

LEGAL CREDIT CRUNCH FIELD GUIDE TO THE LIFE OF A CLAIM

Introduction

The latest statistics from the ABI have confirmed what we all knew anyway that recession Britain has seen a significant increase in property claims.

Commercial property claims (particularly fire claims) have risen by more than 20% since mid-2007 with domestic fire claims rising by almost as much.

As a consequence, insurers are placing ever greater emphasis on scrutinising claims and looking to their advisers (whether adjusters or lawyers) to ensure that only claims which qualify for cover are paid out on.

As fraudulent claims are to be dealt with later, what James and I will be doing this morning is doing "a walk through" of a typical claim from first notification to final settlement

- flagging up those legal issues which adjusters should be looking out for,
- identifying potential pitfalls to be avoided,
- highlighting relevant caselaw and legal principles and
- suggesting some possible ways and means for adjusters to add value in these straightened economic times.

First Attendance

Establishing who has suffered the loss?

One of the most important things, certainly from a legal perspective, to establish as early as possible in the course of the initial attendance at the loss is the correct identity of the policyholder.

This may seem elementary or may be taken for granted given that the name of the policyholder will no doubt be included in the new loss instruction received from insurers but it is critical that this is verified at the earliest opportunity.

It is important to establish that the person or entity you are dealing with on site as the policyholder is indeed the legal owner of the property.

So far as the law is concerned the person or entity who owns the property is the person or entity who has suffered the loss.

The ownership of property, particularly commercial property, may not be straightforward and may, for example, be held by one company within a group of companies or it can often be the case that the principal shareholder in a small or medium size enterprise may own the property and may lease it to his/her company.

If the matter is not clarified at an early stage, it can subsequently be overlooked and, on several occasions, we have come across situations where a claim has been dealt with and a substantial payment made to an entity which has no legal interest in the property and which, accordingly, has, in the eyes of the law not suffered any loss. So far as the law is concerned, a payment has been made to an entire stranger.

This can lead to serious difficulties when it comes to making a subrogated recovery.

Such difficulty is not easily cured. An assignment will not rectify the problem because an assignment only transfers the cause of action and if the payee did not own the cause of action in the first place (not having suffered the loss) then an assignment cannot create or improve a cause of action which did not exist in the first place.

One is then thrown back to trying to create an agency situation which can be far from straight forward.

Accordingly carrying out a Land Registry Search to establish the legal owner of the freehold and/or the leasehold is an important early step in the investigation of a property loss of any meaningful size.

It may not be unusual to find that the owner of the legal interest in the property is an entity or a person different from the named policyholder.

If that transpires to be the outcome of the Land Registry Search, then it is important to clarify this matter with the Insured and to refer back to insurers before indemnity is confirmed or any payment made.

Reservation of Rights

Another area of considerable difficulty encountered by adjusters at an early stage in the investigation

of a loss is the risk of waiver and/or estoppel.

It may very often be the case that adjusters do not have a full copy of the applicable policy wording to hand when carrying out initial investigations.

The new loss instruction form may well list applicable warranties but the precise wording of those warranties may not be provided until later in the investigation and, in addition to warranties, there may be conditions, particularly conditions precedent, which may be very material.

Adjusters therefore may be working "blind" in the initial days and weeks of the investigation of a property loss and the question then arises is when and how a reservation of rights ought to be deployed in order to protect insurers position and avoid any possible waiver of breaches of warranty or breaches of conditions precedent.

On the one hand, it is important, in the early stages of an investigation, to work together with the policyholder and their representatives to carry out necessary investigations, obtain all relevant information and cooperate in order to progress the claim towards a resolution.

If a reservation of rights is imposed too swiftly or clumsily, this can have the effect of polarising the position with the policyholder and leading to significant difficulties in the handling of the loss.

On the other hand however, waiver/estoppel is a significant risk for insurers and adjusters and the only effective means of guarding against waiver is a reservation of insurers rights.

The difficulties came into sharp focus a couple of years ago with the decision in the case of ***Kosmar Villa Holidays Plc v The Trustees of Syndicate 1 2 4 3 [2007] EWHC 458 (High Court) and [2008] EWCA Civ.147 (Court of Appeal)***.

On 22 August 2002 a Mr Evans was holidaying at an apartment in Corfu with Kosmar Villa Holidays when he dived into the shallow end of a swimming pool and suffered catastrophic injuries. Kosmar did not notify their insurers, Euclidian, until 4 September 2003, over a year later.

Kosmar's policy with Euclidian contained a notification condition acquiring "immediate notice" of the occurrence of any injury and that was a condition precedent to insurers liability.

Upon notification of the claim, insurers immediately requested further information about the incident from Kosmar.

On 17 September 2003, in an internal communication, Euclidian outlined its strategy which was not to deny liability for negligence at that stage but to wait until all the evidence was gathered and then present it to Mr Evans in the expectation that he would recognise the hopeless nature of his claim.

Shortly after this, Euclidian asked Mr Evans solicitors to "*note our interest in this matter and ensure that all future correspondence is sent direct to us*".

It was not until September 30 that Euclidian expressly required an explanation from Kosmar for its failure to comply with the condition precedent and stated that, while continuing to deal with the claim by Mr Evans, "*we must reserve our position until such time as you have replied and we have had the opportunity to consider your comments*".

On 21 October 2003, Euclidian repudiated liability for breach of condition precedent.

None of these communications, you might think, took insurers into the realms of waiver but everyone was startled (and concerned) at the trial judge's finding that insurers communications in September 2003 showed that they were dealing with the claim and had therefore chosen to accept liability.

While he did agree that insurers were entitled to a reasonable period of time in which to consider their position and he was anxious that insurers should not be forced into the position of having to reject a claim or reserve their rights to do so as soon as they are notified, nonetheless, he took the view that upon notification on 4 September 2003 Euclidian had sufficient facts for it to be able, at the very least, to express its intention to reserve its rights and that by 17 September it had had a reasonable time with which to make its decision so that the communication of September 30 in which Euclidian purported to reject the claim, was too late.

This decision caused something approaching consternation with claims handlers, loss adjusters and insurers' solicitors but, happily, it was overturned by the Court of Appeal, who held that the communications were far from unequivocal and did not amount to a waiver.

Nonetheless it served as a reminder of how seemingly innocuous communications in the early stages of the investigation of a loss can come back to haunt insurers and adjusters.

Certainly the prudent course of action, during the initial phase of the investigation of a loss where adjusters are not aware of the full circumstances, is to reserve insurers rights.

While there may be concerns about how a policyholder will react to an early reservation of rights, if the letter reserving those rights employs carefully chosen words to ensure that the impression is not given that the claim is being rejected, then most of the time the position can be managed quite satisfactorily.

The lesson from the Court of Appeal decision in *Kosmar* is not, as some people seem to believe, that one does not now need to worry about waiver or estoppel in the early stages of the investigation of a loss. The position remains that adjusters and insurers need to be careful as to what they are saying to the policyholder and to the third parties about their approach to the loss.

Before leaving the question of reservation, AIRMIC has agreed a Statement of Principles with various insurers regarding insurers reservations of rights.

This Statement of Principle applies to all potential losses "*reasonably anticipated to exceed £2.5 million*" and under which insurers will agree not to issue any form of reservation of rights for a period of 90 days following the date of the first notification.

The Statement of Principles is not mandatory on the insurer but if the insurer does choose to invoke the Statement of Principles in any loss over £2.5 million, then it will be important to record the agreement with the policyholder that the AIRMIC Statement will apply to that particular loss.

If the policyholder does not agree or fails to respond, then it seems to me that it is important to issue an appropriate reservation of rights at that stage.

Compliance with the terms of the Policy

Conditions and Warranties

As mentioned above, it is important as early as possible in the investigation of a loss to obtain a copy of the applicable policy and schedule in order to establish that there has been compliance with the terms and conditions of cover so as to entitle the Insured to an indemnity.

Once it has been established that an insured peril has operated and/or that the loss does not fall within one of the exclusions in the policy, attention will then turn to applicable warranties and conditions.

Unlike perils and exclusions (which define the scope and limits of the cover available to the

policyholder) conditions and warranties are terms of the policy with which the policyholder must comply if they are to qualify for an indemnity.

Warranties are fundamental terms of the contract of insurance which, if not complied with by the policyholder, automatically discharge insurers from all liability under the contract. The insurance contract effectively comes to an end as at the date of the breach of warranty (unless the terms of the particular policy provide otherwise).

There does not have to be any causal link between the breach of warranty and the happening of the loss. However, many policies now contain a term which provides that breach of a warranty will only lead to a loss of cover where the breach is connected with or materially increases the risk of loss.

Conditions are terms of the policy which are of lesser significance than warranties but still are important.

Conditions can either be conditions precedent or mere (or ordinary) conditions.

Conditions precedent are obligations which are imposed on the policyholder, compliance with which is a pre-condition of the policyholder being entitled to an indemnity in respect of that loss.

Unlike warranties, breach of a condition precedent does not bring the insurance contract to an end but merely disentitles the policyholder from indemnity in respect of that particular claim.

Conditions within the policy do not necessarily need to contain the words "*condition precedent*" in order for them to be deemed to be conditions precedent.

While it would be prudent for the policy to say so explicitly, a general or catch-all condition providing that insurer's liability under the policy is conditional upon the policyholder complying with the terms and conditions of the insurance can be sufficient to make the condition in question a condition precedent.

In ***Aspen Insurance UK Limited v Pectel Limited [2008] EWHC 2804***, the policy contained a term which required the policyholder to notify insurers immediately of any occurrence which may give rise to an indemnity under the policy. The condition itself was silent as to whether it was a condition precedent or not.

However there was a catch-all condition in the policy providing that the liability of insurers was conditional upon the policyholder observing the terms and conditions of the insurance and the High Court found that that condition made the notification condition a condition precedent. Construing the policy as a whole, the trial judge found that there was no other provision in the policy which led to or pointed to a different conclusion.

Mere (or ordinary) conditions are those conditions which are not expressed to be conditions precedent and a breach of a mere condition does not entitle insurers to decline to indemnify the policyholder in respect of the claim. It will only entitle insurers to seek damages from the policyholder in respect of losses suffered by insurers as a result of the breach. Normally this will be very difficult for insurers to do.

Survey Requirements/Risk Requirements

In addition to conditions and warranties, underwriters can seek to impose other obligations upon the policyholder by way, for example, of risk requirements/recommendations arising from surveys (e.g to install or upgrade an alarm system within, say, 3 months).

If it is found that the survey requirements were not fulfilled prior to the loss, does this dis-entitle the policyholder from recovery?

The short answer to this question is no.

Unless there is an express provision in the policy making compliance with any risk requirements a condition precedent to liability or unless specific endorsements have been placed on the Schedule, then the only remedy for failure to comply with a risk requirement or risk recommendation arising from a survey is cancellation of the policy, i.e., the policy remains valid up until the point when insurers elect to cancel it and all claims up to that date have to be paid.

In the normal course, the obligation to follow up on compliance with survey requirements rests on the underwriters.

Essentially therefore, the risk of a loss arising or being caused (or contributed to) by the failure to comply with the risk requirement is a risk resting with the underwriters rather than the insured.

The only situation where this might be different would be where, for example, on a renewal questionnaire the policyholder warranted that all previous risk requirements had been complied with, and if this turned out not to be the case, then insurers would have a right to decline the claim for breach of that warranty.

Alteration Risk Clauses

A potentially important policy condition is the alteration of risk condition.

These clauses usually provide for policy cover to cease or be voidable where there has been an alteration of risk or change of circumstances since commencement of the insurance which increases the risk of loss or damage unless insurers have agreed in writing to accept such alteration.

These conditions receded in importance after the Court of Appeal decision ***Kausar –v- Eagle Star Insurance Company Limited [2000] Lloyds Rep IR 154***. In that case, the Court of Appeal held that these clauses would only permit insurers to terminate cover where there had been a fundamental change in the subject matter of the insurance, such that the new circumstances were something which, on a true construction of the policy, insurers had never agreed to cover. The mere fact that the chances of an insured peril operating increased during the period of cover would not, save in the most extreme of circumstances, enable insurers to terminate cover.

However, clauses of this nature have potentially been given a new lease of life by virtue of the Court of Appeal's recent judgment in ***Ansari –v- New India Assurance Limited [2009] EWCA Civ 93***.

The relevant condition in ***Ansari*** provided as follows:

"This insurance shall cease to be in force if there is any material alteration to the premises or business or any material change to the facts stated in the proposal form or other facts supplied to the insurer unless the insurer agrees in writing to continue the insurance."

In that case, the policyholder under a commercial property insurance policy had answered yes in response to a question in the proposal form, *"Are the premises protected by an automatic sprinkler system?"*.

The property did have an automatic sprinkler system when cover inceptioned but, at a later point, it had been intentionally turned off by the policyholder on a permanent basis.

In reliance on the material change condition, insurers rejected the claim and the policyholder issued proceedings.

To be "*properly functioning*", the Court of Appeal held that an automatic sprinkler system must be "*constantly ready to operate in the event of a fire without the need for human intervention*". Otherwise, the premises could not be said to be "*protected by*" an automatic sprinkler system (to use the words of the proposal form).

Turning off the sprinkler system for a short time for legitimate reasons (such as maintenance or repairs) would not mean that the premises ceased to be protected by a functioning system.

However, turning off the system indefinitely for whatever reason was different and amounted to a change in the facts set out in the proposal form.

Alterations or changes of a kind that take the risk outside that which was in the reasonable contemplation of the parties at the time the policy was issued were to be regarded as material alterations.

On issuing the policy, the insurer would have had in mind that the sprinkler system might be turned off temporarily from time to time but would not have contemplated that the system might be turned off permanently.

The turning off of the system for an indefinite period altered "*the nature of the subject matter of the insurance*" and accordingly insurers were justified in rejecting the claim.

Incidentally, the Court of Appeal drew a distinction in that case between an automatic sprinkler system and an intruder alarm system. While an automatic sprinkler system is set up to operate at all times, an intruder alarm system operates only once armed. In the view of the Court of Appeal, it would not be reasonable to interpret a warranty that premises are fitted with an intruder alarm system as leading to a loss of cover merely as a result of negligence in failing to set the alarm.

Accordingly, it may be well worth while checking the relevant alteration of risk condition within the policy by reference back to the proposal form or insurance submission provided by the policyholder at inception.

In the current economic climate, with more and more premises becoming vacant, the alteration of risk

condition may well become very material if it transpires that the loss has occurred after the property had become unoccupied but insurers were not notified of the unoccupancy.

Investigations and Reports

Contemporaneous Notes and Records

Obviously the importance of making contemporaneous notes and records of your investigation of a loss is self evident.

If reminder was needed, it came with the decision in ***Shinedean Ltd v Alldown Demolition (London) Ltd [2006] EWCA Civ 939***. In the course of demolition work being carried out by the Defendant, an adjoining property sustained damage and a claim ensued. The Defendant sought indemnity under its insurance policy but insurers declined indemnity for breach of the claims co-operation condition (which was a condition precedent to their liability). Specifically the adjuster retained by insurers had been seeking relevant documentation and information from the Defendant but they had repeatedly failed to supply it. In his witness statement prepared for trial, the director of the Defendant asserted that he had in fact sent the documentation to the adjuster on two occasions but the adjuster had never received it. The matter then became an issue of credibility at trial between the adjuster and the director. Mr Justice Havery readily accepted the evidence of the adjuster stating that:-

"I find [the adjuster] to have been a reliable witness who had kept good records. Mr Clarke [the director] did not keep contemporaneous notes. He scarcely wrote any letters. He did not remember dates. His evidence was confused. I found him not to be a credible witness."

The opportunity should always be taken, when investigating a property loss, to obtain and capture evidence which will (or might) be necessary for the pursuit of any potential subrogated recovery down the line.

Obtaining copies of relevant contracts is particularly important, be they leases, installation contracts, maintenance contracts, cleaning contracts, purchase invoices for the piece of equipment that may have malfunctioned etc.

It is considerably more difficult and time consuming to try to obtain copies of such relevant documents 6 months, a year or 2 years after the loss. The Insured becomes much less keen to co-operate once payment of the claim has been made!

Witness Statements

The taking of witness statements is also a crucial part of the investigation of a loss of any size and the importance of taking contemporaneous witness statements, in terms of evidential value, cannot be overstated. Given that a business sustaining a substantial loss can often mean employees being laid off, it is important to capture the evidence of witnesses in a timely fashion before they move on.

As you know, the Court will refuse to admit witness evidence unless it has been recorded in a written statement signed by that witness.

Accordingly, in terms of evidence in Court proceedings, an unsigned statement from a witness or unsigned interview notes are effectively worthless in that form, insofar as they will be inadmissible.

The content, structure and formalities of a witness statement are set out in the Practice Direction to Civil Procedure Rule 32 and that can be found at the following link (www.justice.gov.uk/civil/procrules).

However, in terms of witness statements, care needs to be taken when taking a witness statement from an insured (or a director or employee of an insured) if policy cover is an issue and the purpose of the interview is to establish whether there has been compliance with policy terms.

The purpose of the interview should always be made clear and if it appears that the insured, on the basis of the witness evidence, is in danger of losing indemnity, then it ought to be made clear that he may wish to seek separate advice.

If the insured imparts information to you on the assumption that you are representing his interests and that information is subsequently used by insurers to decline indemnity, that evidence may well be inadmissible and there could well be judicial criticism of the role of the adjuster who took the witness statement.

In the unreported judgment of ***Matalan Discount (Cash & Cash) Limited v Tokenspire Properties (North Western) Limited [18 May 2001]***, the trial judge, Judge Seymour QC, had harsh words where this had been done. He stated that:

"I should not leave the question of the statements taken by [the loss adjuster] without recording my disquiet about the circumstances in which the statements were obtained. I was

told that, at the time the statements were taken, solicitors had been instructed on behalf of [insurers] and the question of cover was under active consideration. It seems to me that it was totally inappropriate in those circumstances for statements to be taken from two of the directors and the contracts manager of the Insured which dealt with matters relevant to cover without [the Insured] being warned that cover was in question and being given an opportunity to obtain independent advice. The fact that the statements gave an emphasis to matters bearing upon cover with which the maker of the statement may well not have agreed had he appreciated the significance which could later be attributed to such emphasis only serves to underline the impropriety of the procedure, it seems to me."

Status of Loss Adjusters' Reports

We then come on to the question as to whether loss adjusters' reports are privileged?

Disclosure is sometimes sought from insurers of loss adjusters' reports they have commissioned into a loss.

The Court of Appeal in ***Re Highgrade Traders Limited [1984] BCLC 151*** made clear that loss adjusters' reports are not privileged unless the dominant purpose of the insurers in commissioning the reports was to submit them to legal advisers for advice on whether or not the claim should be paid.

This is the so called "dominant purpose" test.

Litigation does not have to be imminent and nor indeed do legal advisers have to be instructed at the time the reports are commissioned. As long as litigation was "reasonably in prospect" and as long as the reports were commissioned for the purpose of enabling lawyers to advise whether the claim should be paid or resisted, the reports are privileged and their disclosure cannot be compelled.

In many, if not most, instances, the intention of insurers in commissioning reports from loss adjusters (certainly the earlier reports) will not be for submission to lawyers to advise in respect of prospective litigation but simply to investigate the circumstances of the loss in question.

It may be some time before features come to light which may necessitate the involvement of and advice from lawyers.

Where it is clear at the outset therefore that the loss is major or complex, insurers should certainly give consideration to engaging lawyers at an early stage in order that loss adjusters' reports and experts' reports may attract legal professional privilege.

Communications between a solicitor and loss adjusters and a solicitor and an expert which come into existence after litigation is contemplated and made with the purpose of obtaining or giving advice in relation to such litigation are privileged.

To create that privilege it is necessary that the reports are addressed to the solicitors and are generated on foot of an instruction from the solicitor to produce such reports for that purpose.

Hence you may, on occasions, find that while your initial instruction has come directly from insurers, this is followed shortly thereafter by a letter from solicitors confirming your instructions and asking you to address and direct your reports to them marked *"Privileged – prepared for the purpose of seeking legal advice and/or in contemplation of litigation."*

Unoccupancy

As we are all aware, unoccupied buildings are particularly susceptible to loss, particularly theft and malicious damage, but also fire and burst pipes.

Given the current economic climate, losses occurring in unoccupied buildings are likely to remain at a high level for some considerable time yet.

The vast majority of property insurance policies will contain an unoccupancy warranty or condition either within the standard wording itself or by endorsement.

The requirements of the unoccupancy condition or warranty will mirror closely the Fire Protection Association's Code of Practice on the protection of Unoccupied Buildings.

It will be very important to check that the requirements of the warranty or condition have been complied with so that the loss in question can be validated as qualifying for indemnity.

In the unlikely event that the policy in question does not contain an unoccupancy warranty or condition and it turns out, upon investigation of the loss, that the premises had become unoccupied prior to the loss, then close attention will need to be paid to the alteration of risk condition and to whether full

disclosure had been made at previous renewal.

Duty of disclosure/Utmost good faith

We are all familiar with the principles governing the duty of disclosure and when that duty attaches (i.e. at inception, renewal and with any mid-term modifications).

The adequacy of disclosure will generally be tested against the questions asked on the proposal form or renewal questionnaire but the overall test applied by the courts is whether "a fair presentation of the risk has been made".

The duty of disclosure is breached if there has been non-disclosure (a failure to inform) or misrepresentation (an untruthful answer) of material facts.

There are two limbs to the test as to whether there has been a breach of the duty of disclosure (so as to entitle insurers to avoid the policy ab initio) and they are (1) that the non-disclosure/misrepresentation has to be material (which is judged by the prudent insurer test) and (2) that the misrepresentation/non-disclosure must have induced the issuing of the policy on the terms and at the premium charged.

Both limbs of the test must be satisfied but attention often focuses on whether the matters which were not disclosed were material facts in that they would have influenced the mind of a prudent insurer.

However, inducement must also be proved and therefore the question must be asked of the actual underwriter as to whether, if he or she had been made aware of the material facts, they would have declined the cover or charged a higher premium or imposed more onerous terms.

Insurers came a cropper in two recent cases where this aspect had not been covered off.

In ***Lewis –v- Norwich Union Healthcare Limited [2009] Misc 2*** Mr Lewis had an income protection health policy with the Defendant. In the proposal form for the insurance, the Claimant had not disclosed a previous visit to his GP during which he complained of a stiff knee (although nothing untoward was found).

Subsequently the Claimant was forced to give up work but the insurers declined his claim relying on non-disclosure.

The court found that the visit by the Claimant to his GP was a material fact and that he was guilty of non-disclosure of that fact on the proposal form.

However, the underwriter in question had left the employment of the Defendant and no evidence was obtained from him. Instead, the Defendant adduced evidence from another underwriter within the same department, which simply set out the Defendant's general practice and offered the view that the underwriter in question would have refused the risk or imposed an exclusion.

The court said that they required evidence from the actual underwriter involved and, in the absence of that evidence, they were not satisfied that the underwriter in question would indeed have refused the risk or imposed an exclusion, particularly as it had been shown that the underwriter had not in other respects acted prudently (for example, he had issued the policy without awaiting the results of an allergy test).

A similar issue arose again in the case of ***Laker Vent Engineering Limited v Templeton Insurance Limited [2009] EWCA Civ 62***. In that case, the Claimant had a policy of legal expenses insurance with the Defendant. The Claimants were sub-contractors for the installation of piping at a major engineering project in Nottinghamshire and various contractual disputes arose between the parties to that project. The Claimant made a claim against the Defendant in respect of pending legal expenses in an arbitration arising out of the contract and the Defendant argued that it was entitled to avoid the policy for non-disclosure of that pending dispute at last renewal. The High Court and subsequently the Court of Appeal found that there was no non-disclosure in that the dispute was not one which, at the time of renewal, showed a real risk of escalating into a need for formal dispute resolution procedures. In any event the Defendant had produced no evidence from their underwriters to confirm that if they had been made aware of the dispute they would not have renewed the policy or imposed terms and therefore were unable to establish inducement.

Accordingly when instructed by insurers to issue an avoidance decision to a policyholder, it is important that adjusters check that insurers are satisfied that both limbs of the test have been satisfied i.e. both materiality and inducement.

Indeed the prudent course of action would be to obtain a signed witness statement from the underwriter in question prior to the letter of avoidance being issued.

Communicating to the policyholder that the policy does not respond

Brendan has already outlined, in his section of this talk, how adjusters must tread carefully, when investigating claims, to ensure that their communications do not end up precluding insurers from avoiding a policy for non-disclosure or declining indemnity for breach of condition/warranty, through waiver or estoppel.

Waiver occurs where an insurer:

- (a) has a right to avoid the policy or decline indemnity;
- (b) is aware that it has such a right; and
- (c) communicates to the policyholder (either through words or by conduct) that it intends not to enforce its strict legal rights.

Estoppel is a similar concept. An insurer will be estopped from relying on its strict legal rights, if:

- (a) it makes a representation, by words or conduct, to the policyholder that it will not rely on its strict legal rights; and
- (b) the policyholder relies upon that representation to its detriment.

While the concepts of waiver and estoppel are similar, there is nevertheless an important distinction. For waiver to operate, the policyholder does not have to prove that it relied upon insurers' representation, though insurers must have been aware that they had a right to either avoid the policy or decline indemnity, when they made the representation. Conversely, for estoppel to operate, insurers can be entirely oblivious to the fact that they might have a right to avoid the policy or to decline to indemnify the policyholder. They can end up being estopped from relying on their rights when they find out about them, if they have either themselves, or through their agents (such as adjusters), acted in such a way as to give the policyholder the impression that the claim would be dealt with under the policy and the policyholder relied upon that to their detriment.

It is for that reason that Brendan talked about the importance of putting a reservation of rights in place, where you are handling a claim in which there may be potential coverage issues.

Whether or not there is a reservation of rights in place, adjusters must always tread carefully to ensure that their words or conduct does not preclude insurers from relying upon their rights under the policy. A good example would be recommending to insurers that they make an interim payment under the

policy. If a payment is made at a time when insurers knew or ought to have known that there had been some breach of the policy by the Insured, then unless that interim payment is made to the policyholder “*Without prejudice to insurers’ rights under the policy*”, then that is just the sort of act which is capable of waiving insurers’ rights to take a policy point.

Once adjusters’ investigations are complete, if it transpires that there are grounds either to avoid the policy for non-disclosure or to decline indemnity for breach of condition/warranty, then it is important not to delay in seeking instructions from insurers as to whether they are going to take issue with the relevant breach.

Delay itself will not usually amount to waiver or estoppel. In the case of ***Callaghan & Hedges v Thompson [2001] Lloyd’s Rep IR 125***, insurers instructed loss adjusters to investigate a claim. During the course of the investigation, it was discovered that the policyholder had failed to disclose a criminal conviction. Upon discovering that non-disclosure, insurers did not exercise their right to avoid the policy for a further 2 months. The policyholder argued that that amounted to an unequivocal representation that liability had been accepted under the policy. However, the Court decided that insurers’ silence could not conceivably amount to an unequivocal representation that they had accepted liability.

However, whilst delay would not ordinarily, of itself, amount to waiver or estoppel, there are always exceptions to the rule. For example, in the case of ***Simner v New India Assurance Co Ltd [1995] LRLR 240***, reinsurers chose not to avoid a policy for non-disclosure for some months after becoming aware of a potential failure by the reinsured to disclose material facts. In that case, the Court decided that a delay of several months amounted to a continuing representation to the reinsured that the claim would be covered under the policy and that reinsurers could not then back track on that position. Whilst this case should be treated as an exception rather than the rule, it does highlight the importance of not delaying in seeking insurers’ instructions where your investigations reveal that there might be grounds to avoid the policy or decline indemnity.

Where such grounds do exist and a decision is taken to take a policy point, extreme caution must be taken, when communicating to the policyholder the reasons why the claim is being rejected.

Rejecting a particular claim on one ground may result in insurers waiving their rights to reject the claim on other grounds.

Insurers have to be particularly careful, in this regard, where grounds exist to avoid a policy for non-disclosure and/or misrepresentation. If such grounds exist, then insurers are entitled to avoid the

whole policy; that is to say the policy is treated as if it had never existed in the first place (hence the reason why insurers have to return the premium to the policyholder).

In the Court of Appeal decision of **WISE Underwriting Agency Limited v Grupo Nacional Provincial SA [2004] Lloyd's Rep IR 764**, reinsurers became aware that there were grounds to avoid the policy for material non-disclosure. When they found out about certain facts which had not been disclosed, they gave the reinsured an oral notice of cancellation of the policy, in accordance with a cancellation provision in the policy. The Court of Appeal decided that, by cancelling the policy (rather than avoiding it), insurers were effectively treating the policy as if it existed up until the point of cancellation and had therefore waived their right to avoid the policy from the outset for non-disclosure. Consequently, insurers had to deal with a claim which they would not have had to, had they avoided the policy, rather than cancelling it.

So, it is important to identify the reasons why a claim is being rejected:

- (a) For non-disclosure or misrepresentation, it is the whole policy which is avoided (not just the particular claim). For that reason, insurers must use the word "avoid" and must return the premium to the policyholder (unless there is evidence of fraud);
- (b) If a claim is being declined for breach of condition precedent, then the policy itself remains in force. It is just the claim itself which is being declined;
- (c) Where there has been a breach of warranty, unless the terms of the policy dictate otherwise, the whole policy comes to an end as from the date of the breach and not from the beginning of the policy. There is no need to return the premium, unless the breach of warranty occurred at inception of the policy (i.e., as if the policy never existed).

As we have seen with the **WISE** case, it only took an oral notice of cancellation to cause insurers to lose their rights to avoid a policy for non-disclosure. For that reason, adjusters should be extremely cautious about conveying decisions on coverage to policyholders on an informal basis. It is far better to ensure that any decisions taken to reject a claim or avoid a policy are set out in writing.

We would ordinarily expect such a letter to be sent by insurers to their policyholder. However, in many cases insurers ask adjusters to tell the policyholder the reason why a claim is not being dealt with and, in those scenarios, you will have to be very careful to ensure that any letter of declination or avoidance is carefully worded, so as to preserve all of insurers' rights.

We would usually recommend that insurers make it clear that the grounds given for repudiation are without prejudice to any other grounds upon which they may wish to rely and that all their rights in that regard remain reserved.

Where the claim is covered by the policy

Turning now to the situation where your investigations demonstrate that there are no rights to avoid the policy or decline indemnity to the policyholder.

In that scenario, pressure will be placed on adjusters, particularly in the current economic climate, for a swift settlement of the insurance claim.

As the common law presently stands, unless the terms of the policy dictate otherwise, there is no obligation on insurers to settle an insurance claim within a reasonable time frame. The obligation to indemnify the policyholder arises as at the date of the loss. That means that, technically, the policyholder could sue their insurers the very next day to secure a complete indemnity.

In practice, of course, that is unlikely ever to happen. If insurers do delay in making a payment, as the law presently stands, the policyholder is not entitled to compensation through the Courts for any losses which are consequential upon that delay. All the policyholder will be awarded is the amount of the indemnity, together with interest on that money over the period during which the policyholder was kept out of pocket.

Having said that, the Law Commission proposes to reform insurance law and one of their proposals will be to impose liability on insurers for consequential losses arising out of delays in settling insurance claims.

Moreover, irrespective of the present legal position, evidently it reflects badly on both insurers and adjusters alike, if delays are encountered by the policyholder in having their claim settled. The FSA requires insurers to treat their customers fairly and the Financial Services Ombudsman can order insurers to pay compensation to their policyholders for unjustified delays.

AIRMIC has reached outline agreement with a number of insurers on a scheme to guarantee that large claims are settled promptly and policyholders are not left with cash flow problems which might otherwise arise out of a large loss.

The document sets out a framework for speeding up claims settlement processes. In the current economic climate, it is much more difficult for policyholders who have suffered major property losses to acquire bridging capital from their banks except at prohibitive cost.

The outline agreement envisages that loss adjusters would have to produce a cash flow model for the period of interruption caused by the insured peril to the policyholder's business. The cash flow model would indicate how much the policyholder had lost in terms of production and sales at any time.

This will enable insurers to make sure that interim payments are made in such a way as to ensure that the policyholder's cash flow position remains similar to how it would have been in the absence of the loss.

Who should the settlement monies be paid to?

As Brendan mentioned earlier, it is very important to check:

- (a) who the policyholder is; and
- (b) whether it is in fact the policyholder who has suffered the loss.

Provided that it is the policyholder who has suffered the loss and not some other person or company related to the policyholder who has no rights under the policy, then the settlement monies under the insurance policy should be paid to the policyholder.

In the current economic climate, adjusters will undoubtedly encounter policyholders who are in a precarious financial state; ranging from individuals on the brink of bankruptcy to companies which have gone into liquidation. Indeed, a major loss might very well have catastrophic consequences for a company which is already in financial difficulty.

If an individual policyholder has already been made bankrupt, then when adjusters request a settlement cheque from insurers, that cheque should be paid to the Trustee in Bankruptcy and **not** to the individual who may be named under the policy.

Likewise, if a corporate policyholder has gone into liquidation, then payment should be made to the Liquidator.

Where a company has gone into administration or administrative receivership, settlement monies are still payable to the company (since the company is still “live”) but you should make sure that you deal with the company through the administrator or administrative receiver and not through the existing directors of the company.

Forms of discharge should be signed by those empowered to deal with the company’s affairs, i.e, the liquidator, administrative receiver, administrator and not the former directors.

If, for whatever reason, a policyholder directs that you should ask insurers to make payment to a third party, then it is increasingly important to make sure that that mandate is set out in writing with an appropriate release of liability for insurers, and then signed by the policyholder or, where the policyholder is insolvent, by the person with power to deal with the policyholder’s affairs (i.e, trustee in bankruptcy, liquidator etc).

The last thing any adjuster would want to find is that payment is made to the wrong person (e.g, a bankrupt individual or an errant director), leaving insurers exposed to making the same payment again to the correct entity.

Transactions at an undervalue

Loss adjusters may find that some policyholders will want quick cash settlements and that there are opportunities to secure settlements which are more financially advantageous to insurers than might have been the case when the country was not in recession.

It is perhaps just worth being aware that if the policyholder has its insurance claim settled at a significant undervalue, and that policyholder subsequently becomes insolvent, there is a risk that the insurance settlement could be set aside.

Section 238 of the Insolvency Act 1986 provides that:-

- (a) where a company enters into administration; or
- (b) goes into liquidation; and
- (c) the company enters into a transaction at an undervalue (i.e. for a consideration, in money or monies worth, the value of which is significantly less than the consideration provided by the company);

- (d) within a 2 year period ending with the onset of insolvency; and
- (e) the company is, at that time, unable to pay its debts or becomes unable to pay its debts because of the transaction at undervalue,

then the liquidator or administrator can apply to court to have the transaction set aside.

There is a similar provision at Section 339 of the Insolvency Act 1986 for individuals who enter into transactions at an undervalue in a period of 5 years ending with the day of presentation of the bankruptcy petition.

There is a risk (albeit relatively minor) that a liquidator, administrator or trustee in bankruptcy could apply to have an insurance settlement set aside, if the policyholder concerned had accepted a cash settlement which was significantly lower than the true value of the insurance claim.

I think that the risk is really quite low, since the Act provides that the court is not entitled to set aside such a transaction if the company entered into the transaction:

- (i) In good faith;
- (ii) For the purpose of carrying on its business; and
- (iii) Where there were reasonable grounds for believing that the transaction would benefit the company.

There may be many scenarios in which a corporate policyholder will have good reason to accept a quick, but low, cash settlement to keep the business going.

Nevertheless, adjusters ought to be aware of this risk.

Forms of Discharge/Settlement Agreements

It goes without saying that settlements reached with policyholders should be recorded carefully in writing and be signed off by the policyholder, or, as we have seen, where the policyholder is insolvent, signed off by the relevant person entitled to exercise the policyholder's rights.

Direct Line Insurance Plc v Fox [2009] EWHC 386 (QB) demonstrates that insurers and adjusters must be very careful with the mechanism they use to settle insurance claims, in order to preserve insurers rights in relation to fraud.

In that case, the Defendant made a claim under his household policy following a fire in his kitchen. Insurers accepted the buildings claim at just under £50,000. It was agreed that the policyholder would arrange the repairs himself due to his professional contacts allowing him access to lower tenders.

This was recorded in a written settlement agreement, whereby insurers made an interim payment of approximately £42,000, to be followed by a VAT payment for the remainder once invoices were provided. The interim payment was made and the policyholder subsequently presented an invoice for the VAT element of the work. The invoice purportedly came from a supplier who had not in fact carried out any work. Insurers queried the authenticity of the invoice and the policyholder swiftly dropped the VAT claim.

When insurers realised that the policyholder was attempting to fraudulently recoup VAT which had not been paid, they relied on the fraud condition within the policy wording, which provided that, in the event of fraud, all benefits under the policy would be forfeited. They sought to recover the payment of £42,000 from the policyholder.

The insurers' claim failed. The court decided that a written settlement agreement was a contract which compromised insurers' rights under the insurance policy. The settlement agreement was not one to which the principles of utmost good faith applied and there was no provision within it, which entitled insurers to recoup the £42,000 paid, in the event that the policyholder sought to make a fraudulent claim in respect of the VAT element of the work.

The settlement agreement effectively resolved the insurance claim and replaced it with a new agreement, in relation to which the policyholder had simply failed to meet the condition necessary for payment of the VAT. Consequently, the policyholder could not recover the VAT, but was entitled to keep the £42,000 paid in relation to the net building's element of the claim.

In light of this decision, it would certainly be prudent to ensure that forms of discharge and settlement agreements include a provision which entitles insurers to recover the entirety of their outlay in the event of fraud.

Double Insurance and Contribution

You will all be aware that double insurance arises where the policyholder has two or more policies which cover

- (a) the same subject matter:

- (b) the same policyholder;
- (c) for the same interest.

In order to minimise the amount of claims leakage and ensure that your insurer clients only end up paying what they have to under their policies, it is always important to identify any double insurance at an early stage in any claim.

It is beyond the scope of this talk today to run through all of the principles of double insurance. You will, no doubt, be aware that where there are, for example, two policies covering the same interest, whether your insurer principal can insist on the other insurer dealing with the entirety of the claim, or at least paying a rateable proportion of it, will depend upon the wording of the two policies concerned.

The important point which we want to reinforce today is that, if you have discovered that there is another insurer who should be contributing towards the claim, you should make sure that those other insurers pay their rateable proportion **before** the claim is settled by your insurer principals.

It is unwise to recommend insurers to pay the entirety of an insurance claim and then let them seek a contribution from other insurers at a later date. It may be too late then.

In the case of *Legal and General Assurance Society v Drake Insurance Co Ltd [1992] 1 All ER 283*, the policyholder had taken out two motor policies, each containing a rateable proportion clause. The policyholder made a claim on only one of the policies. That insurer paid the entire claim and then sought to recover 50% from the other insurer by way of contribution.

The Court of Appeal determined that the first insurer had only been legally obliged, under its policy, to pay 50% of the loss. The fact that it chose to pay 100% of the loss meant that it had voluntarily made a payment to the policyholder which it had no legal liability to do. The first insurer could not recover a contribution from the second insurer towards a payment which it had no liability to make in the first place.

The decision may seem harsh, but it provides a stark warning to insurers and adjusters to make sure that contribution issues are sorted out, before payments are made to the policyholder.

If, however, there is a dispute between the two insurers as to whether one has any right of contribution against the other, and there is concern that that may impact upon treating the policyholder fairly and settling its claim expeditiously, then there may be another way to get around this problem.

In the case of *Drake Insurance Co v Provident Insurance Co [2004] Lloyd's Rep IR 277*, the Court considered very similar facts to those which arose in the *Legal and General* case.

Throughout the claim, the first insurers had tried to involve the second insurers, but had been unsuccessful in doing so. The first insurer paid the entirety of the policyholder's claim, but made it clear that it was only doing so under sufferance and that it was reserving all of its rights to bring a contribution claim subsequently. In those circumstances, the Court of Appeal said that the first insurer had clearly not made a "voluntary" payment. It was entitled to subsequently seek a contribution from the second insurer.

It follows, therefore, that if you encounter difficulties in getting another insurer to contribute towards a claim, and there is no option but to indemnify the policyholder, both the policyholder and the other insurer should be made aware that you are reserving insurers' rights and that payment of the full claim is not being made voluntarily.

Subrogation

In the current economic climate, more so than ever before, insurers are keen to maximise the prospects of recouping some or all of their outlay from third parties who may be legally responsible for the loss.

Loss adjusters have a key role to play in:-

- (a) identifying potential subrogation opportunities; **and**
- (b) collating the necessary evidence to enable a subrogated recovery action to be brought.

Whilst policyholders are, of course, under an obligation under their insurance policies to co-operate in any subrogated recovery proceedings, the reality is that once a policyholder has received its insurance settlement, it may often have little or no interest in getting involved in any recovery. Indeed, policyholders can feel aggrieved at the amount of time they subsequently have to invest in assisting with a recovery.

They are far less likely to be resistant, if they are being asked to co-operate at an early stage in the claim, when they have not been indemnified by their insurers in relation to their losses.

For that reason, it is important for adjusters to identify subrogation opportunities as early as possible and to make sure that:-

- (a) They take copies of pertinent documents from the policyholder, which may be relevant to issues of liability, such as contracts, invoices, correspondence passing between the policyholder and relevant third parties, photos and the like.
- (b) If appropriate, they instruct forensic experts to prepare reports on the cause of the loss.
- (c) They remind the policyholder of their obligation to retain all documents which may be pertinent to issues of liability and quantum, whether those documents assist or adversely affect the case and whether they are stored in paper form or electronically. With 70% of documents now estimated to be stored in paperless form, it is particularly important to check the policyholder's computers, laptops, mobile phones and the like to ensure that all key electronic documents are captured.
- (d) evidence supporting the quantum of the claim is collated and retained.

Whilst the principles to be applied in determining the quantum of a policyholder's claim against a third party may not necessarily be the same as the principles which will be applied to determining the measure of indemnity to which the policyholder is entitled under its policy, much of the evidence which the adjuster will see in the course of adjustment of the insurance claim will be required to prove the quantum of the third party claim in subsequent recovery proceedings. For that reason, it is particularly important, in cases where there is likely to be a subrogated recovery, that loss adjusters do not just inspect the policyholder's documents to support the insurance claim, but retain copies of all relevant documents, so that the quantum can be proved as against a third party in due course.

In many cases, particularly with large losses, or losses where the quantum is likely to be controversial, it may be prudent to notify the third party at an early stage in the claim (i.e. before the insurance claim has been settled) and invite them to review/agree the quantification of the claim as it progresses. If the third party has been kept informed of the adjustment of the claim as it progresses (and given the opportunity of appointing their own adjusters), there is less likely to be disagreement on the quantum element of the claim, thereby saving insurers considerable costs in the long run.

In many cases, where adjusters identify potential recoveries, it may be possible for them to settle subrogation claims themselves, without resort to lawyers or legal proceedings.

In those circumstances, adjusters should be conscious for the need to ensure that they do not prejudice the policyholder's rights to recover their own uninsured losses.

As a general rule, it is an abuse of process for a person to instigate two claims arising out of the same loss. So, if you settle a subrogated claim, without including a policyholder's uninsured losses, you may end up precluding the policyholder from subsequently trying to recoup its uninsured losses.

There is nothing to stop you settling only the insured element of a claim and preserving the policyholder's right to pursue a separate recovery of their uninsured losses, provided that the culpable third party is aware of that and the terms of any settlement agreement reached clearly preserve that right.

Clearly, if you are only settling part of the claim (i.e. the insured element) you must be careful not to sign up to a settlement agreement which purports to be in full and final settlement of the entire claim. Our experience is that most third parties would be resistant to settling only part of a claim, so you will usually need to find a way of dealing with uninsured losses too.

Distribution of recoveries

Where a successful recovery is made and there are both insured and uninsured losses, a decision needs to be taken as to how to distribute the proceeds of any recovery, in the event that the amount for which the claim was settled is insufficient to cover both insured and uninsured losses.

Principles of distribution are not straightforward. The leading authority is ***Napier and Ettrick (Lord) v R F Kershaw Limited & Others [1999] 1 WLR 756***.

The court used the following hypothetical example to explain the general principles.

Insured's loss - £160,000.

Settlement monies received from third party - £130,000.

Insurers' outlay - £100,000.

Policy excess - £25,000.

So, we have a situation where there is a shortfall between the policyholder's total loss and what it has received from insurers of £60,000, made up of £35,000 of pure uninsured losses and a £25,000 excess. The settlement monies received from the third party are £30,000 short of the total loss (insured and uninsured losses combined).

The House of Lords decided that the policyholder should receive its uninsured losses first. So, the first £35,000 went to the policyholder.

Conversely, the court decided that the excess should be the last thing to be paid back to the policyholder, meaning that the balance of £95,000 went to the insurers.

Where the policyholder is underinsured and the policy is subject to average, insurer and insured are deemed to be co-insurers of the loss, which means that any subrogated recovery proceeds are apportioned between the policyholder and insurers on a pro-rata basis.

The position is different again, where the policy is a valued one.

So, if a policyholder under a valued policy (which is not subject to average) is insured to the full agreed value of the subject matter (say £80,000) but the agreed value is less than its actual value of £100,000 and the recovery from the third party is only £70,000, it is arguable that the entire £70,000 would be payable first to insurers and the policyholder would recover nothing.

The rules are complex and may work an injustice on either policyholder or insurers, depending on the particular circumstances of the case and the level of recovery.

It therefore makes sense to agree a formula between insurers and their policyholder before embarking on any recovery, so there is no dispute as to how the recovery proceeds should be distributed between them at the end of the claim. Perhaps, a more equitable approach would be to distribute insurance recoveries on a pro-rata basis between insurers and insured.

Conclusion

Finally, to pull everything together which we have talked about this morning, we have produced a checklist of some of the issues which we believe adjusters should be thinking about, to ensure that:-

- (a) Claims do not get paid which should not be paid;
- (b) The right person is paid; and
- (c) The prospects of recovering some or all of insurers' outlay from other insurers or third parties are maximised.

<p>First Attendance</p>	<p>Identify who the policyholder is by reference to the Schedule of Insurance.</p> <p>Check that the policyholder owns or is responsible for the premises/contents which have been lost or damaged.</p> <p>If not, and if the policy does not confer benefits on any third parties, then the policyholder is not entitled to be indemnified.</p>
<p>Reservation of Rights.</p>	<p>If likely to be coverage issues, or lengthy investigation, then advisable to put in place a written reservation of rights.</p>
<p>Scope of Cover.</p>	<p>Identify relevant perils and exclusions within the policy.</p> <p>Check that loss is caused by an insured peril and does not fall within an exclusion.</p>
<p>Policy Compliance.</p>	<p>Identify whether policyholder was required to comply with certain risk requirements.</p> <p>Check Schedule for specific endorsements and call for any risk recommendations/requirements from underwriters.</p> <p>Identify legal status of such requirements. Are they:-</p> <p>(a) Warranties, non-compliance with which will bring the insurance policy to an end;</p> <p>(b) Conditions precedent, non-compliance with which will entitle insurers to decline indemnity;</p> <p>(c) Mere conditions, non-compliance with which</p>

	<p>will not entitle insurers to decline indemnity.</p> <p>(d) Risk recommendations and requirements imposed by surveyors, non-compliance with which will only entitle insurers to decline indemnity, if the policy wording specifically dictates that they are to be given condition precedent or warranty status.</p> <p>Identify any breaches of conditions and warranty which will entitle insurers to decline indemnity.</p> <p>If property unoccupied, but there is no unoccupancy condition, might the policyholder have notified the claim late, due to the fact that the property was unoccupied when the loss occurred? If so, are there grounds to decline indemnity for breach of a notification condition precedent?</p> <p>If no specific conditions or warranties have been breached, have there been any breaches of more general conditions, such as conditions requiring policyholders to notify insurers of any increase in risk, or conditions requiring policyholders to take reasonable precautions to prevent loss or damage?</p>
<p>Fraud/Fraudulent Devices</p>	<p>Check for fraud indicators</p>
<p>Non-Disclosure/Misrepresentation.</p>	<p>Call for proposal form from underwriting file</p> <p>Identify whether there are any grounds to avoid the entire policy for non-disclosure and/or misrepresentation.</p>
<p>If a policy coverage point is to be taken.</p>	<p>Identify the grounds upon which the claim will be repudiated; i.e.</p>

	<p>(a) Non-disclosure/misrepresentation;</p> <p>(b) Breach of warranty;</p> <p>(c) Breach of condition precedent.</p> <p>Once grounds have been identified, do not delay in advising insurers of their options.</p> <p>Insurers to draft suitable letter of declinature, being careful to select the appropriate wording for repudiating liability which is consistent with the grounds which have been identified to repudiate the claim. So, for example, if there is evidence of non-disclosure/misrepresentation, the policy must be avoided and the premium returned. Cancelling the policy would be inconsistent with an avoidance and waive insurers rights to subsequently rely on an avoidance for non-disclosure and/or misrepresentation.</p>
<p>If claim is covered under the policy.</p>	<p>Comply with AIRMIC Speed of Settlement Guidelines.</p> <p>Produce cash flow framework for policyholder and authorise interim payments to be made at timely intervals.</p> <p>Identify what the correct measure of indemnity is under the policy. It may be, for example, that if the policyholder does not intend to rebuild the property, the correct measure of loss is diminution in value and not cost of rebuilding.</p>
<p>Contribution`</p>	<p>Identify whether there are any other insurers who cover the same loss.</p> <p>If there are, ensure that they contribute their rateable proportion (if that is what the policies</p>

	<p>envisage). Do not allow one insurer to pay 100% of the claim and then seek to recoup a rateable proportion from the other insurer.</p> <p>Alternatively, if it is not possible to get the second insurer to contribute, at the very least, the first insurer's rights should be reserved and it should be made clear to the policyholder and second insurer that any payment beyond the first insurer's rateable proportion is not being made voluntarily.</p>
<p>Settlement</p>	<p>Ensure that the payee is the policyholder.</p> <p>If the policyholder is bankrupt or in administration or liquidation, ensure that the payment is made to the trustee in bankruptcy, liquidator or routed via the administrator/administrative receiver.</p> <p>If the policyholder provides a mandate authorising insurers to make payment to a third party instead, that mandate should be in writing and contain a release of liability for insurers.</p> <p>Ideally, any form of discharge/settlement agreement should contain written warranties from the policyholder/its directors, confirming that:-</p> <ul style="list-style-type: none"> • There are no other policies of insurance which cover the same loss. • The policyholder is not unable to pay its debts at the time of settlement of the insurance. <p>Any settlement agreement/form of discharge should be worded to preserve insurers' rights to recoup all of the monies paid, should any fraud be identified or fraudulent devices used by the</p>

	policyholder.
Subrogation.	<p>Identify potential subrogation targets early on in investigations.</p> <p>Retain evidence to assist in subrogated recovery including:-</p> <ul style="list-style-type: none"> • Hard copy documents, such as contracts, invoices, correspondence, photographs. • Electronic documents. <p>Take witness statements when appropriate, though caution should be taken over securing statements whose primary purpose is to find insurers a way out of paying the claim under the policy.</p> <p>Consider appointing forensic experts.</p> <p>Capture and retain all evidence relating to the quantum of the claim.</p> <p>Notify third party's loss adjusters at an early stage and invite them to review the adjustment of the quantum of the claim.</p> <p>Identify any uninsured losses suffered by policyholder and agree, in advance, a methodology for distributing settlement proceeds between policyholder and insurers.</p>

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