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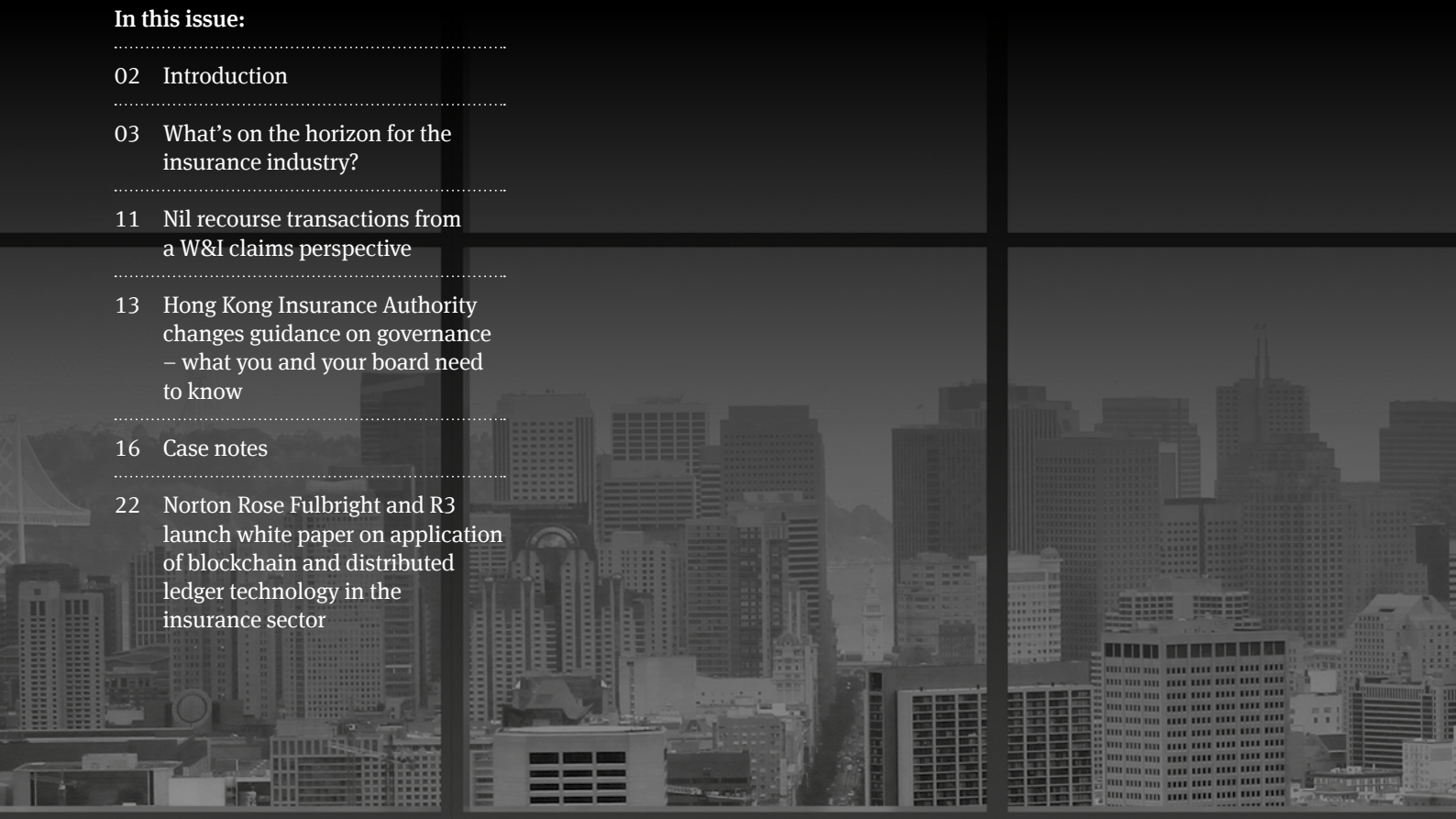
NORTON ROSE FULBRIGHT

Insurance focus

Our analysis of key legal developments in the insurance industry over recent months

July 2017

In this issue:



Introduction

In this edition of *Insurance Focus*, we have asked colleagues across the firm to describe the issues that they think are having the greatest impact on their local insurance industry. Technology and the rise of InsurTech are common factors having an effect on insurers as is the growing demand for cyber cover as attacks become more frequent. In a number of countries, increased regulation and costs of compliance are the main factors changing the operational landscape.

We consider changes to the minimum corporate governance standards for Hong Kong based insurers and review the impact of "nil-recourse" M&A deals on the warranty and indemnity insurance market.

We also provide a review by marine insurance lawyer WenHao Han of the recent Gard Marine decision by the UK Supreme Court, while UK Court of Appeal decision Ashfaq raises interesting questions about the blurred lines between acting as a consumer or a business and the resulting impact on coverage.

For more information contact:

Maria Ross
Partner, London
Tel +44 20 7444 3557
maria.ross@nortonrosefulbright.com

Susan Dingwall
Partner, London
Tel +44 20 7444 2349
susan.dingwall@nortonrosefulbright.com

Laura Hodgson
Senior knowledge lawyer, London
Tel +44 20 7444 3985
laura.hodgson@nortonrosefulbright.com

What's on the horizon for the insurance industry?

In this article we have asked some of our partners across the firm for their views on the big issues that will affect the insurance industry in their region over the next few months.

Canada

Increasing compliance costs

Insurers, reinsurers and market intermediaries in the Canadian market face stringent compliance statutory requirements regarding solvency, disclosure and implementation of equitable consumer protection measures including the protection of personal information. As a result, regulatory compliance is a growing sector of interest in Canada. Insurers will need to implement risk management processes and to increase control functions within their firms.

Tech

In a fast evolving technological environment, Canadian Property and Casualty insurers are going to need to review their operations. For instance, the changes in other digitally enabled industries are prompting customers to demand more personalized services from insurers. Customers are asking insurers to provide them with greater opportunities for comparison shopping on the web. Greater use of digital technologies will redefine the insurance market in a very competitive environment. Insurers will need to act fast to keep ahead of market shifts.

The economy

Slow global economic growth, the decline in the Canadian dollar and the weakness of the oil and gas industry are also major downside risks for insurers. Liability claims from oil and gas development and transportation as well as "fracking" may have an impact throughout the supply chain.

Cyber risk

Cyber insurance and data management risks will obviously continue to be an area of growth in Canada. Businesses are becoming increasingly alert to risks associated with greater reliance on information technologies, data theft and political activism. Privacy breaches give rise to concurrent reputational and legal risk. The emergence of class actions for the tort of "intrusion on seclusion", coupled with stringent privacy protections required in Quebec, make privacy a particular focus for concern for insurers in the Canadian market.

Environmental risks

Environmental risks linked to climate change are becoming important issues for insurers who need to consider their response to related risks and climate related losses whether arising from weather related events such as floods and storms or liability risks from third party claims, for instance, under professional liability or directors' and officers' insurance contracts.

Germany

Automation

In Germany, there is currently a debate regarding the effect of automated driving on the law relating to road traffic accidents and vehicle insurance. The debate surrounds the appropriate allocation of liability between driver, owner and manufacturer (and their respective insurers) – in particular, automation is likely to lead to a greater shift towards the manufacturer or software provider carrying the liability for road accidents.

It is easy to imagine that disputes will increase between the vehicle owner's insurer and the manufacturer's insurer as to who should pay a claim. A change to the law regarding autonomous driving will raise a number of questions in relation to who needs to be covered under the policy and the type of coverage. For example, will the policy be one of product liability or is the risk

really a cyber insurance issue (if an accident is caused by hacking)? Does the manufacturer of the vehicle need to be covered under the policy, or the driver?

In light of the changing road environment, the German Federal Ministry of Traffic and Digital Infrastructure has amended the German Road Traffic Act, revised by the Federal Ministry of Justice and Consumer Protection (BMJV), to provide for automated driving functions and autonomous parking. The amended Act contains a duty for drivers to take control of motor vehicles in certain circumstances when using automated vehicles.

Another consideration for insurers is how autonomous driving will affect claims and premiums. Driverless cars are expected to increase the safety of vehicles. However, connected driving and interaction with other technology, components and people will raise new challenges. The frequency of loss may decrease due to an increase in safety, yet in some cases there may be larger claims due to the costs of replacing damaged technology. This has been reflected in the revised draft bill for automated driving; the maximum amount of statutory liability has generally been increased by 100 percent, which will likely affect insurance premiums.

Warranty & indemnity insurance market

The trend for corporate sellers or buyers to take out warranty and indemnity insurance (W&I insurance) for M&A transactions has continued into 2017. In the past this product has been used by both sellers and buyers; however now it is predominantly used by buyers. While the product has mainly been used by private equity buyers, it is also increasingly used in acquisitions by strategic buyers or family owned businesses. W&I insurance provides opportunities for clear exits by private equity funds, distressed M&A transactions and transactions with multiple sellers. W&I insurance is also increasingly used in structured auction processes, where it has a potential to make bids more comparable and competitive.

It is expected that W&I insurance cover will be provided for new types of transactions. Currently W&I insurance cover relates to targets in M&A transactions in a wide range of industries (e.g. automotive, life sciences and health care, technology and innovation, real estate and many more). More recently W&I insurance cover has been provided for renewables and different types of infrastructure projects. A recent innovative example is the W&I insurance cover of an off-shore wind farm, which was still in the phase of obtaining a permit, i.e. prior to construction. Innovative use of W&I insurance is also expected for other types of transactions, particularly in relation to cyber risks.

The Netherlands

Dutch Central Bank investigates impact of FinTech

The Dutch Central Bank (De Nederlandsche Bank, DNB) recently announced that in 2017 it will invite a number of insurers to discuss the opportunities and challenges that technological innovation brings to the Dutch insurance sector. DNB believes that technological innovation in the financial sector (FinTech) will greatly impact the insurance sector in the coming years. Therefore, DNB will be contacting insurers to obtain feedback on the expected impact on the market structure, value chain, strategies and operational as well as business risks. DNB is interested to learn which technological innovations are relevant to insurers and what actions are taken in respect of such developments. FinTech has been in the centre of DNB's attention for over a year now and it is expected that DNB will continue to closely monitor financial undertakings, in particular insurers, to see how they deal with technological developments.

Dutch Central Bank and its vision for the future of the Dutch insurance sector

At the end of last year, the DNB published a report titled "Vision for the future of the Dutch insurance sector" (the Report) containing an analysis of the impact that various developments will have on the Dutch insurance sector over the next five to ten years, taking into account technological and economic developments, trends in society, shifting customer behavior and changes in laws and regulations. In the Report, DNB notes that insurers will need to make fundamental choices (e.g. cutting costs, investing in innovation, going international, vertical or horizontal integration) in order to safeguard a financially solid insurance sector due to the low interest rate environment, competition in the insurance market and innovative technologies.

Life insurers are particularly vulnerable to the low interest rate environment due to their long-term commitments, while non-life insurers are facing increasing competitiveness in the market and a reduction of profit margins. DNB recommends that life insurers should limit their capacity and secure the long-term interest of their policyholders by adopting their operations to the shrinking portfolio, as well as by making realistic cost assumptions in their technical provisions and subject these assumptions to stress tests. In case of negative results, insurers should investigate opportunities to consolidate, going into run-off or transfer portfolios to specialised third parties. We expect that the DNB will be closely monitoring insurers in the Netherlands to ensure that they are taking sufficient measures to safeguard their stability (and that of the financial markets as a whole).

Insurers and compliance with the Dutch Sanctions Act

Over the last four years, the DNB has investigated the compliance of insurers (both life and non-life) with the Dutch sanctions rules and regulations. DNB has published its findings stating that during this period improvements were made, but that there is still a lack of awareness among insurers of the risks that they face in the sanctions domain. The continuous attention that DNB is giving to compliance with the Dutch sanctions rules and regulations by insurers shows the importance of having robust policies and procedures in place in order to assess whether a certain transaction is in breach of those rules and regulations.

France

The ACPR regulates communication by financial institutions via social networks

The French regulator and supervisor of the financial sector (ACPR) issued a recommendation on advertising financial products on social media. ACPR has observed that financial institutions, including insurers and intermediaries, have now integrated social media into their communication strategies. ACPR reminds firms that:

- Communication through social networks is subject to the same regulatory constraints as communication through more traditional means and customers should receive the same level of protection, regardless of the channel (e.g. the ACPR indicated that the dissemination of misleading reviews or false recommendations, the purchase of "likes", of "views" or of "subscribers" will be considered to constitute deceptive commercial practice).
- Firms can be held liable for the content they post on social networks, including when they relay content initially published by a third party (i.e. "sharing", "retweets"...).

ACPR recommends firms adopt a number of measures as best practice from the October 1, 2017. These include: ensuring that corporate accounts are created, separate to personal accounts – for example the accounts of employees or directors, for social media activities; ensuring that account makes clear the commercial nature of its online activity; ensuring that messages on social media (even if merely "shares") are fair and clear. In this respect, the advertising nature of the message should be explicitly indicated (if this is not clear from the message itself) and its content must remain balanced, including with respect to the terms and conditions of a service or a product. Firms should adopt internal procedures and controls over social media activities and should adopt monitoring measures to ensure compliance with internal procedures. Archiving of all social media activities must be developed in order to allow monitoring and control of the messages circulated.

New anti-corruption measures introduced by Sapin II Act

The Sapin II Act has introduced new anti-corruption measures in France. The measures will apply to chairmen and managers of companies, the (consolidated) turnover of which is higher than €100 million and which employ a minimum of 500 employees; or, form part of a group of companies employing a minimum of 500 employees the parent company of which has its headquarters located in France.

Sapin II introduces the offence of the corruption or influence by a French citizen (or by a person ordinarily resident or carrying out its business activity in France) of a foreign official. The new law also creates a requirement to have measures in place to prevent corruption, including a whistleblowing policy, a Code of Conduct, risk-mapping of exposure to corruption, systems for the management of third-parties and training and accounting procedures.

Significantly, Sapin II creates a new French Anti-Corruption Agency and more importantly, its Sanction Commission. The Anti-Corruption Agency may direct a company and its executives to adapt their compliance procedures and may impose financial penalties (of up to €200,000 in the case of individuals and up to €1 million in the case of legal entities) and to require the company to submit to monitoring of a compliance program by the Agency (for a maximum five-year period).

Lastly, Sapin II introduces the convention *judiciaire d'intérêt public* – similar to deferred prosecution agreements – to deal with violations of anti-corruption regulations.

United Kingdom

Brexit

In the UK, the most prominent issue that will affect the insurance market over the course of the coming year is, of course, Brexit. Following the triggering of Article 50 in March 2017, the UK has entered a period of uncertainty. Following the recent election and the conservative minority government, the proposals for a "hard" Brexit have been thrown into doubt.

In her Brexit speech on January 17, 2017, Prime Minister Theresa May stated that the UK will work to negotiate a bespoke Free Trade Agreement (FTA) with the EU, emphasizing that the FTA should be concluded by the end of the two year period contained in Article 50. Such

a deadline is unprecedented in trade negotiations and meeting it will be challenging to say the least; any FTA will need to be agreed by all of the European Parliament and possibly by all Member States, not all of whom will have aligned interests.

Moreover, the Prime Minister also stated that her proposals for Brexit "cannot mean membership of the single market" which would mean that the UK could not use the EU "passport" to allow financial services companies to continue to sell their services throughout the bloc. An alternative option would be to establish a regulatory equivalence framework; however this would require further negotiation followed by a legal act by the European Commission and equivalence is not necessarily always available – it is limited under Solvency II and non-existent under the Insurance Distribution Directive (IDD).

In addition the UK will need to negotiate FTAs with non-European countries. To do this, the UK would need to retake its full membership in the World Trade Organisation (WTO) and present its own schedule of tariffs and commitments. This might by itself bring specific challenges should any other WTO members raise any concerns.

The Prime Minister has said that countries such as China, Brazil and the Gulf States have already expressed interest in negotiating FTAs with the UK, and that the UK has already started conversations with Australia, New Zealand and India. Nevertheless, concluding FTA negotiations with these states would likely still prove to be challenging as those countries would have to wait for the conclusion of a UK-EU agreement before agreeing to any bilateral deal. Moreover, there are political and legal constraints on the UK negotiating those agreements before exiting the EU.

The Prime Minister's planned approach – a clean exit from the Single Market and Customs Union – looks far less likely to be the outcome of Brexit after the recent elections with public support for "hard" Brexit limited.

ILS

The UK government's plans to promote London as an insurance linked securities (ILS) hub will continue to be an area of growth in 2017. The outcomes of a number of consultations are anticipated over the course of the year. Once a fit-for-purpose framework has been created, the UK can participate in the growing market for ILS or alternative reinsurance capital which currently stands at around US$70 billion. It is estimated that the ILS market could grow to US$87 billion by 2019.

London, with its global insurance and capital market expertise, would be well placed to contribute to the continued growth and development of ILS business. However, the UK is not alone in seeking to capture ILS business; jurisdictions such as the Cayman Islands, Gibraltar, Guernsey and Bermuda all have established, competitive regimes. Coupled with the current uncertainty surrounding Brexit, it is important that whatever final rules are produced create the necessary incentives to attract investors and provide the robust regulatory framework to place London as the market leader for alternative risk transfer.

European Union

Data protection

The EU's General Data Protection Regulation (GDPR) comes into effect in May 2018, replacing the current legislative framework which dates back to 1995. The GDPR contains some new ambitious, far-reaching and strict rules on the use of personal data. The European Commission has confirmed that these rules will need to be complied with from day one.

Insurance companies doing business in the EU will need to start implementing GDPR rules as soon as possible in order to realize compliance by May 2018. The most significant change compared to the current framework is that the new rules require businesses to take a pro-active instead of reactive approach in data protection compliance: data protection will be taken into account during product development (known as "privacy by design"). The rules also demand that businesses clearly document and keep track of how they achieve data protection compliance.

A lot of material rules will remain unchanged, such as restrictions on data exportation or the obligation to implement appropriate security and operational measures to secure personal data. However, the sanctions for non-compliance will be increased significantly and will be comparable with the sanctions for breaching competition law. Data protection is clearly high on the agendas of EU and national legislators requiring data sensitive businesses, such as insurance companies, to take timely action towards compliance.

Distribution rules

Following the implementation of Solvency II, EU member states have turned their attention towards the IDD. The IDD will require all "distributors" of insurance products, both insurance and reinsurance undertakings selling directly and insurance and reinsurance distributors to meet requirements for registration, operating across EU borders, professional qualifications, information to customers, and product governance. Importantly, the IDD requires distributors of insurance products (but not reinsurance products) to act honestly, fairly and professionally in accordance with "the best interests of customers" – an overarching requirement that will require customers' interests to be taken into account in all distribution

arrangements, including in incentive and remuneration arrangements. Importantly, acting in customers' best interests will mean making sure that insurance products offer value for the customer, not just at point of sale but throughout the life of the product.

In terms of national markets, the implementation of the IDD raises a number of concerns. There are concerns in European markets about the increased regulation brought in by the IDD which has increased requirements for professional qualifications and ongoing training and requires both manufacturers of insurance products (usually insurers) and distributors to have in place agreements that more clearly delineate responsibility for mis-selling and other obligations between the parties.

South Africa

The role and remuneration of intermediaries

The South African government has proposed regulations to cap binding authority (binder) fees, prohibit binder arrangements for commercial lines policies and include administrative services within the definition of intermediary services so that no additional outsourcing fees can be charged for services such as issuing policies. These new remuneration restrictions on intermediaries may limit the activities of intermediaries and bar new entrants to the market. As a result, many policyholders who have a trusted relationship with their brokers will no longer be able to obtain the broker services they have become accustomed to. As the proposed regulations have been published without any proper study as to their impact on the market, it is possible that they could cause detriment to consumers and the wider market, should they be implemented in their current form.

Treating customers fairly

"Treating Customers Fairly" (TCF) principles were introduced into the South African market as an outcomes-based method of regulating insurers and intermediaries following a similar approach to that taken by the Financial Services Authority and its successor in the UK. Insurance companies are expected to build the TCF principles into their culture and ensure that at every level of the company the interests of policyholders are recognized and enhanced. The outcomes-based approach was said to be an improvement on rule-based regulation which is difficult to police. The problem with TCF principles is that the outcome is achieved or not achieved in the mind of whoever is looking at it.

The TCF approach has led to the publication of policyholder protection rules for the protection of personal lines policyholders. The draft regulations seek to control claims handling, complaints handling, advertising by insurers and policyholder protection in general. Problematically, the proposed regulations are written in such vague terms that insurers may not be able to clearly understand what should be done to avoid bad regulatory consequences. Although a breach of the rules can be a criminal offence, insurers must meet obligations to "act with due skill, care and diligence" when dealing with policyholders and to achieve an outcome where "policyholders are confident they are dealing with an insurer where the fair treatment of the policyholder is central to the insurer's culture". Without greater clarity as to how to meet these obligations and with criminal sanctions available for breach some insurers may struggle to understand their obligations under the new outcomes-based approach. It remains to be seen whether the policyholder protection rules will be finally published in the form of the draft that has been issued. If they are, the regulation of insurance in South Africa is going to be entering unchartered waters.

Demarcation of health insurance

Demarcation regulations which govern medical gap cover, hospital cash plans and primary healthcare policies came into effect in April. The regulations, which have been under consultation for the past 15 years, draw a line between what insurers can do under accident and health policies and what medical aid schemes can do to bear the cost of medical expenses for their members. The Treasury has described the regulations as an attempt to curb market abuses and protect consumers. It is concerned that because many South Africans cannot afford expensive medical scheme memberships, they are looking to health insurance policies as an alternative without necessarily understanding policy limitations. Under the regulations, gap cover will be limited to 250,000 Rand for each insured a year and hospital cash plan pay-outs will be limited to 3,000 Rand a day but with an annual cap of 20,000 Rand a year, irrespective of the number of days spent in hospital. However, critics suggest that the regulations are a threat to low-income earners, particularly those who cannot afford medical scheme membership but can afford health insurance. People with long term and/or serious illnesses could also be negatively affected by the regulations.

Reinsurance regulatory review

Under the proposals put forward by the Financial Services Board (FSB), foreign reinsurers will be allowed to register branches in South Africa, provided they are authorised and supervised in an "equivalent" jurisdiction. It is anticipated that equivalent jurisdictions will be those with risk-based solvency requirements, such as the UK and other EU countries. Additionally, credit ratings for foreign reinsurers will be adjusted to reflect the reduced supervisory powers that the regulator has over them,

whereas locally registered reinsurers' credit ratings will be adjusted for the purposes of the local direct insurer's solvency calculations, to avoid the effect of the sovereign cap on the locally registered reinsurer. Foreign reinsurers will be prohibited from soliciting business in South Africa on a cross-border basis. Furthermore, the FSB proposes a prohibition on fronting by placing a 75 per cent limit on cession to an unrelated counter party and an 85 per cent limit on cession if ceding to an entity within the same group. Underwriters at Lloyd's will be permitted to conduct insurance and reinsurance business in South Africa as in the past, subject to certain additional regulatory conditions.

Legislation review

In the longer term, a major revision of South African insurance laws is envisaged. A new Insurance Bill has been published which will deal with the prudential requirements of insurers far more strictly than is the case at present. There is a regulatory overreaction to the current financial crisis so that the cost of running an insurance company and the cost of compliance is ever increasing. The new Insurance Act which deals with these prudential issues will be running in parallel with the proposed Conduct of Financial Institutions Act (COFI) which will deal with market conduct. That COFI Act is a long way off. In the meantime insurers are going to struggle to get on top of the two existing insurance acts (for life and non-life), the parallel new Insurance Act and the umbrella financial legislation. At the same time there is rollout of the Retail Distribution Review which will steadily introduce more laws regarding the marketing and distribution of insurance and other financial products.

Australia

At the beginning of the year, the chairman of the Australian Securities and Investments Commission (ASIC), Greg Medcraft, delivered a speech to the Insurance Council of Australia Forum on the current insurance environment and ASIC's priorities for the coming year, with a focus on the insurance industry.

Current environment

Mr Medcraft acknowledged that 2016 had been an eventful year for the insurance industry, due to the increased public, media and government focus, as well as continued progress on law reforms in the industry. Mr Medcraft noted that technology and social media has impacted the insurance industry as it now means that customers are more empowered than they were before. Consumers are now able to provide their feedback concerning businesses and their engagement with them through social media.

As a result of this consumer feedback, ASIC will continue its investigation into life insurance (commenced during 2016) and that its focus on regulatory investigation will continue with a Senate Committee Inquiry into general insurance later in the year. ASIC will also review whether the unfair contract terms protection in the Australian Consumer Law should extend to insurance contracts.

Claims handling

As a result of findings made following an industry review of life insurance claims handling practices released in October 2016, ASIC has been focusing its attention on claims management in 2017.

Product governance

Another key area of review for the year will be in relation to the introduction of a new product design and distribution framework for financial products, and a product intervention power which will enable ASIC to take direct action to deal with any shortcomings in products or conduct, that results in consumer detriment. This will include a review of "add-on insurance", such as add-ons sold through car dealerships.

ASIC considers that issuers of financial products (including general insurers) should be obliged to:

- Identify an appropriate target market for their products.
- Consider whether the product meets the needs of those individuals and is capable of being understood by them.
- Select distribution channels that are likely to deliver the products into the hands of the individuals in the target market.

In light of this, ASIC is considering whether to implement a product intervention power which would enable it to take action on product features, the types of consumers who can access a product, and the circumstances in which they can do so.

Similarly, as part of the Government's review of ASIC's enforcement handling, it will be considered whether there will be more significant penalties for misconduct relating to insurance claims handling. ASIC considers that this will strengthen the regulatory framework for claims handling.

Given ASIC's funding increase and its clear commitment to increasing enforcement, we anticipate that there will be a rise in regulatory investigations and scrutiny of insurers. ASIC has recommended that insurers carefully review the operation and disclosures of their products and claims handling processes in light of the regulator's priorities for the coming year. We will continue to watch this space for any developments.

Hong Kong

Regulatory change

There will be a considerable number of challenges facing the insurance industry in Hong Kong over the coming year, as the responsibility for the supervision of insurance is transferred from the Insurance Authority of the Office of the Commissioner of Insurance (OCI), to the new Independent Insurance Authority (IIA). Other major developments anticipated in 2017 include the introduction of a statutory licensing regime and new conduct standards for intermediaries; the establishment of a policyholders' protection fund; and the introduction of a risk-based capital regime which is intended to come into effect in 2018. In particular, Hong Kong's first risk based capital quantitative impact study is planned for 2017. The aim of these developments is to bring Hong Kong in line with existing international supervisory standards and global regulatory trends; however it is anticipated that the cost of regulation for insurers will increase as Hong Kong moves from self-regulation to a statutory mode of regulation.

Cyber risk

Last year in May 2016, the Hong Kong Monetary Authority (HKMA) announced its Cybersecurity Fortification Initiative (CFI). The CFI establishes a framework for assessing vulnerability to cyber risks, creates a programme for building cybersecurity expertise in the region and also provides a platform for industry sharing of cyber intelligence.

The CFI is expected to lead to clearer standards for managing these risks which may emerge over the course of the year.

Singapore

RBC2

Preparations for Singapore's new Risk Based Capital regime (RBC2), which is expected to come into effect by 2019, will continue in 2017. In July 2016 the Monetary Authority of Singapore (MAS) published its third consultation paper on RBC2, setting out revised proposals and detailed technical specifications for insurers to conduct the second full scope Quantitative Impact Study (QIS 2). The objective of RBC2 is not to raise the industry's regulatory capital requirements, but to ensure that the framework for assessing capital adequacy is aligned to insurers' business activities and risk profiles.

RBC2 review will also bring Singapore's framework in line with international standards and best practices.

Cyber risk

Cyber insurance gained greater traction in 2016 and this growth in demand is expected to continue into 2017. Businesses are increasingly aware that data leaks not only result in financial losses by way of compensation pay-outs, but also cause long-term reputational damage and loss of consumer confidence. Well publicized hacking events, such as the cyber-attacks on Singaporean telecom operator StarHub in October 2016, have also emphasized the need for cyber insurance.

Thailand

2017 is expected to be a continuation of 2016 with rates continuing their downward trend. However, that sixty percent of premiums in the market are controlled by the top ten insurers may see an increase in M&A activity to gain market share and strengthen market position. In addition, last year saw Thailand's regulator, the Office of Insurance Commission (OIC) increase death benefits attached to compulsory motor vehicle insurance to 300,000 Baht. Although this will mean higher pay-outs in 2017, it is unlikely that insurers will be greatly affected as approximately 5000 new motor vehicles are registered in Thailand every day; thus the higher pay-outs are offset by the increase in premium volume.

Indonesia

Changes in reinsurance

Historically, Indonesia's domestic reinsurance needs have always been met by foreign insurers, which has sparked concern from the Ministry of Finance and the Indonesian financial services authority Otoritas Jasa Keuangan (OJK). To address these concerns, in 2015 Indonesia's Ministry of State Owned Enterprises announced that it was merging three Indonesian reinsurance companies to create IndoRe. While the impact of IndoRe on existing reinsurers is not currently known, it is anticipated that compulsory cession to IndoRe will be mandated and it is assumed that property and auto primary lines will see a requirement of 100 per cent local retention for nearly all risks. Thus 2017 will see much of the groundwork in achieving such goals, particularly as Officials have said their aim is to boost IndoRe's market share to 50 per cent by 2019.

For more information contact:

Hélène Lefebvre
Partner, Montréal
Tel +1 514 847 4457
helene.lefebvre@nortonrosefulbright.com

Andreas Börner
Partner, Munich
Tel +49 89 212148 412
andreas.boerner@nortonrosefulbright.com

Eva-Maria Barbosa
Partner, Munich
Tel +49 89 212148 461
eva-maria,barbosa@nortonrosefulbright.com

Floortje Nagelkerke
Partner, Amsterdam
Tel +31 20 462 9426
floortje.nagelkerke@nortonrosefulbright.com

Orsolya Hegedus
Of counsel, Paris
Tel +33 1 56 59 53 56
orsolya.hegedus@nortonrosefulbright.com

Benedicte Denis
Partner, Paris
Tel +33 1 56 59 53 65
benedicte.denis@nortonrosefulbright.com

Laura Hodgson
Senior knowledge lawyer, London
Tel +44 20 7444 3985
laura.hodgson@nortonrosefulbright.com

Patrick Bracher
Director, Johannesburg
Tel +27 11 685 8801
patrick.bracher@nortonrosefulbright.com

Victoria Chalmers
Senior associate, Brisbane
Tel +61 7 3414 2723
victoria.chalmers@nortonrosefulbright.com

Anna Tipping
Partner, Singapore
Tel ++65 6309 5417
anna.tipping@nortonrosefulbright.com

Sarah Chen
Of counsel, Bangkok
Tel +662 205 8518
sarah.chen@nortonrosefulbright.com

Nil recourse transactions from a W&I claims perspective

Where a seller has limited or no liability in a M&A transaction, Simon considers options W&I insurers might have to better protect themselves

The M&A market has seen a rise in the number of deals being structured as "nil recourse" transactions in recent years (a nil recourse transaction is where the seller's liability under the transaction documents for breach of the warranties is set at nil or a nominal amount (absent of seller fraud)) and there is little sign of the trend abating. This stems both from the fact that they represent an attractive solution for sellers who are looking to achieve a "clean exit" and the increase in the number of sales via a competitive auction, which can result in buyers agreeing to such a transaction in order to seek to differentiate themselves from other bidders. However, these transactions also depend on warranty & indemnity insurance to get off the ground as otherwise the buyer would be left without a remedy in the event of a breach of the warranties by the seller. This article considers some of the risks as well as the advantages that can result from a nil recourse transaction, particularly from a W&I claims perspective.

Insurers tend to treat a nil recourse transaction with a degree of caution as the fact that the seller has "no skin in the game" gives rise to the risk that it may not be incentivized to carry out a thorough disclosure process (with the result that known issues may not be revealed to the buyer) or negotiate the warranties as hard as it might otherwise (with the result that the buyer may have a better chance of successfully establishing that there has been a breach of warranty). It is important that this risk is properly managed at an underwriting stage and, for this reason, insurers will typically scrutinise the disclosure process and the negotiated position on the warranties more closely and insist that the deal proceeds as if the policy was not being put in place. Further, in these situations, the insurer is less likely to agree to a low retention under the policy in order to provide it with added protection.

In the event of a claim under the policy, part of an insurer's investigations may extend to making enquiries with the seller in situations where the warranty that is alleged to have been breached is qualified by the seller's awareness (albeit, where the seller is a company, the transaction documents will typically state that the seller is deemed to have the awareness that it would possess if it made due and careful enquiry of specific individuals, usually comprising those directors and employees who report directly to the seller in relation to the relevant items being warranted). The risk for an insurer, particularly so far as nil recourse transactions are concerned, is that a liability free seller has little incentive to co-operate (or to encourage others to do so) which may impact on the quality of its coverage investigations.

However, a nil recourse transaction does remove a potential difficulty for an insurer when it comes to considering whether it can pursue a fraudulent seller to recover, via a subrogated claim, the losses that it has paid out to the insured (i.e. the buyer) under the policy. This is because of the difference in a buyer's typical approach to a breach of warranty claim depending on whether the seller has retained any liability under the transaction documents or not (as illustrated below).

Where the deal has not been structured as a "nil recourse" transaction, it is common for the buyer to pursue a claim both against the seller under the transaction documents (up to the limit of its liability cap) and against the insurer under the policy. The seller will often look to settle the claim against it quickly on a "full and final" basis. The motives for this can vary and do not necessarily reflect a belief that the buyer has a good claim. In our experience, there are often commercial factors behind such a step. For instance, the seller could be part of a management team that is staying on

with the target post completion. In this situation, a dispute could be disruptive to the business. Alternatively, the seller may be in the process of being wound-up following the sale. The buyer's claim may hold up this process and thus prevent the proceeds of sale from being distributed to the shareholders. A view may be taken, therefore, that a quick settlement is desirable. Further, where the seller's liability is capped at a relatively low amount, it may undertake only limited investigations before settling the claim against it. However, regardless of the motives behind it, a full and final settlement between the buyer and seller gives rise to a difficulty for the insurer because it will be bound by the settlement thus extinguishing any subrogation rights that it may have obtained against the seller in due course. This is because the insurer is placed in the position of the insured when bringing a subrogated claim and it is not entitled to exercise rights that are not available to the insured. This can create a tension between a buyer who wants to complete a settlement with the seller and an insurer who would like to keep open the possibility of a subrogated claim, at least until it can satisfy itself that there is no evidence of seller fraud. The ideal solution in these circumstances is for the settlement between the buyer and seller to carve out fraud, but this is unlikely to be accepted by the seller who will want to have certainty that it faces no further liability in return for making a payment. The reality, therefore, is that, in many instances, the only remedy that an insurer may be left with is a possible claim against the insured for having prejudiced its position in the event that it later emerges that there is evidence of seller fraud. However, this is not an attractive option for an insurer and the best course of action is to try and avoid such a situation arising in the first place by considering the issue of seller fraud at an early stage and raising any concerns with the buyer before it enters into a settlement with the seller with a view to discussing ways in which the insurer's potential right of subrogation might be preserved.

Where the deal has been structured as a "nil recourse" transaction, it is common for the buyer to pursue a claim against the insurer under the policy only. Whilst it would be open to the buyer to pursue the seller too, the fact that it would have to prove fraud in order to bring a successful claim means that, in practice, this is rare. In these circumstances, the difficulty highlighted above does not arise. The insurer will, in the event that it makes a payment under the policy, be free to pursue a subrogated claim against the seller. Of course, fraud is not an easy hurdle to prove and it is not an issue in many breach of warranty claims, but the fact of the matter is that warranty and indemnity insurance is not immune from the risk of an unscrupulous seller deliberately withholding material information from the buyer. An insurer's potential right of subrogation is, therefore, an important, if seldom used, tool at its disposal in the event that it makes a payment under the policy and the fact that nil recourse transactions, where the risk of seller fraud is arguably higher, are likely to result in a greater freedom to exercise this right compared to when the deal has not been structured in this way will be of some comfort to warranty and indemnity insurers.

For more information contact:

Simon Radcliffe
Senior associate, London
Tel +44 20 7444 3210
simon.radcliffe@nortonrosefulbright.com

Hong Kong Insurance Authority changes guidance on governance – what you and your board need to know

Earlier this year the minimum governance standards for Hong Kong authorized insurers changed as part of a two-phase reform. James Parker and Marina Sherer from our Hong Kong office set out a summary of the key changes.

From January 1, 2017, the first phase of changes to the Hong Kong Insurance Authority's Guidance Note on the Corporate Governance of Authorized Insurers (GN10), took effect. The second phase of changes (which are more substantive) will take effect from January 1, 2018, allowing more time for transition. A new requirement for persons in "control functions" to be fit and proper and for their appointment to approved by the newly established Insurance Authority (IA), will take effect when section 13AE of the Insurance Companies Ordinance (as amended) (ICO) commences.

GN10 sets out the minimum standards of corporate governance that are expected of Hong Kong's authorized insurers, with many of the changes being made to reflect the International Association of Insurance Supervisors' Insurance Core Principles 7 (Corporate Governance) and 8 (Risk Management and Internal Controls).

Application

As part of the amendments, the application of GN10 has been extended.

From January 1, 2017, GN10 applies to

- Authorized insurers incorporated in Hong Kong generally, save for those in run-off (provided that, in the case of a long-term insurer, its annual gross premium income from renewal business is less than HK$20 million).
- Authorized insurers incorporated outside Hong Kong where 50 per cent or more of the insurer's annual gross premium income pertains to its Hong Kong insurance business (unless an exemption is obtained from the IA).

Captive insurers are encouraged to adopt GN10 as appropriate.

Summary of the key changes

We set out below a short summary of the key changes, when they take effect and a list of potential action items.

Changes effective January 1, 2017	
Change	**Action item**
Spread and level of expertise in Board It is advisable for the Board to have an adequate spread and level of expertise in key areas of insurer's business, such as underwriting, claims, actuarial, finance, and investment (paragraph 4.2.2).	Consideration to be given to the composition of your board of directors and whether your existing board has an adequate spread and level of expertise in the areas most relevant to your business.
Chairman/chief executive The role of Chairman and chief executive should not be performed by the same person (paragraph 4.4.1).	If your board is currently chaired by your chief executive, a new Chairman will need to be appointed.
Fair treatment of policy holders When setting business objectives and strategies, the board should consider the fair treatment of policy holders as well as the long term financial soundness of the insurer and the legitimate interests of its stakeholders (paragraph 5.1.1(a)).	Boards need to keep policyholders front of mind when setting business objectives and strategies. GN10 indicates that the Hong Kong regulator's intention is that policy holder interests should be considered a board issue as well as a regulatory issue.
Review of committees The Board should review its committees, at least annually, to ascertain whether the members of the committees collectively and individually remain effective in discharging their responsibilities (paragraph 6.7.1).	Schedule at least an annual review of any committees to assess and consider the effectiveness of the committee and its members.
Chair of the audit committee An independent non-executive director (INED) should chair your audit committee (paragraph 8.4.2).	Consider appointing an INED as chair of the audit committee, if an INED does not currently hold that role.
Cyber security Insurers are encouraged to have policies and procedures in place to identify, prevent, detect and mitigate cyber security threats (paragraph 7.17.1).	To the extent not already in place, consider adopting a cyber security policy commensurate with the scale and complexity of your business.
Business continuity planning It is suggested that insurers should have a business continuity policy and a business continuity plan for both going-concern and gone-concern situations. The policy and plan should identify viable measures and actions the insurer can take to restore its business activities under different stressed conditions or by way of precautionary measure (paragraph 7.18.1).	Consider adopting a business continuity policy and a business continuity plan.
Changes effective January 1, 2018	
Change	**Action item**
Standalone risk committee* Insurers will need to have separate audit and risk committees (paragraph 8.2).	If you currently have a combined audit and risk committee you will need to consider when you split them into separate committees and which personnel will sit on each. If you currently have only an audit committee you will need to establish a risk committee. Terms of reference for the risk committee will need to be prepared.
INEDs* From January 1, 2018, the number of independent directors sitting on your board will need to increase from 1/5th to 1/3rd (paragraph 4.2.3).	Across the market this will result in much greater demand for INED services. Consider approaching any additional INED(s) in advance.

* Indicates that small authorized insurers are subject to slightly different requirements or benefit from an exemption.

Change	Action item
Remuneration Insurers will need to have a written remuneration policy which "should not induce inappropriate or excessive risk taking" (paragraph 9.1). The remuneration policy should motivate directors and employees to pursue the long-term growth and success of the insurer and demonstrate a clear relationship between performance and remuneration (paragraph 9.2.3).	If you do not currently have a remuneration policy, you will need to adopt one. If you already have a remuneration policy, it will need to be reviewed for compliance with the revised guidance note.
Changes effective when section 13AE of the ICO commences	
Change	**Action item**
Fit and proper persons in "control functions" Whilst GN10 envisages delegation, insurers will need to satisfy themselves, and the IA, that any persons solely or jointly responsible for the performance of a "control function" are fit and proper. For these purposes "control functions" include actuarial, financial control, internal audit, compliance, risk management and intermediary management functions (paragraph 4.6).	The IA's prior consent will need to be obtained before a senior executive who will carry out a control function is appointed, so additional time will need to be factored in when an appointment is proposed.

For more information contact:

James Parker
Partner, Hong Kong
Tel +852 3405 2590
james.parker@nortonrosefulbright.com

Marina Sherer
Senior associate, Hong Kong
Tel +852 3405 2307
marina.sherer@nortonrosefulbright.com

Case notes

The *Ocean Victory* – the impact of contractual terms on subrogated claims

The recent UK Supreme Court decision in *Gard Marine and Energy Limited v China National Chartering Company Limited & another* (The "*Ocean Victory*") [2017] UKSC 35 considers whether an insurer can bring a subrogated claim against a co-insured to recover loss paid to another insured, in light of the terms of the contract pursuant to which the insurance was arranged.

Background

The *Ocean Victory*, a Capesize bulk carrier, was demise chartered on the Barecon 89 form and then time chartered to China National Chartering Co Ltd (Sinochart). Sinochart in turn sub-chartered her to Daiichi Chuo Kisen Kaisha (Daiichi) for a time charter trip. On October 24, 2006, the vessel grounded at the port of Kashima in Japan and became a total loss. Gard Marine & Energy Ltd (Gard), one of the vessel's hull insurers, after paying the loss, took assignments of rights from the owners and the demise charterers in respect of the grounding and total loss of the vessel, and subsequently brought a claim against Sinochart who in turn sought to recover from Daiichi. Gard's case (as assignees of the demise charters) was that the demise charterers had a liability to owners, which in turn enabled demise charterers to claim damages down the charterparty chain.

At first instance, Teare J held that the casualty was caused by the unsafety of the port and that the owners, although indemnified by the insurers, had a subrogated claim against demise charterers for breach of the safe port undertaking, which entitled Gard to recover damages for breach of the safe port warranty from Sinochart who in turn were entitled to recover an indemnity from Daiichi. On appeal by Daiichi, Teare J's decision was overturned by the Court of Appeal. Gard were granted permission to appeal to the Supreme Court.

The Supreme Court upheld the Court of Appeal's decision that there was no breach of the safe port undertaking. As a result, it was not strictly necessary for the Supreme Court to consider the insurance issue but the Justices recognized the importance of the issue.

The Supreme Court decision

As a general principle of English law, co-insureds cannot bring claims against each other in respect of an insured loss. This means that an insurer cannot bring a claim in the name of one insured (to whom an indemnity has been paid) in order to recover loss paid to another co-insured. The juridical basis of the principle is, however, not settled. Some earlier authorities suggest that the doctrine of circuity of action or the implication of an implied term into the insurance contract forms the basis of this principle, whereas more recent authorities suggest that construction of the underlying contract rather than the terms of the insurance policy made pursuant to the contract is the more favorable basis.

In this case, the Supreme Court endorsed that construction of the underlying contract of the parties should determine whether a subrogated insurer can claim against the co-insured in respect of an insured loss. Nonetheless, the Justices are divided in their construction of the underlying Barecon form which creates the co-insurance.

The Supreme Court considered Barecon 89 (clause 12) which provided that marine and war risks insurances were to be taken out by the charterers at their expense to protect the interests of owners, charterers and any mortgagees, and to be in the joint names of owners and charterers, as their interests may appear.

The majority of the Supreme Court (Lord Mance, Lord Toulson, and Lord Hodge) took the view that clause 12 was clearly intended comprehensively to deal with the risks of loss or damage to the vessel and what was to happen in such an event. Lord Mance noted that the principle that insurers cannot claim against their own co-insured in respect of an insured loss rested on a natural interpretation of or implication from the contractual arrangements giving rise to such co-insurance. In agreement, Lord Toulson added that:

"[T]he question in each case is whether the parties are to be taken to have intended to create an insurance fund which would be the sole avenue for making good the relevant loss or damage, or whether the existence of the fund co-exists with an independent right of action for breach of a term of the contract which has caused that loss. Like all questions of construction, it depends on the provisions of the particular contract..."

Lord Toulson agreed with the Court of Appeal that the proper construction of clause 12 was that there was to be "an insurance funded result in the event of loss or damage to the vessel by marine risks" and that, had the demise charterers been in breach of the safe port clause, they would have been under no liability to the owners for the amount of the insured loss because they had made provision for looking to the insurance proceeds for compensation. He concluded that "the insurance arrangements under clause 12 provided not only a fund but the avoidance of commercially unnecessary and undesirable disputes between the co-insured".

However, Lord Sumption and Lord Clarke, in the minority, considered that clause 12 did not contain an express exclusion of liability on the part of the demise charterer for breach of the safe port undertaking and there was no need to imply a term to the contrary. Lord Sumption noted that under clause 12, the demise charterer's liability for the loss of the ship was not excluded but satisfied through the insurance payment. It followed that the demise charterer could claim against the time charterer who is not party to the insurance or any of the contractual arrangements connected with it. In his view, a different question arose in this case as between a co-insured (or his insurer) and a third party wrongdoer, which none of the existing English authorities purports to answer. He also raised the question what if an insurer becomes insolvent after a loss – in other words, if owners and demise charterers look to an insurance funded outcome, what happens if the insurance does not or cannot pay? Would owners still be precluded, as a matter of principle, from recovering against demise charterers? Lord Mance and Lord Toulson regarded that as a remote eventuality which cannot be a guide to the meaning of clause 12.

The demise charterers also relied upon clauses 13 and 29 of Barecon. Under clause 13 (if chosen), owners maintain marine and war risks insurance while demise charterers have to maintain P&I insurance. It contains express exclusion of a right of recovery or subrogation in the context of insurances taken out by owners. Clause 29 contains the safe port undertaking for employment "only between good and safe berths, ports or areas where vessel can safely lie always afloat". It was submitted that unlike clause 13 there was no express exclusion of subrogation in clause 12 and that charterers must have some liability towards owners under clause 29 because otherwise there can be no back-to-back claim down the charterparty chain. Lord Mance dismissed these submissions. In his view, there was no reason to think that clauses 12 and 13 were devised as anything other than two routes to the same substantive allocation of responsibilities for repairs and total loss, irrespective of fault, and clause 29 cannot have been intended to give rise to a system of recourse for loss of the hull, by way of damages for breach of contract, separate from the no fault scheme of responsibility and insurance recovery for a hull loss introduced by clause 12.

Comments

This decision should be heeded by underwriters. Although it is a decision on a particular (albeit important) provision of Barecon 89, it may well have wider implications on the ability of Underwriters to subrogate where the contract pursuant to which joint insurance is purchased is in similar terms and where the subrogated claim itself relies on an ability to pass a claim down a contractual chain. What seems clearer now is that the underlying contractual arrangement between the parties which gives rise to the co-insurance in their joint names will dedicate whether any such subrogated recovery claim will succeed at the end of the day.

For more information contact:

Wenhao Han
Associate, London
Tel +44 20 7444 2402
wenhao.han@nortonrosefulbright.com

The shadowy world of Ombudsman decision-making

The High Court has quashed a decision of the Financial Ombudsman Service (FOS) against Aviva on the basis that it was inadequately reasoned but confirmed that it is open to the FOS to depart from the law in reaching its decisions on the basis of what is "fair and reasonable". The complaint will now be re-determined by the FOS.

The complaint related to Aviva's handling of two life insurance policies taken out in 2006 and 2013. Following cancellation of the first joint policy in 2013, a second single life policy for £500,000 was taken out and a claim on this second policy was made in December 2013. In April 2014, Aviva declined the claim and avoided the second policy on the basis of failure by the insured to make relevant disclosures regarding his health. A complaint was made to the FOS in relation to both policies.

The Ombudsman determined that Aviva's decision not to reinstate the first policy was fair but that the misrepresentations in relation to the second policy were innocently made and so the information that was not disclosed should be disregarded, the second policy should be reinstated and the claim should be considered.

Aviva applied for judicial review of this decision. The FOS agreed that more detailed reasoning could have been given and that the complaint should be considered afresh but did not accept that the decision was, in any event unreasonable and tantamount to a money award of £500,000.

The Court considered the jurisdiction of the FOS under s. 228(2) of FSMA, which provides that complaints are to be determined by reference to what the Ombudsman considers to be fair and reasonable. The FCA Handbook also provides that, in considering this, the Ombudsman will take into account relevant laws, regulations, codes of practice and where appropriate, what the Ombudsman considers to have been good industry practice at the time (DISP 3.6.4 R). The Court held that

- The Ombudsman did not, and was not required to, follow relevant law, guidance and practice but that, when departing from the relevant law, the Ombudsman should say so in the decision and explain why.
- The Ombudsman's decision should be entirely quashed and the complaint should be re-determined.
- It would be open to the FOS's Ombudsman, when reconsidering the complaint, to reach a different decision on the 2006 joint policy as well as the 2013 single life policy;. the question for the Ombudsman was whether Aviva had acted fairly and reasonably in all the circumstances of the case. The Ombudsman might decide that Aviva did not do so even where it adhered to sound legal principle, guidance and practice.
- An Ombudsman might rationally conclude that it was fair and reasonable for Aviva to reinstate the joint policy and a differently reasoned decision upholding the complaint in relation to the single life policy would not necessarily be irrational.
- If the complaint was upheld and Aviva had to pay out under the policy, its liability would be limited to £150,000 (and it would be good practice to spell this out in the decision).

In reaching its decision, the court recognized that it was unclear as to whether the FOS was now applying a general policy to the effect that insurers should be bound where innocent representations are made and that the FOS may have to explain its broader rationale as the breadth of its jurisdiction did not absolve it from consistency in decision-making. The judge also commented that he had "personal concerns" regarding the jurisdiction of the FOS which "occupies an uncertain space outside the common law and statute" where "the relationship between what is fair and reasonable and what the law lays down is not altogether clear". He queried who or what defined the contours and content of fairness and reasonableness and commented that it might be said that the jurisdiction of the FOS was "penumbral because its shadows cannot be illuminated".

For more information contact:

Katie Stephen
Partner, London
Tel +44 20 7444 2431
katie.stephen@nortonrosefulbright.com

Ashfaq v International Insurance Company of Hannover PLC [2017] EWCA Civ 357

On May 12, 2017 the Court of Appeal considered an appeal against summary judgment dismissing an insured's claim for an indemnity under a Residential Let Property Owners insurance policy.

The insured, Mr Mohammed Ashfaq, owned a residential property in Huddersfield which he let out to students. On July 6, 2012, a fire broke out, causing extensive damage to the property and the insured claimed under the policy. By April 2013 the insurer, International Insurance Company of Hannover PLC, had made two interim payments totalling £38,232 before becoming concerned that the claim was fraudulent. Upon investigation of the suspected fraud, the insurer became aware that the information provided on the insured's proposal form was incorrect as the insured had a prosecution pending at the time that the application for insurance was made. Consequently, the insurer declined to make any further payments to the insured and avoided the policy for material non-disclosure and misrepresentation.

The insured issued proceedings in October 2014 and the insurer counterclaimed for the return of the interim payments. The judge at the summary judgment hearing held that the insured had no realistic prospect of succeeding in his claim at trial and gave judgment for the insurer on the counterclaim for the return of the interim payments, less the amount of the premium.

The insured appealed on the basis that the judge had erred in failing to appreciate that the Unfair Terms in Consumer Contracts Regulation 1999 (UTCCR 1999) and the Insurance Conduct of Business Sourcebook (ICOBS) rules were relevant in determining the insurers application for summary judgment as he was a consumer for the purposes of those rules; had the judge done so, he would have found that the "basis of the contract" and "subject to" clauses were unenforceable against the insured.

However the Court of Appeal dismissed this argument and held that the insured had no real prospect of successfully establishing that he was a "consumer" within the meaning of either UTCCR 1999 or ICOBS. The online proposal form completed by the broker was clearly an application for a policy under the Residential Let Property Owners Scheme regarding a property let to students, not an application for ordinary domestic house insurance. The purpose of the insurance was related to the insured's trade, business or profession of property letting, and he was not a consumer.

In addition, the fact that the insured was carrying on the trade or profession of company director did not mean that he was not also carrying on the trade, business or profession of a building's owner letting out a property for profit. A person who takes out a policy covering property bought under a buy to let mortgage is a "commercial customer" for the purposes of classification under ICOBS and, as Flaux LJ noted, "it is neither here nor there that the person may also be a company director of a company whose business is unrelated to property letting". Furthermore, the language used on the proposal form, such as "home" and "you and all members of your Family", did not mean the insurance was taken out as a consumer, nor did it convert business insurance into consumer insurance.

Moreover, the insured had not sought to adduce any further evidence to support the assertion that he was a consumer within the meaning of the UTCCR 1999 or ICOBS, nor did he present any evidence from which the Court of Appeal could infer that the property being let to students was a temporary arrangement.

While the circumstances of this case may seem straightforward, it raises a number of interesting questions in relation to the sharing economy, such as "do you cease to be a consumer from the moment you rent out your flat, your car, or any other personal asset?" The Court of Appeal certainly seems to think so. However, the lines between acting as a consumer and as a business continue to blur as technology develops and offers more opportunities for consumers to make money from their personal assets. Customer interaction with and reliance upon such technology is driving their expectations of other services, including insurance providers. Consequently there will be an increase in demand for insurance products that can instantly and seamlessly switch between commercial and domestic coverage, keeping pace with customer lifestyles, behaviors and circumstances.

For more information contact:

Amy Teece
Knowledge assistant, Legal (Insurance), London
Tel +44 20 7444 3797
amy.teece@nortonrosefulbright.com

Industry specific policies: how intimately should you know the tricks of the insured's trade?

A recent decision of the NSW Court of Appeal highlights some pitfalls with targeted industry insurance policies where insurers ultimately accept undisclosed risks. Underwriters of an insurance package targeting the adult industry and insuring premises operating as a brothel were found to have accepted the risk that persons operating or frequenting the premises may have affiliations with criminal networks.

Background

Stealth Enterprises Pty Ltd (Stealth) owned and operated a brothel in the ACT under the name "The Gentlemen's Club". The premises were damaged by fire in 2012.

At the time of the fire, Stealth was insured by Calliden Insurance Limited (Calliden) through a policy described as a "Business Pack, Adult Industry Insurance Policy".

At first instance, Calliden successfully reduced its liability to nil by claiming Stealth had failed to disclose that its sole director and manager were members of the Comancheros bikie gang and that, at the time of renewal, Stealth's registration under the Prostitution Act 1992 (ACT) had lapsed.

Unsatisfied with the result, Stealth appealed.

Issues on appeal

The issues to be decided on appeal were

- Whether a reasonable person in Stealth's circumstances could have been expected to know that the association with the Comancheros was relevant to Calliden's decision whether to accept the risk by renewing the policy.
- Whether, had that association been disclosed to Calliden, it would have renewed the policy.
- Whether at the time of renewal, Stealth knew the company's registration as a brothel had lapsed and, if so, had that disclosure been made to Calliden, whether it would have renewed the policy and been on risk at the time the premises was damaged by fire.

The industry specific hypothetical person test – should Stealth have expected the link to criminal organizations to be relevant to Calliden's decision?

The test for disclosure in s 21 of the Insurance Contracts Act 1984 (Cth) is whether a hypothetical reasonable person, in the circumstances of the insured, would know the undisclosed matter would have been relevant to the insurer in deciding whether, and on what terms, to grant insurance.

In determining the circumstances of the hypothetical reasonable insured in this case, the Court considered the "nature of the business conducted by Stealth, the type of insurance sought, the identity of the insurer, the circumstances in which the insurance was entered into and renewed, as well as the fact of the association between the insured's director and general manager and the Comancheros".

The Court found that a reasonable insured could understand that an insurer specializing in the insurance of brothels would expect that people with criminal connections were likely to be involved in the use of the premises. If it was relevant to the insurer to know of any particular association between the insured and any particular criminal activity or organization, a reasonable insured would expect the proposal to contain questions directed to the subject.

In this instance, the proposal directed specific questions to the claims histories of the insured and the criminal history of its directors. Quite crucially, however, the proposal did not direct any questions to any criminal or other associations of the directors.

The Court therefore found that a hypothetical reasonable brothel owner in Stealth's circumstances would not have been expected to know the association with the Comancheros was relevant to Calliden in renewing the policy, given it did not feature anywhere in the questions asked in the proposal. Rather, the Court saw this as "the sort of association the insurer would expect and take into account as part of the general risk of insuring a brothel".

Failure to disclose lapse of registration

Though the Court found Stealth was aware of the fact its registration as a brothel had lapsed, there was evidence from Stealth that the issue would have been remedied. It was otherwise not established that, had such disclosure been made, Calliden would not have renewed or otherwise insured the premises at the time of the fire.

Calliden was therefore unable to reduce its liability to nil and judgment was awarded in Stealth's favour.

The takeaway message

It is clear from the Court's reasoning that insurers should be aware of inherent risks for targeted policies having regard to the nature of an insured's business. If insurers want to place any weight on these risks, questions need be directed towards the issue in the proposal.

In this instance, had Calliden asked more probing and specific questions in its proposal the outcome might have been quite different.

Post script – further developments?

Just prior to publication, an interesting development arose. On June 6, 2017, Calliden was successful in staying enforcement of the judgment pending determination of Calliden's special leave application. This was in part because Justice Macfarlan accepted that, once paid, Calliden was unlikely to see its money again even if successful.

Further, in granting the stay, his Honour stated Calliden's application for special leave was "strongly arguable" and had a "significant chance of success". His Honour's comments made clear that should the High Court choose to address this question, its judgment is "likely to provide guidance to practitioners in an important area of insurance law and practice".

We'll be keeping a close eye on this one.

For more information contact:

Joshua Carton
Senior associate, Sydney
Tel +61 2 9330 8161
joshua.carton@nortonrosefulbright.com

Elyse O'Sullivan
Lawyer
Tel +61 2 9330 8726
elyse.osullivan@nortonrosefulbright.com

Obligation to pay the premium as condition precedent to insurance policy cover (UK)

The due observance of and compliance with the terms, provisions and conditions of the policy by the insured was a condition precedent to liability by the insurer to make payment. This was an after-the-event legal costs policy where the premium was payable once the matter was finalized and the costs could be determined.

The court held that there is no rule that premium is payable at any particular point in time and the policy attached no time limit to the payment of the premium. There was nothing in the policy that imposed a condition precedent for the premium payment which was only calculated once the costs had been established. There had been no request for payment of the premium and the insurers could not rely on non-payment to defeat the claim.

If insurers want the premium paid on a particular date, and if they want to make the cover subject to that payment (subject to days of grace) the policy must say so explicitly.

[The case is *Denso Manufacturing UK Ltd v Great Lakes Reinsurance (UK) PLC*]

For more information contact:

Patrick Bracher
Director, Johannesburg
Tel +27 11 685 8801
patrick.bracher@nortonrosefulbright.com

Asbestos exclusion upheld in US

An exclusion for claims "arising out of asbestos" was upheld by a US appeal court because it is unambiguous and therefore enforceable.

The appeal court overturned a US$36 million judgment against the insurer, which is only part of the policyholder's liability for US$120 million worth of asbestos-related claims. The court did not accept the argument that the exclusion was ambiguous and that it only related to raw asbestos in its unprocessed form. The court held that the phrase "arising out of" is unambiguously satisfied by the "but for" causation test. Because the losses relating to the underlying asbestos suits would not have occurred but for asbestos, raw or within finished products, the exclusion was upheld and the local court's judgment was set aside.

This decision comes after a ten year-long battle between the insured, General Refractories Co, and insurers relating to tens of thousands of claims brought by plaintiffs who say they were injured after being exposed to the company's asbestos-containing products.

[The case is *General Refractories Co. v First State Insurance Co.*]

For more information contact:

Patrick Bracher
Director, Johannesburg
Tel +27 11 685 8801
patrick.bracher@nortonrosefulbright.com

Norton Rose Fulbright and R3 launch white paper on application of blockchain and distributed ledger technology in the insurance sector

As a sector, the insurance industry is particularly well placed to benefit from distributed ledger technology and applications enabled by it, such as smart contracts.

The automation and digitization of the insurance value chain through these technologies has the potential to lead to value creation through the development of innovative new products and new business models, which could prove revolutionary to the industry.

Digitizing the insurance value chain through the use of blockchain or other distributed ledger technologies (DLTs) has the potential to revolutionise the insurance sector, according to a new whitepaper prepared by global law firm Norton Rose Fulbright in association with financial innovation firm R3.

The Norton Rose Fulbright-R3 white paper illustrates potential use cases for DLTs in the insurance sector and examines the legal, regulatory and commercial factors that the industry should consider before deploying such technologies.

Macroeconomic factors, regulatory requirements and a soft market have focused insurance market participants on investing in new and developing technologies (including DLT) with the aim of reducing costs, increasing competitiveness and profitability, and improving customer experience.

Insurance value chains involve multiple market participants who share and transact on the basis of a huge amount of data. A significant industry issue is the maintenance of multiple records of the same data within the same business for use in different aspects of the lifecycle of the insurance of the same underlying risk or book of business. This data requires reconciliation and verification. DLT has the potential to remove the inefficiencies associated with reconciliation and verification of siloed data by facilitating shared control of transaction specific data which is available to all (or selected) participants in the relevant network and can be updated almost in real time.

When combined with smart contracts and information fed into the distributed ledger by IoT (Internet of Things) devices and other open data sources, DLT can automate and streamline significant parts of the insurance value chain, from the acceptance of risk through to policy administration, payment of claims and regulatory oversight. This level of automation will reduce inefficiency and error and has the potential to lead to an improvement in customer outcomes, through more responsive insurance products with a higher degree of certainty of outcome.

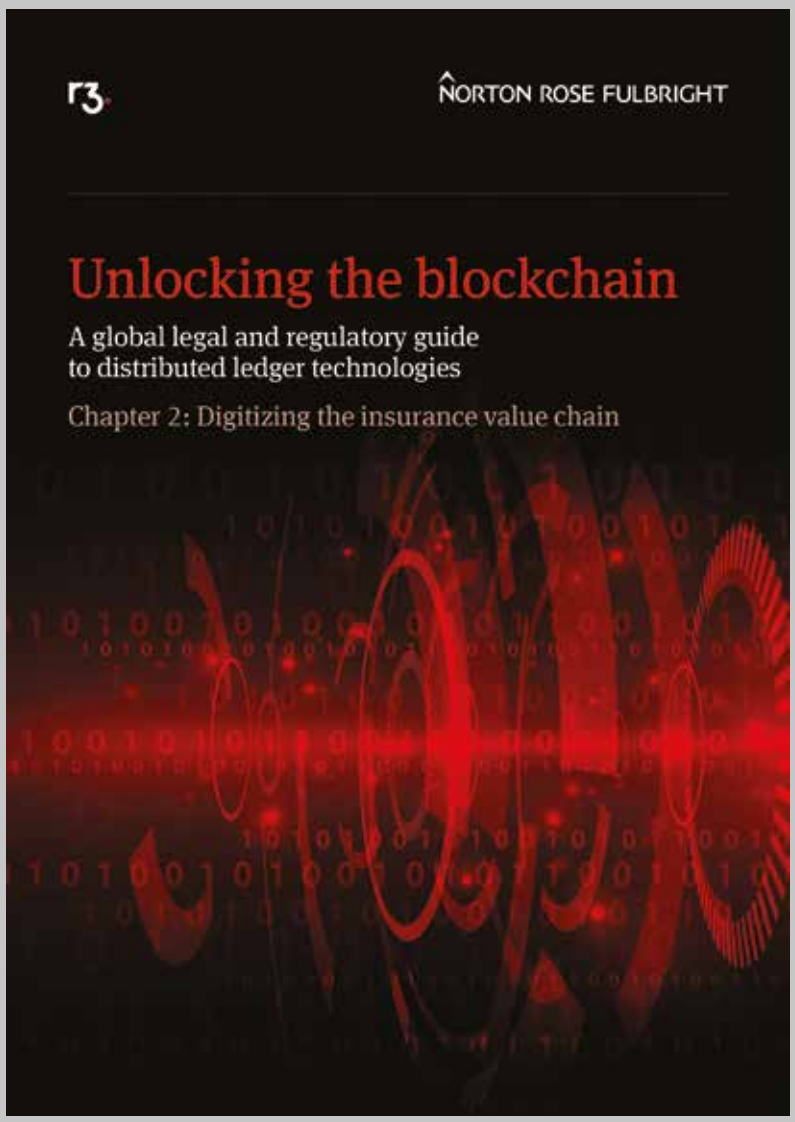
Perhaps as exciting as the benefits of digitizing the value chain through DLT and smart contracts, is the potential for innovative new products and new business models to be developed, which could prove revolutionary to the industry.

To realize the true value of DLT and DLT-enabled applications across the insurance industry, those looking at the technology must avoid getting drawn into a siloed approach. Incumbent insurance players will need to collaborate with technology firms and other organizations. Collaboration with regulators will also be necessary to ensure that regulatory frameworks evolve in step with the direction of travel of the industry.

Nicholas Berry, partner in the London corporate and regulatory insurance team from May 1, 2017, commented: “We are delighted to publish this white paper on distributed ledger technology use cases in the insurance sector in association with R3. Distributed ledger technology itself, and as an enabler of other complementary technologies, has the ability to revolutionise insurance products and services and the way in which insurance business is transacted. The shift in thinking as industry players open their minds to ways in which traditional market processes can be transformed through new technologies is gathering momentum.”

Sean Murphy, Global head of the distributed ledgers, blockchains and smart contracts practice at Norton Rose Fulbright, said: "Because the insurance sector is characterized by legacy systems that are expensive to maintain, distributed ledger technology raises the prospect of being able to implement transformational business change in the sector while at the same time achieve cost savings. The insurance sector is but one of a number of sectors where the technology could have this impact."

David Rutter, CEO of R3 commented: "Distributed ledger technology (DLT) has enormous potential for the insurance industry, not least to change the way insurers manage and utilise data. R3 now counts a number of insurance companies amongst its member base and we are exploring and developing applications that improve the efficiency of insurance processes such as claims handling and premium payments. In order to further our efforts, we recently launched a Centre for Excellence for DLT in partnership with ACORD to encourage knowledge sharing and collaborative working amongst the global insurance industry."



To request a copy of *Unlocking the blockchain: Digitizing the insurance value chain* please contact julie.frizzarin@nortonrosefulbright.com.

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