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HOW MUCH DETAIL OF POTENTIAL CLAIMS IS NEEDED PRIOR TO RENEWAL?

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Legal Briefings – By **Mark Darwin and Anne Hoffmann**

When it comes to renewing "claims made and notified" policies (such as D&O insurance and Professional Indemnity), policyholders must be careful to disclose full details of any facts known to them which have the potential to give rise to a claim, otherwise they run the risk of disentitling themselves to cover under both the expiring policy and the renewed policy.

BACKGROUND CONTEXT

"Claims made and notified" policies are triggered by notice to the insurer by the policyholder of a claim (typically defined as a demand for compensation) first made against the policyholder during the period of insurance, regardless of when the conduct giving rise to the allegations occurred. Cover can also be triggered by giving notice of facts that might give rise to a claim, even if the claim does not arise until after the policy expires (under a policy option or s.40(3) of the *Insurance Contracts Act*).

Prior to renewal, policyholders have a duty to disclose any facts known to them that might give rise to a claim. Claims which later arise from the facts disclosed will be excluded from the renewed policy (either expressly or by virtue of the exclusion for "prior known circumstances") but will typically by covered by the expired policy.

Policyholders may be tempted to downplay the risks in disclosing relevant facts prior to renewal. Human nature leads some to be optimistic that no claim will develop, while others may be concerned that fulsome disclosure might lead to premium increases. Two recent cases highlight the dangers for policyholders being less than candid in their interactions with insurers.

THE FINANCIAL PLANNER

Between 2006 and 2009, a financial planner advised clients on a number of investments which he put through a company in which he was the sole director and shareholder.[1] Some of the money invested was mishandled, and no payments of interest, principal, dividends or distributions were ever made to the clients before the company was eventually wound up and de-registered.

In 2014, the clients sued the financial planner's professional indemnity insurers directly (under s 601AG of the *Corporations Act 2001* (Cth)).

The financial planner was potentially covered under two insurance policies – one which was current in 2013 and the other current in 2014. Prior to renewal for the 2014 policy, the financial planner made the following disclosure in response to the question about his knowledge of any facts or circumstances which might give rise to a claim:

> *A small number of clients have invested/lent funds to property investments and/or companies that have to date been unable to repay those funds in total.*
>
> *At the time of the investment all appropriate disclosures were made and clients invested/lent funds with full knowledge of the circumstances at the time.*
>
> *At this stage no loss has been crystallised and no claim or complaint has been formally lodged.*
>
> *We wish to advise the insurance company that there is a chance of a claim against [the company] in relation to any loss that may be incurred.*

The first instance Court held – and the Court of Appeal has recently confirmed that:

- the answer given was insufficient to amount to a notification of "facts that might give rise to a claim" which would have triggered cover under the 2013 policy. The Court held that the disclosure was "no more than bare possibilities" which was not enough to constitute "facts" which might give rise to a claim, so no cover was available under the 2013 policy.
- the statements made in the context of renewal were misleading and constituted a fraudulent misrepresentation of the facts, given the financial planners knowledge of what had really happened (and even if the non-disclosure was innocent, insurers could reduce their liability to nil since they would not have covered the claim had fulsome disclosure been made), meaning there was no cover under the 2014 Policy either.

This is a great example of the policyholder “falling between 2 stools” because he was not sufficiently candid about the risk of a claim being made. Full disclosure would have at least triggered the 2013 policy, even if insurers had refused cover for 2014 (but what it is point of securing policy renewal if it is likely to be avoided for non-disclosure in the event of a claim?).

THE SURGEON

The second case concerned a cosmetic surgeon who performed certain surgeries at The Cosmetic Institute Pty Ltd (**TCI**)’s premises.[2] The surgeon held professional indemnity insurance with Avant from September 2011 to June 2019, and with a different insurer, MIGA, from July 2019 to June 2021. All policies were “claims made and notified” policies.

In 2017, a class action had been commenced against TCI for any surgeries which took place in its premises. The surgeon was joined to those class action proceedings in June 2020. The surgeon initially made a claim against the second insurer, MIGA, for coverage of legal costs and any liability. MIGA, however, denied the claim on the basis of various exclusions in the policy so the surgeon sought to claim cover under the prior policies he had held with Avant.

Avant refused his claim on the grounds that no “claim” had been made against him during his period of cover, ie September 2011 to June 2019 (remember, the class action was commenced in 2017 but the surgeon was not joined until 2020, after the Avant policies had expired).

While he had been covered by Avant, the surgeon had made various notifications in relation to individual claims brought by individual patients, some of whom later fell within the represented class of the class action. The court had to decide whether any of those were sufficient to constitute a “claim made” under the policy in relation to the class action.

Relevantly, the Court held that the notification of an individual claim by a patient who fell within the class of patients subject of the class action, did not constitute sufficient notice of the class action, as it only referred to the individual’s standalone claim. However, by early 2019 the surgeon’s lawyers (defending the individual’s claim) were writing to the insurer pointing out that the surgeon might be joined to the class action, and this was considered sufficient notification of facts giving rise to a claim. Avant was therefore liable to indemnify the surgeon in respect of the class action.

Interestingly, the Court also held that Avant was in breach of its duty of utmost good faith when it failed to advise the surgeon of what is required to be able to rely on s40(3) of the ICA. The surgeon had sought advice from the insurer in relation to a subpoena served on him in the class action proceedings prior to being joined himself. He sought advice from the insurer, but never sent the insurer a copy of the subpoena. The Court held that had the insurer been sent a copy of the subpoena, that would have constituted valid notice of facts giving rise to a claim. However, the insurer failed to give the surgeon the advice to send a copy of the subpoena which would have constituted valid notice and, as a result, breached its duty of utmost good faith.

KEY TAKEAWAY

Notifications of claims and notifications of facts which might give rise to claims are not straightforward and require careful consideration of policyholders' circumstances and potential claims. It might become very important in the future to have identified the relevant circumstances and used the right wording to describe the issue in the notification so that the insurer is required to indemnify for the loss.

Policyholders should consider carefully what is included in those notifications and how those notifications are drafted.

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1. *P & S Kauter Investments Pty Ltd v Arch Underwriting at Lloyds Ltd* [2021] NSWCA 136.
2. *Darshn v Avant Insurance Ltd* [2021] FCA 706.

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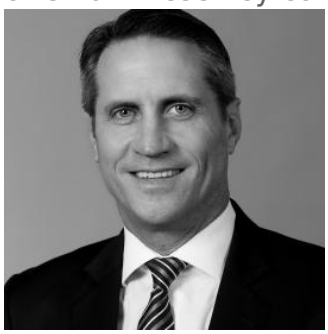

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