high a burden on insureds and whether a more subjective test would be preferable. Its conclusion was that s 21(1)(b) imposed an undue burden on consumer assureds but that the law worked satisfactorily in the context of commercial insurance. Its recommendation<sup>11</sup> was that the test should remain the same but that it should be applied by reference to considerations such as: the nature and extent of the cover provided by the contract of insurance; the class of persons who would ordinarily be expected to apply for cover of that type; and the circumstances in which the contract of insurance is entered into, including the nature and extent of any questions asked by the insurer. The Treasury agreed with this conclusion and the proposed new version of s 21(1)(b), set out in the *Insurance Contracts Amendments Bill 2007* lays down a non-exhaustive list of factors to which the court is to have regard when determining whether a reasonable person in the circumstances could be expected to know a matter was relevant to the decision of the insurer whether to enter the contract of insurance.

The revised s 21(1) would require the assured to disclose every matter known to him, being a matter:

- (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*

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<sup>11</sup> Recommendation 4.1.

- (b) *a reasonable person in the circumstances could be expected to know to be a matter so relevant, having regard to factors including, but not limited to:*
- (i) *the nature and extent of the insurance cover to be provided under the relevant contract of insurance; and*
  - (ii) *the class of persons for whom that kind of insurance cover is provided in the ordinary course of the insurer's business; and*
  - (iii) *the circumstances in which the relevant contract of insurance is entered into, including the nature and extent of any questions asked by the insurer.*

It is interesting to note that all these factors are extrinsic by nature which strengthens the argument, I would have thought, that the insured's individual proclivities are not relevant.

#### **4. ELIGIBLE CONTRACTS**

Eligible contracts, essentially all domestic policies, are defined in reg 2B of the *Insurance Contract Regulations* 1985 to be: motor vehicle insurance, home buildings insurance; home contents insurance; sickness and accident insurance; consumer credit insurance and travel insurance. The disclosure requirement in respect of these types of policies is set out in s21A. This section only applies to new business and not to renewals and effectively applies so that an insurer is deemed to have waived disclosure unless they take one of two options.<sup>12</sup>

The first option, set out in s 21A(3), is that the insurers can request the assured to answer one or more specific questions that are relevant to the decision of the insurers. Faced with such specific questions, the assured will be seen to have satisfied the duty of disclosure if he discloses every matter that is known to him and which a reasonable person in the circumstances could be expected to have disclosed by way of answer: s21A(6). In other words the extent of his duty is to answer the questions. If the

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<sup>12</sup> The outline of the effect of s21A is based on the summary by Professor Merkin at paras 4.19 and 4.20 of his report.

assured does not comply with his obligations under s21A(6), then the duty of disclosure is not waived and the assured will be in breach of it.

The second option, set out in s 21A(4), is designed to protect insurers who believe there may be exceptional matters of which the assured is aware. In this case the insurers have to take two steps. The first step is the same as before, that is, the insurers have requested the assured to answer one or more specific questions that are relevant to the decision of the insurers to accept the risk and, if so, on what terms. The second step is that the insurers have expressly requested the assured to disclose any exceptional circumstance that: (i) is known to the assured; (ii) the assured knows, or a reasonable person in the circumstances could be expected to know, is a matter relevant to the decision of the insurers whether to accept the risk and, if so, on what terms; (iii) is not a matter that the insurers could reasonably be expected to make the subject of an express question; and (iv) is not excluded from disclosure under s 21(2).

In such a case, if presented with a request for disclosure of exceptional circumstances coupled with specific general questions, the assured is treated as having satisfied the duty of disclosure if he discloses every matter that is known to him and which a reasonable person in the circumstances could be expected to have disclosed by way of answer, and if he complies with the request to disclose exceptional circumstances: s 21A(7). If the assured does not comply with his obligations under s 21A(7), then the duty of disclosure is not waived and the assured will be in breach of it.

Professor Merkin in his Report to the English and Scottish Law Commissions<sup>13</sup> summarises the effect of s21A this way:

“It follows that, in the ordinary course of events, if no specific questions have been asked, there is no duty of disclosure at all. It is only if questions are asked that a duty of disclosure arises. The section attempts to discourage general open-ended questions requiring disclosure of other matters that the assured may think relevant. While insurers remain free to ask such general questions, if they do so, then the duty of disclosure is deemed to have been waived in respect of such matters and the only

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<sup>13</sup> Professor R Merkin, A Report for the English and Scottish Law Commissions on the Australian Experience of Insurance Law Reform, “Reforming Insurance Law: Is there a Case for Reverse Transportation?”, April 2007 at para 4.21.

possible dispute is as to the correctness of the assured's answers (s 21A(5)).”

Obviously 21A is a little difficult to follow.

The new provision makes two major changes:

1. It applies to renewals as well as placements; and
2. There is no longer any right to ask “catch-all” questions. This means that the risk that exceptional circumstances might exist rests with the insurer.

Under the new provision: the insurer waives compliance with the duty of disclosure if:

1. the insurer does not ask specific relevant questions of the insured; or
2. if the insurer asks the insured to disclose to the insurer any other matter that would be covered by the duty of disclosure.

## **5. NON-DISCLOSURE BY LIFE INSURED**

Life insurance contracts are often entered by one person to cover the life of another. Although that person is not a party to the contract, practically that person whose life is to be insured will usually provide the insurer with relevant information. This has been dealt with by s25 which covers misrepresentation by a life insured. The proposal is to add a new s31A which will impose a duty to disclose also on such a person.

## **6. NOTIFICATION BY INSURER: S22**

Section 22 requires an insurer to notify an insured before the contract is entered into of the nature and effect of the insured's duty of disclosure. There are a few changes proposed for this provision.

- First, the insurer will have to notify the insured in addition that the duty to disclose continues right up until the contract is entered into.

- Secondly, if the contract is a life insurance contract, of the effect of the new proposed s31A (that life insureds owe a duty of disclosure as well).
- Thirdly, that s22 notification must also be given to a life insured.
- Fourthly, if the insurer's acceptance or counter-offer in relation to the proposed contract is made more than two months after the insured's most recent disclosure then along with the acceptance or counter-offer, the insurer must also provide a further reminder that the duty continues up until the contract is entered into.

## **7. COURT'S POWER TO INTERVENE IN PRE-CONTRACTUAL REMEDIES**

There is a proposal to extend the power of the court to intervene in relation to pre-contractual remedies. In the current Act, pursuant to s31, the court has the power in certain circumstances to disregard the avoidance of a contract for fraud.

The proposal is to expand the reach of s31 to cover innocent non-disclosure and misrepresentation so that insureds have an opportunity "to obtain a just result in exceptional cases where a reduction of liability under sections 28 or 28A is harsh or unfair". Presumably this means that the court will be given the power to adjust a s28(3) outcome where that outcome is considered inequitable.

## **8. ELECTRONIC COMMUNICATION BETWEEN INSURER AND INSURED**

At present insurers who are required to give notices in writing under the *Insurance Contracts Act 1984 (Cth)* can not give them via e-mail or the internet. This is because the ICA is exempt from the *Electronic Transactions Act 1999* which permits electronic communication provided certain conditions are met. This will change under changes proposed to sections 72 and 77 of the Act. Obviously this has the potential to significantly reduce costs for insurers.

# **Important Aspects of the Proposed Reforms to the Insurance Contracts Act 1984 (Cth)**

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# Reform Proposals

1. Section 54
2. Utmost good faith
3. Test for disclosure
4. Eligible contracts disclosure
5. New disclosure requirement for life insured
6. Increased notification requirements for insurers
7. Greater scope for court intervention in pre-contract remedies
8. Electronic communication

# Background: s54

- 6 August 2003: Ministerial Meeting on Insurance Issues
- 10 September 2003: Review of Insurance Contracts Act
- Issues Paper on s54, October 2003
- Final Report on s54, November 2003

# Background: other provisions

- Submissions called for by 31 December 2003
- Issues paper – March 2003
- Proposals Paper – May 2004
- Final Report – June 2004

# Section 54

# Section 54

- Applies to conduct of insured which would have otherwise entitled insurer to refuse the claim
- Requires a causal link between insured's conduct and the loss
- If there is a link, reduction of the claim on a proportionate rather than absolute basis.

# Distinguishes between

- Conduct which could have contributed to the loss:  
s54(2)- (4)
- Conduct which could not:  
s54(1)

# Effect of s54:

- Excuses failure to notify a claim or, where the policy provides, facts and circumstances giving rise to a claim: *FAI Insurance Co Ltd v Australian Hospital Care Pty Ltd* (2001) 204 CLR 641
- Failure to exercise a right, choice or liberty is an omission: *Antico v Heath Fielding Australia Pty Ltd* (1997) 188 CLR 652
- Does not apply where 3<sup>rd</sup> party suffers a loss but fails to inform insured during policy period: *Greentree v FAI General Insurance Co Ltd* (1998) 158 ALR 592

# Practical applications of s54

- Failure to obtain consent of insurer to defence costs: *Antico* (1997) 188 CLR 652
- Failure to take procedural steps to comply with the terms of cover: *Ferrcom Pty Ltd* (1993) 176 CLR 332
- Failure to notify insurers of a change of use of relevant premises: *Gibbs Holdings Pty Ltd v Mercantile Mutual Insurance (Australia) Ltd* [2000] QCA 524
- Failure to set alarm: *McNeill v O'Kane* [2004] QSC 144

## 54A Exclusion of certain omissions from s54

(1) This section applies ...to a contract of liability insurance to which s40 applies

(2) Despite 54(1), the insurer may refuse to pay a claim against the insured or any third party beneficiary under the contract if

## 54A (cont'd)

- (a) The insured or 3<sup>rd</sup> party beneficiary became aware, during the period in which insurance cover was provided by the contract, of facts that might give rise to such a claim; and
- (b) The insured or 3<sup>rd</sup> party beneficiary did not give notice in writing to the insurer of those facts:

## s54A (cont'd)

- (i) during the period in which insurance cover was provided by the contract;  
or
- (ii) within 28 days after that cover had expired

# Effect of 54A

- Excludes from s54 relief situation where the insured becomes aware of facts which might give rise to a claim against it but fails to notify the insurer within the policy period (+ 28 day extension).

# Australian Hospital Care (2001) 204 CLR 641 plutoed



# Draft Regulation Impact Statement

Two reasons given for sidelining late notification of facts and circumstances from s54 relief:

- Led to higher ongoing claims reserves, believed to have contributed to less affordable liability insurance
- Insurers are removing these “fact or circumstance notification” clauses anyway

## Another reason:

- S54 was not intended to alter the essential character of cover provided

# “Claim”

- Ambiguous word
- New point of contention will be whether something is a “claim” or only “facts that might give rise to a claim”

# Draft Regulation Impact Statement

- Option A: s54A Draft Bill: cover late notice of claims but not of facts
- Option B: Do not cover either
- Option C: No change

**Utmost Good Faith**

# Utmost good faith: s13

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

# S13: utmost good faith

- Implied as a term in the contract
- Applies to the parties to the contract



# Duty has been held to apply to third parties

- *Wyllie v National Mutual Life Association of Australasia Limited* (1997) 217 ALR 324
- *Hannover Life Re of Australasia Limited v Sayseng* [2005] NSWCA 214
- *Dumitrov v SC Johnson & Son Superannuation Pty Ltd* [2006] NSWSC 1372



## ***s13(2): a breach of the Act***

- S13(2) makes a breach of the implied provision a breach of the Act
- This brings into play s55A of the ICA.
  - s55A permits ASIC to commence a representative action on behalf of an insured
  - Also may enable ASIC to access various remedies under the Corporations Act (eg, s920A Corporations Act: banning order, or suspension of insurer's licence)

## ***S13(3) and (4) : third parties and good faith***

- The obligation to act with the utmost good faith is extended to apply in relation to third parties but only after the contract is entered into.

# S13 and third parties

- Impractical for obligation to apply pre-contractually
- Potential application
  - Mitigation of damages by third party
  - Good faith in claims process by both insurer and third party

# Test for Disclosure

# S21 duty of disclosure

- Insured must disclose every matter known to it that the insured knows to be relevant [21(1)(a)]; or
- a reasonable person in the circumstances could be expected to know to be a matter so relevant [21(1)(b)]
- Two tests: subjective and objective

# Bone of contention

- Does the objective test require or permit reference to intrinsic matters such as the education, cultural background or level of business acumen of the insured or is it restricted to a reasonable person in the extrinsic circumstances of the insured.

## 21(1)(b)

- The more subjective the better for insureds



# Proposed s21(1)(b)

- Seeks to clarify that part of the test by setting out non-exclusive factors to which the court may have regard

## ***S21(1)(b)***

- A reasonable person in the circumstances could be expected to know to be a matter so relevant, *having regard to factors including, but not limited to:*

## ***21(1)(b) factors***

- (i) The nature and extent of the insurance cover to be provided under the relevant contract of insurance; and*
- (ii) The class of persons for whom that kind of insurance cover is provided in the ordinary course of the insurer's business; and*
- (iii) The circumstances in which the relevant contract of insurance is entered into, including the nature and extent of any questions asked by the insurer.*

## 21(1)(b): comments

- None of the listed factors are intrinsic matters such as education, cultural background or level of business acumen of an insured
- Now a stronger argument that intrinsic circumstances are irrelevant: education of the insured, for example, inconsistent with requirement to look at “class of persons...”

# **Eligible contracts disclosure**

# Eligible contracts

- Motor vehicle insurance; home buildings insurance; home contents; sickness and accident; consumer credit insurance; travel insurance
- Current provisions:
  - Apply only on placement
  - Permitted insurers must to couple request for answers to specific questions with a “catch-all” question (thereby undermining specific question requirement)

# Two options under current 21A

- Ask specific questions
- 21A(3)
- Ask specific questions; and
- Ask insured to disclose “exceptional circumstances”
- 21A(4)

# New 21A

- Additional protection for insurers because disclosure obligation will apply upon renewal as well as placement (but insurer must again ask specific questions).
- Balancing that, the insurer is no longer permitted to ask a “catch-all” question, and insurer must now bear risk of exceptional circumstances.

**Non-disclosure by life  
insured**

# ***s31A Non-disclosure by life insured***

- Contracts of life insurance often entered into by one person to cover the life of another
- S25 deems a misrepresentation by prospective life insured to be a misrepresentation by the contracting insured
- New s31A treats non-disclosure by life insured in the same way
- This is an important change

**Notification by insurer**

# Current obligation of insurer under s22

- Under ICA insurer obliged to inform insured in writing of duty of disclosure and that s21A applies in appropriate circumstances

## New s22

- must also tell insured that duty continues right up until contract entered into
- also in relation to life insurance policies, insurer must now inform the life insured of their obligation to disclose under proposed 31A

**Court greater power to  
intervene in pre-contract  
remedies**

# Court's power to disregard avoidance: s31

- Extends the power to disregard not only an avoidance for fraud, but also where liability has been significantly reduced (including to nil) under 28(3) or proposed 28A(4)
- Removes requirement that court may intervene only where the insurer has not been prejudiced by the failure or misrepresentation or if the prejudice is minimal.

**Electronic communication  
possible: application of  
*Electronic Transactions Act*  
1984 (Cth)**