to policies of insurance.[88] However, this does not mean that the whole of the contract between the parties will necessarily be embodied in the policy: non-marine warranties frequently appear in the proposal alone. Moreover, statements of a promissory nature in a prospectus delivered by the insurers to the assured may form part of a collateral agreement between them and bind the insurers, although no mention is made of them in the policy,[89] but such statements cannot be called in aid to construe the terms of the policy itself.[90] But a statement in a prospectus that loans would be made at the rate of four per cent on an assurance company's policies was held not to amount to a collateral agreement to charge no higher rate[91] and the publication in a prospectus of a company's practice in the distribution of profits was held not to affect its right to vary that practice by altering its bylaws, where the policy was issued subject to the deed of settlement of the company (by which they could be altered) and its byelaws.[92] In *Sun Life Assurance Co of Canada v Jervis*[93] it was held that an illustration setting out the benefits the assured would receive formed part of the contract between him and the company, since the proposal form was incomprehensible unless read in conjunction with it.

1.018 **Rectification of policy.** Should the contract of insurance[94] contain terms contradictory to or inconsistent with a prior understanding between the parties, either of them may seek the rectification of that agreement, either as a separate action or – more commonly – in the course of a claim on the policy.[95] The position was lucidly summarised by Bankes LJ in *A Gagniere & Co Ltd v The Eastern Co of Warehouses Insurance*:[96]

> If you prove the parties have come to a definite parol agreement, and you then afterwards find in the document which is intended to carry out that definite agreement something other than that definite agreement has been inserted, then it is right to rectify the document in order that it may carry out the real agreement between the parties. But in order to bring that doctrine into play it is necessary to establish beyond doubt that the real agreement between these parties was that which it is sought to insert in the document in place of the agreement which appears there.

More recently, the requirements for rectification have been restated as being convincing proof that: (a) there was a previous common intention as to what was

[88] *Quin v National Assurance* (1839) Jones & Carey 316 (Ire); *Beacon Life v Gibb* (1862) 1 Moo PCC (NS) 73, 97; Greer LJ in *Newsholme Brothers v Road Transport Insurance* [1919] 2 KB 356.

[89] *Thiselton v Commercial Union Ass Co* [1926] 1 Ch 888. See also *Sun Life of Canada v Jervis* [1944] AC 111; *Excess Life v Firemen's Insurance of Newark, New Jersey* [1982] 2 Lloyd's Rep 599.

[90] *British Equitable Assurance Co v Baily* [1906] AC 35, 41, *per* Lord Lindley.

[91] *Thiselton v Commercial Union* Ass Co [1926] 1 Ch 888.

[92] *British Equitable Assurance Co v Baily* [1906] AC 35.

[93] [1944] AC 111.

[94] Rectification often involves an error between the slip and the policy, a matter discussed below. However, given that the slip is a binding contract in its own right, the issue may arise where there is a variation between the documents leading up to the slip and the slip itself: *Dunlop Haywards (DHL) Ltd v Erinaceous Insurance Services Ltd* [2009] EWCA Civ 354.

[95] *Motteux v London Assurance* [2009] Lloyd's Rep IR 464; *Mutual Reserve v Foster* (1904) 20 TLR 715: *Letts v Excess Insurance Co Ltd* (1916) 32 TLR 361; *Universal Dockyard Ltd v Trinity Insurance Co Ltd* (unrep, HK High Court, 1986).

[96] (1921) 8 Ll LR 365, 366–367. *Cf Harper v Interchange Group* (2007) 104 LSG 28.

intended to be in the policy, together with some outward expression of the accord; (b) the common intention had to continue up to the date that the parties entered into a binding contract; (c) there had been clear evidence that the instrument as executed did not accurately represent the true agreement of the parties at the time of its execution; and (d) the instrument would, if rectified, have to accurately represent the true agreement of the parties at that time.[97]

It is unlikely that this doctrine will be of any importance in consumer insurance, since this class of business normally consists of the issue of a standard form policy; and it will be impossible to show that the insurer ever intended to issue anything else. However, rectification is in theory available upon proof of the necessary facts. Thus, for example where, as a result of clerical error, the assured is given incorrect information as to premium rates, the policy may be rectified. Again, where the proposal was made by reference to an illustration setting out the scale of the policyholder's benefits and a policy was subsequently executed on less advantageous terms after acceptance of the proposal by the company, it was held that the assured was entitled to rectification of the policy in order to give effect to the contract contained in the illustration and the proposal.[98]

The right to rectification arises in its simplest case where there has been a prior contract binding on the parties.[99] Normally, however, the question will be whether the parties had a common understanding short of agreement which they intended to be manifested in the final contract.

The initial question is the existence of a previous common intention which has been manifested in some way.[100] If it appears that the assured intended one thing and the insurers intended something else, the assured has no right to insist on a policy of the kind he wants,[101] as the governing principle is that if only one of the parties is under some misapprehension, no rectification is possible.[102] Thus in *Cape Plc v Iron Trades*

[97] *The Nai Genova* [1984] 1 Lloyd's Rep 353; *Dunlop Haywards (DHL) Ltd v Erinaceous Insurance Services Ltd* [2009] Lloyd's Rep IR 464. *Chartbrook Ltd v Persimmon Homes Ltd* [2009] 3 WLR 267.

[98] *Sun Life Assurance Co of Canada v Jervis* [1944] AC 111.

[99] *Hvalfangerskapet v Unilever* (1932) 42 LI LR 215, 220; *Mackenzie v Coulson* (1869) LR 8 Eq 368, 375; *PT Berlian Laju Tanker TBK v Nurse Shipping Ltd, The Aktor* [2008] 2 Lloyd's Rep 246; *Dunlop Haywards (DHL) Ltd v Erinaceous Insurance Services Ltd* [2009] Lloyd's Rep IR 464.

[100] *Alliance Aeroplane Co v Union Insurance Society of Canton* (1920) 5 LI LR 406; *Maignen & Co v National Benefit Insurance Co* (1922) 10 LI LR 30; *Joscelyn v Nissen* [1970] 2 QB 86; *Mint Security v Blair* [1982] 1 Lloyd's Rep 188; *Pindos Shipping Corp v Raven, The Mata Hari* [1983] 2 Lloyd's Rep 449. *Dunlop Haywards (DHL) Ltd v Barbon Insurance Group Ltd* [2009] EWHC 2900 (Comm).

[101] *Fowler v Scottish Equitable Life* (1858) 28 LJ Ch 225; *South-East Lancashire v Croisdale* (1931) 40 TLR 22; *Hvalfangerskapet v Unilever* (1932) 42 LI LR 215.

[102] *Lowlands Steam Shipping Co Ltd v North of England P & I Association* (1921) 6 LI L R 230; *Pasquali v Traders & General Insurance Association* (1921) 9 LI LR 514; *Stanton & Stanton v Starr* (1920) 3 LI LR 259; *Re London County Commercial Reinsurance Office Ltd* [1922] 2 Ch 67; *Gullett v Evans* (1929) 35 LI LR 239; *Pindos Shipping Corp v Raven, The Mata Hari* [1983] 2 Lloyd's Rep 449; *Agip SpA v Navigation Alta Italia SpA, The Nai Genova* [1984] 1 Lloyd's Rep 353; *Thor Navigation Inc v Ingosstrak Insurance, The Thor II* [2005] 1 Lloyd's Rep 547; *Kyle Bay Ltd (t/a Astons Nightclub) v Certain Lloyd's Underwriters* [2006] Lloyd's Rep IR 718, affirmed [2007] Lloyd's Rep IR 460 without reference to this point.

Employers Insurance Association[103] it was held that there was no common understanding as to scope of pneumoconiosis exclusion in employers' liability policy. The assured may, however, be able to recover any premiums he may have already paid as money paid to the insurers under a mistake of fact.[104] Mere clerical errors may be rectified on this principle. In *Nittan (UK) Ltd v Solent Steel Fabrication Ltd*[105] the policy named the insured as "Sargrove Electronic Controls Ltd"; this was the name of a dormant company controlled by the plaintiffs, who were trading under the name "Sargrove Automation". The Court of Appeal held that the error could be ignored, and treated the policy as referring to the plaintiffs.[106]

The common intention must continue up to the date on which the parties entered into the binding contract, which in a London market placement may be the slip rather than the policy itself.[107] The fact that there has been a later contract plainly cannot of itself be determinative of what was intended, as if that was the case then rectification would never be possible. In ascertaining whether there was an intention which continued up to the date of the executed instrument, an important indication may be whether there have been a number of changes at the stage between provisional and final agreement: if there have been many alterations to the wording then it may be difficult to prove a continuing common intention to maintain any particular term, but if only that term has not been recorded accurately or at all in the executed instrument then the applicant for rectification may have a somewhat easier task in showing that a mistake had been made.[108]

As to the third stage, there is a strong presumption that the policy embodies the real contract between the parties, and a strong case is required to rebut that presumption and to support a claim for rectification, especially after the loss.[109] Thus, in *Kiriacoulis Lines SA v Compagnie d'Assurance Maritime, The Demetra K*[110] a marine policy on a vessel was originally drafted in September 1995 on the terms of the Institute Hulls Clauses 1982, containing the usual coverage for fire (whether or not deliberately set) and excluding loss caused by war risks and malicious acts relating to the detonation of weapons of war. The underwriter agreed by endorsement in October 1995 to extend cover to these excluded perils. On renewal in September 1996 the broker presented a slip which referred to war risks being insured perils, but the underwriter was by this time unwilling to provide such cover and deleted the references to war risks on the slip. The vessel was subsequently destroyed by fire set by an unknown person and the underwriter asserted that it had been the common intention of the parties on renewal to delete cover for malicious acts. The Court of Appeal rejected the rectification argument. The Court of Appeal noted that the

[103] [2004] Lloyd's Rep IR 75, followed on the same point in *T & N Ltd v Royal & Sun Alliance Plc* [2004] Lloyd's Rep IR 134, where a further argument based on estoppel by convention was similarly rejected on the ground that consensus between the parties had not been demonstrated.

[104] *Fowler v Scottish Equitable Life* (1858) 28 LJ Ch 225.

[105] See also: *Whittam v David* [1962] 1 QB 271; *Riverlate Properties v Paul* [1975] Ch 133.

[106] [1981] 1 Lloyd's Rep 633.

[107] *Dunlop Haywards (DHL) Ltd v Erinaceous Insurance Services Ltd* [2009] Lloyd's Rep IR 464.

[108] *Dunlop Haywards (DHL) Ltd v Erinaceous Insurance Services Ltd* [2009] Lloyd's Rep IR 464.

[109] *Henkle v Royal Exchange* (1749) 1 Ves Sen 317.

[110] [2002] Lloyd's Rep IR 795.

1995 policy in its original format would not have precluded recovery, as the original exclusion for malicious acts was operative only in relation to war risks. The 1995 endorsement had not, therefore, affected the claim. The renewal merely deleted the 1995 endorsement, restoring the policy to its original form and there was no evidence of any common intention to go further and to remove cover for all malicious acts. On the facts, the parties had not considered the total exclusion of loss caused by malicious acts but had confined their attention to the slip itself and none of the requirements for rectification had been satisfied.

A court can refuse rectification if insurers claiming rectification have for a period of years not raised any objection to the operation of the policy in unamended form.[111]

3. Formation of Insurance Contracts

Ordinary contractual principles. There will be a binding contract only if the terms are agreed with reasonable certainty, although the law does accept that a binding contract can exist if there is a mechanism for agreeing unresolved terms at a later stage.[112] A policy made on the basis that the premium is to be agreed is perfectly valid.[113] The rule in the Marine Insurance Ordinance, s 26(1), that the subject-matter must be specified with reasonable certainty is an application of the general rule that a contract is void for uncertainty if there is a fundamental gap in the agreement between the parties which makes it impossible for the court to determine the obligations of either of them. The fact that the terms of a policy may be varied, by one party or the other, does not bring the uncertainty rule into play.[114] Equally, the fact that one party has discretion as to how the contract should operate is not enough to make an insurance contract void for uncertainty.[115] **1.019**

It is also necessary for the parties to have an intention to create legal relations. There will rarely be a dispute about this as regards the creation of a contract of insurance as the matter is to be determined objectively rather than by the understandings or intentions of the parties,[116] although the position may be complicated in the event of an apparent agreement for the settlement of claims under a policy.[117] An apparent

[111] *Cape Plc v Iron Trades Employers Insurance Association* [2004] Lloyd's Rep IR 75.

[112] There is no such thing as a contract to negotiate. Lord Wright however in *Hillas v Arcos* [1932] All R 494 seems to have accepted that there could be, where he said *obiter,* "if there is good consideration . . . though in the event of repudiation by one party the damages may be nominal . . ." Lord Denning M R in *Courtney v Tolani* [1975] 1 All ER 716 rejected that *dictum* as bad law, because no court could estimate the damages for breach of such a contract and that view was subsequently upheld by the House of Lords in *Walford v Miles* [1992] 1 All ER 453 on the basis that a contract to negotiate is too uncertain to be enforced.

[113] *Gliksten v State Insurance* (1922) 10 Ll LR 604.

[114] *Baynham v Philips Electronics Ltd* (unrep, *The Times,* 19 July 1995).

[115] *Brown v GIO Insurance* [1998] Lloyd's Rep IR 201.

[116] *Clark v Tull (trading as Ardington Electrical Services)* [2002] Lloyd's Rep IR 524; *Wong Mui-Mui v Wing On Life Assurance Co Ltd* (unrep, HKDC, 1976), where the applicant was led to believe that she was applying for a job rather than for a life policy.

[117] See: *Orion Insurance Co Plc v Sphere Drake Insurance Plc* [1990] 1 Lloyd's Rep 465; *Sphere Drake Insurance Plc v Basler Versicherungsgesellschaft* [1998] Lloyd's Rep IR 35; *Re Odyssey (London) Ltd* [2001] Lloyd's Rep IR 1 (all cases arising out of the same facts, with different conclusions being reached).

insurance agreement may also fail on ordinary contractual principles for want of consideration, although it has been held that a notional insurance premium of £1 was sufficient consideration where the insurance formed a part of a wider arrangement under which the assured was to be provided with a hire car following damage to his own.[118] Finally, the contract must not be vitiated by fundamental mistake, as where the subject matter has been lost[119] before the contract was entered into or never existed.[120] A mistake is, however, operative only if the agreement is incapable of performance:[121] thus, a policy is not vitiated by mistake simply because the parties wrongly believed that an earlier policy had been cancelled.[122]

Offer

1.020 *Offer by the assured.* The first step in the making of a contract of insurance is the proposal or application by means of which the assured gives to the insurers particulars of the risk which he wishes them to undertake. This will generally be the offer, which the insurer is free to accept or reject. Before that the assured will probably have found out from the insurers, either directly or through an agent, the terms on which they are usually willing to grant insurances of the kind he wants, but, where the contract is subsequently reduced into writing, its terms will not be affected by anything which is said or done at this stage.[123] In accordance with general principle, there is a binding contract as soon as the insurer has unconditionally accepted the offer on terms which do not differ from those proposed by the assured and there are no major terms to be agreed.[124] There is a serious conceptual problem here, in that a proposer for insurance is unlikely to be aware of the insurer's usual terms; and there is indeed some authority for the proposition that for this reason any offer must come from the insurer and not the assured, who merely makes an invitation to treat.[125] However, this approach would seem to rest on the old theory of subjective consensus in contract and the better and generally, accepted view is that of objective consensus: the proposer applies for insurance on what are understood to be the insurer's general terms. If the insurer has accepted the offer on those terms, they form the terms of the cover and it is thus not open to the assured to seek to reject the policy on the basis that it contains terms not mentioned in the proposal form issued by the insurer on the basis that the insurer has responded with a counter-offer,[126] nor may the assured successfully argue that certain terms of the policy are not binding for want of having been brought to his attention in the pre-contractual period.[127] The now accepted position is that the insurer's terms are

[118] *Dennard v Plant* [2002] Lloyd's Rep IR 524.
[119] *Pritchard v The Merchants' Life* (1858) 3 CB (NS) 622; *Scott v Coulson* [1903] 2 Ch 249. Note that marine policies may be made on a lost or not lost basis.
[120] *Micro Design Group Ltd v Norwich Union Insurance Ltd* [2006] Lloyd's Rep IR 235.
[121] *Great Peace Shipping Ltd v Tsavliris Salvage (International) Ltd, The Great Peace* [2002] 4 All ER 689.
[122] *O'Kane v Jones* [2005] Lloyd's Rep IR 174.
[123] *Dunn v Campbell* (1920) 4 Ll LR 36. In *Pearl Life v Johnson* [1909] 2 KB 288 the recitals to a life policy by deed stated that it was made on the basis of a proposal the proposal had not in fact been signed by the policy holder or her authority, and premiums had been paid. Held, that the insurers were estopped from contending that there was no contract.
[124] *Mulchrone v Swiss Life (UK) Plc* [2006] Lloyd's Rep IR 339.
[125] *Alliss-Chalmers Co v Fidelity & Deposit Co of Maryland* (1916) 114 LT 433.
[126] *General Accident Insurance Corp v Cronk* (1901) 17 TLR 233.
[127] *Super Chem Products Ltd v American Life and General Insurance Co* [2004] Lloyd's Rep IR 446.

binding on the assured even if they have not been brought to the assured's attention prior to the making of the contract, at least provided that the terms are incorporated by some form of express wording on the proposal form;[128] and it is irrelevant that the assured has not read them.[129] That said; the common law recognises an exception in relation to terms which are particularly harsh or unusual, as these must be drawn specifically to the attention of the other party if they are to be treated as binding.[130] Moreover, in the case of consumer insurance it may be that the assured's express attention has to be drawn to obligations imposed upon him by the insurer's usual terms.[131] The assured is for his part entitled to the benefit of terms offered by the insurer.[132] If there have been previous dealings between the insurer and the assured, the argument that the contract is made on previously agreed terms is plainly overwhelming.[133]

It is often the case that an insurance contract incorporates, by reference, the terms and conditions of some other document, including another insurance policy. In such a case, the court must try to give effect to express terms and incorporated terms, and this may mean adapting the incorporated terms to make sense of them in the context of the policy into which they have been incorporated. This is typically a reinsurance problem, as it is standard practice for the terms of the direct policy to be incorporated into the facultative reinsurance, giving rise to a variety of inconsistencies and irrelevancies, although the same problem may be encountered at the direct level. The court will do its best to make sense of the composite contract, but exactly what has and has not been incorporated – and in what form – remains a matter of uncertainty until resolved by a court.[134]

1.021 *Offer by the insurer.* There are a number of situations in which the offer to insure may come from the insurer. The following lists some of the possibilities:

(1) The insurer has introduced new terms or conditions while purporting to accept the assured's offer, or has spelt out issues left open in the original offer by the assured (such as the level of premium): in such cases the insurer is making a counter-offer, which takes effect in law as an offer in its own right.[135]

(2) On the renewal of a policy it is common for insurers to send to assureds a renewal notice. The wording of such a document might well be construed as

[128] *Wyndham Rather Ltd v Eagle Star & British Dominions Insurance Co Ltd* (1925) 21 Ll LR 214; *Nsubuga v Commercial Union Assurance Co Plc* [1998] 2 Lloyd's Rep 682; *Anders & Kern Ltd v CGU Insurance Plc* [2007] Lloyd's Rep IR 555, affirmed on other grounds [2008] Lloyd's Rep IR 460; *US Trading Ltd v Axa Insurance Co Ltd* (unrep, 17 March 2008). *William McIlroy Swindon Ltd v Quinn Insurance Ltd* [2010] EWHC 2448 (TCC).
[129] *Watkins v Rymill* (1883) 10 QBD 178.
[130] *Interfoto Picture Library Ltd v Stiletto Visual Programmes* [1989] 1 QB 433; *US Trading Ltd v Axa Insurance Co Ltd,* (unrep, 17 March 2008).
[131] This was the view of Thomas J in *Nsubuga v Commercial Union Assurance Co Plc* [1998] 2 Lloyd's Rep 682, based on Statements of Insurance Practice 1986 in force in England at the time.
[132] *Sun Life Assurance Co v Jervis* [1943] 2 All ER 425.
[133] *Adie & Sons v Insurance Corp* (1898) 14 TLR 544.
[134] *CNA International Reinsurance Co Ltd v Companhia de Seguros Tranquilidade SA* [1999] Lloyd's Rep IR 289; *HIH Casualty Co & General v New Hampshire Insurance* [2001] Lloyd's Rep IR 596.
[135] *South-East Lancashire Insurance v Croisdale* (1931) 40 Ll LR 22; *New Hampshire Insurance Co v MGN Ltd* [1997] LRLR 24.

an offer to grant a further policy on the same risk. However, the assured's duty of utmost good faith is owed on every renewal of an indemnity policy, so that a renewal notice could equally well be construed as either a conditional offer to renew, or as an invitation to treat requesting the assured to make a fresh offer.[136]

(3) Open covers, binding authorities and reinsurance treaties – indeed, all contracts for insurance under which contracts of insurance are subsequently to be made[137] – may amount to standing offers by the insurers or reinsurers to provide cover for any risk falling within the contractual description which may subsequently be accepted by the assured or reinsured. Accordingly, each individual declaration to the insurers or reinsurers is probably an acceptance of the standing offer.[138]

(4) The insurer may have made a direct approach to the assured stating that insurance is available at given rates. More generally, insurance might be offered to any person fulfilling specific conditions, such as the possession of a particular newspaper or some other form of certificate.[139]

It has been held that if an insurer submits a tender in request for bids for an insurance scheme, there is an implied contract that the tender will not be withdrawn within the deadline for acceptance set out in the document requesting tenders.[140]

Acceptance

1.022 *Acceptance or counter offer by insurers.* Where the assured has made an offer to the insurer, there may be circumstances in which the insurer's positive response cannot be construed as an acceptance and instead is to be regarded as a counter offer. One illustration of this possibility is where a condition is imposed by the insurer on binding acceptance, for example that the premium be paid or that a policy be issued. A condition may not be imposed by the insurers once the contract has been made.[141] If the condition is one which is to be found in the insurer's standard terms, it may be assumed that the assured's offer was made on the basis of the condition and that there is a binding contract subject to the fulfilment of a condition subsequent. If, on the other hand, the condition is an unusual one, it is better to regard the insurer as having made a counter offer which the assured is free to accept or to reject. There

[136] The former view of matters appears to have been taken in *Taylor v Allon* [1966] 1 QB 304.

[137] See the distinction drawn by Aikens J in *HIH Casualty & General v Chase Manhattan Bank* [2001] Lloyd's Rep IR 191.

[138] *Bhugwandass v Netherlands India Sea and Fire Insurance Co of Batavia* (1888) 14 App Cas 83; *General Accident v Tanter, The Zephyr* [1985] 2 Lloyd's Rep 529; *Youell v Bland Welch (No 2)* [1990] 2 Lloyd's Rep 431; *Kingscroft Insurance v Nissan Fire & Marine Insurance Co Ltd (No 2)* [1999] Lloyd's Rep IR 603; *Glencore International AG v Alpina Insurance Co Ltd* [2004] 1 Lloyd's Rep 111; *BP Plc v GE Frankona Reinsurance Ltd* [2003] 1 Lloyd's Rep 537; *Bonner v Cox* [2006] Lloyd's Rep IR 385; *Crane v Hannover Ruckversicherungs-Aktiengesellschaft* [2008] EWHC 3165 (Comm).

[139] *General Accident Fire and Life Assurance Corp v Robertson* [1909] AC 404.

[140] *City Polytechnic of Hong Kong v Blue Cross (Asia Pacific) Insurance Ltd* [1995] 2 HKLR 103.

[141] *Mulchrone v Swiss Life (UK) Plc* [2006] Lloyd's Rep IR 339; *Bonner v Cox* [2006] Lloyd's Rep IR 385. *Leading Synthetics Pty Ltd v Adroit Insurance Group Pty Ltd* [2011] VSC 467.

is nevertheless a clear distinction between a suspensory provision which operates to prevent any agreement between the parties; and a suspensory provision which does not affect the binding nature of any agreement but merely provides for the suspension of cover under the policy until the necessary conditions have been fulfilled. This distinction, which rests solely upon the words used, is of particular significance where the risk has in some way altered between the date of the apparent agreement and the date on which the risk begins to run; and is discussed further below.

A further possibility is that, at the date of the assured's offer to the insurer, major terms of the subsequent insurance required to be settled, for example the level of premium to be paid. The insurer's response, detailing the missing term,[142] is, in the absence of clear wording, best construed as a counter-offer which the assured is free to accept or reject either by communication or by tender of the proper premium. In rare cases the proper construction might be that the insurer is setting out an invitation to treat, requesting the assured to make an offer for insurance on the stated terms, but in general the insurer's response ought to be regarded in a more serious light and as an offer capable of acceptance.[143] Finally, the insurers may simply issue a policy which does not conform to the cover requested by the assured. Such conduct amounts to a counter offer which the assured is free to accept or reject.[144]

1.023 *Acceptance by the insurer.* Assuming that all material terms have been agreed between insurer and assured; and that the insurer has not determined to insert into the policy terms other than those generally applicable, at least without the assured's consent, a binding contract will arise as soon as the insurer has performed an unqualified act of acceptance. This may occur in a number of ways: the assured may be notified by the insurer of his acceptance;[145] or a policy may have been issued;[146] or the assured may have tendered and the insurer accepted, the premium.[147] It is to be noted, however, that the mere fact that the insurers have banked a cheque tendered by the assured does not of itself amount to acceptance, as there may be other conditions to be met by the assured.[148] The ordinary rule that the fact of acceptance must be notified will be fulfilled in most of the cases where there has been acceptance in fact by the insurer. However, where an insurer signs a policy in the form of a deed without

[142] There can be a perfectly good contract if the matter is held over: see above.

[143] *Canning v Farquhar* (1866) 16 QBD 727.

[144] *South East Lancashire Insurance v Croisdale* (1931) 40 Ll LR 22; *New Hampshire Insurance Co v MGN Ltd* [1997] LRLR 24.

[145] *Adie & Sons v Insurance Corp* (1898) 14 TLR 544, which makes the point that subsequent correspondence between the parties seemingly denying agreement cannot affect the earlier binding agreement. See also *Allianz Insurance Co-Egypt v Aigaion Insurance Co SA (No 2)* [2008] 2 CLC 1013, where notification of acceptance was held to create a binding contract even though the offer made by the assured omitted an important warranty that the parties had previously agreed should be included: in such circumstances there is a binding contract; and the missing term is to be resolved by rectification and not by a denial of overall consensus.

[146] *General Accident Insurance v Cronk* (1901) 17 TLR 233; *Rust v Abbey Life Assurance Co* [1979] 2 Lloyd's Rep 334. In accordance with the postal acceptance rule, the posting of the policy may be enough to complete the contract: *Sanderson v Cunningham* [1919] 2 Ir 234.

[147] See s 54 of the Marine Insurance Ordinance, which provides that, in the case of a marine policy effected by the broker which acknowledges the receipt of an unpaid premium, the acknowledgment is binding as between insurer and assured although not as between insurer and broker.

[148] *Fontana v Skandia Life Assurance Ltd* (unrep, 2002).

Their Lordships did not go as far as abolishing the continuing duty of utmost good faith, but held simply that, in the context of the presentation of claims, fraud was required. Their reluctance to go further was prompted for the most part by the consideration that s 17 was clear in its words and imposed a general duty of utmost good faith during the currency of the contract, a duty which Lord Hobhouse characterised as one of "fair dealing"[630] and which was flexible in that it took on a lesser form post-contract in order to maintain congruity between the rights of assured and insurer:[631]

> It is not right to reason . . . from the existence of an extensive duty pre-contract positively to disclose all material facts to the conclusion that post-contract there is a similarly extensive obligation to disclose all facts which the insurer has an interest in knowing and which might affect his conduct. The courts have consistently set their face against allowing the assured's duty of good faith to be used by the insurer as an instrument for enabling the insurer himself to act in bad faith. An inevitable consequence in the post-contract situation is that the remedy of avoidance of the contract is in practical terms wholly one-sided. It is a remedy of value to the insurer and of disproportionate benefit to him; it enables him to escape, retrospectively the liability to indemnify which he has previously and validly undertaken . . .
>
> [I]t is hard to think of circumstances where an assured will stand to benefit from the avoidance of the policy for something that has occurred after the contract has been entered into; the hypothesis of continuing dealings with each other will normally postulate some claim having been made by the assured under the policy.

A number of points may be derived from the judgments.

First, as to the assured's state of mind, their Lordships did not take the step of saying that only fraud brings the duty into play: that reservation was confined to fraudulent claims in so far as the rules relating to fraudulent claims were derived from the continuing duty of utmost good faith. However, Lord Scott did opine that "unless the assured has acted in bad faith he cannot . . . be in breach of a duty of good faith, utmost or otherwise".[632] Fraud would, therefore, appear to be the touchstone.

Second, the House of Lords did not define the matters to which the continuing duty might apply. Lord Hobhouse recognised that the scope of the duty was elusive and went no further than stating that: (a) the duty did not extend to post-contractual increases of risk, as the cases were clear that the assured was entitled to increase the risk and was not, contract aside, required to disclose any such post-contract increase to insurers; and (b) the ship's papers cases had nothing to do with the continuing duty of utmost good faith.[633] Beyond that he refused to be drawn, although his

[630] At para 48.
[631] At para 57.
[632] At para 111.
[633] At paras 58 to 60.

Lordship would appear to have been of the view that there was relatively little scope for the duty. It would seem, however, that their Lordships did not wish to treat fraudulent claims as an aspect of good faith, and there are comments which indicate a severance of claims from good faith. Lord Hobhouse treated good faith and claims as distinct issues in his speech,[634] specifically stating that the right of the insurer to refuse to pay for a fraudulent claim derived from the rather different principle that a person should not benefit from his own wrong;[635] and Lord Scott similarly recognised that the rule against fraudulent claims might or might not derive from s 17.[636]

Third, the question of remedy was analysed by their Lordships. Lord Hobhouse indicated that, at least as regards fraudulent claims, the appropriate remedy was not avoidance *ab initio* but rather the loss of the right to derive any benefit from or claim under the policy.[637] It followed from his approach that fraudulent claims were disallowed not by the continuing duty but rather by common law principles. Their Lordships' comments on the consequences of a breach of the continuing duty of utmost good faith under the general provisions of s 17 are less clear. Lord Scott refused to be drawn. There are nevertheless powerful indications in the speech of Lord Hobhouse that the matter should be dealt with purely on the basis of breach of contract. In his words:[638]

> A coherent scheme can be achieved by distinguishing a lack of good faith which is limited to the making of the contract itself (or some variation of it) and a lack of good faith during the performance of the contract which may prejudice the other party or cause him loss or destroy the continuing contractual relationship. The former derives from requirements of the law which pre-exist the contract and are not created by it, although they only become material because a contract has been entered into. The remedy is the right to elect to avoid the contract. The latter can derive from express or implied terms of the contract: it would be a contractual obligation arising from the contract and the remedies are the contractual remedies provided by the law of contract.

Finally, as to the duration of the duty, Lord Clyde rejected the argument that the duty of utmost good faith could continue beyond the commencement of litigation:[639] "the idea of a requirement for full disclosure superseding the procedural controls for discovery in litigation is curious and unattractive". Lord Hobhouse agreed: once the parties were in litigation it was the procedural rules which governed the extent of the disclosure in litigation, s 17. His Lordship's reasoning was that the commencement of proceedings crystallised the rights of the parties, and their relationship was from that point governed by the rules of procedure and the orders which the court made on

[634] At para 64.
[635] At para 61.
[636] At para 111.
[637] At para 64.
[638] At para 52.
[639] At para 14.

the application of one or other party. Orders for disclosure were discretionary; and there were appropriate sanctions for non-compliance. The need for any other form of disclosure was, thus, removed.[640] Lord Scott inclined to the same view, but reserved his position as he was troubled by the possibility that a claim honestly begun was to be dishonestly continued, in particular where a claim was for the loss of goods which were found or otherwise restored to the owner. It is submitted that Lord Scott's reservation was overcautious. Once the assured has suffered a loss of goods for which he has made a claim, the goods are forfeited to the insurer under the salvage principle and the assured is fully entitled to pursue a claim for the policy moneys and indeed he has a vested right to them: what the assured cannot do, of course, is both retain the goods and make a claim and, if he does so, then plainly the insurers are entitled to take the goods. This, however, is nothing to do with utmost good faith.

As to *The Litsion Pride*,[641] Lord Hobhouse held that its overruling was inevitable. The decision could not be supported as a matter of law, in that the scope given to the duty of utmost good faith by Hirst J decoupled the duty from what was set out in s 17 and in particular the remedy of avoidance. The issues in *The Litsion Pride* ought to have been dealt with as a matter of contract. As to the facts of the case, Lord Hobhouse's view was that there had not been a fraudulent claim at all, as the actual claim made was a valid claim for a loss which had occurred and had been caused by a peril insured against when the vessel was covered by a held covered clause. The fraud related to an attempt to deprive the insurers of premiums to which they were entitled under the policy. Lord Hobhouse was nevertheless of the view that the result might have been supportable on other grounds, but he did not elaborate. It may be speculated that the correct approach in *The Litsion Pride* was that the assured was not required to disclose the entry of the vessel into a war zone, as the held covered clause gave automatic protection in those circumstances,[642] and that the only claim by the insurers would have been breach of contract in not paying premiums for the additional premium area. Whether that failure amounts to a repudiation of the contract is extremely doubtful, as time is not generally of the essence in paying a premium unless the contract so provides, and the fact that a breach of contract is fraudulent does not of itself convert a breach which is non-repudiatory by nature into a repudiatory breach. If all of this is right, it follows that the insurers' remedy in *The Litsion Pride* was simply to claim the unpaid premium.[643]

6.111 *Mercandian Continent*.[644] The reasoning of the House of Lords in *The Star Sea*[645] was considered by the Court of Appeal in *K/S Merc-Skandia XXXXII v Certain Lloyd's Underwriters, The Mercandian Continent,* which concerned a document fraudulently

[640] At para 75.
[641] [1985] 1 Lloyd's Rep 437.
[642] Had the held covered clause required a further assessment of the risk as a condition of cover, then the duty of utmost good faith would have been attracted by the held covered clause. The clause was, however, automatic.
[643] But *quaere* whether it is right. In *K/S Merc-Skandia XXXXII v Certain Lloyd's Underwriters* [2001] Lloyd's Rep IR 802 Longmore LJ (at para 29) commented that *The Litsion Pride* was a case of making a fraudulent claim and to that extent the decision was good law.
[644] [2001] Lloyd's Rep IR 802.
[645] [2001] Lloyd's Rep IR 247.

manufactured by the assured in the course of negotiations with its liability insurers, the purpose of which was to demonstrate that the assured had not entered into a contract with the plaintiff third party conferring exclusive jurisdiction on the English courts: such an agreement was at the time thought by the assured to be damaging, in that the measure of damages was (wrongly) believed to be greater in England than in the natural forum for the hearing of the action, Trinidad. The insurers sought to avoid the claim and the policy for breach of the continuing duty of utmost good faith by the assured. The analysis of Longmore LJ in the Court of Appeal in *K/S Merc Skandia* was at points at variance with that of the House of Lords in *The Star Sea.* It was accepted by Longmore LJ that a continuing duty did exist, as it was not open to the Court to overturn the express provisions of s 17 Longmore L.J's main proposition was that there was an inextricable link between the continuing duty of utmost good faith and the terms of the policy, for while it was the case as regards pre-contractual breach of duty that the subsequent contract was not a relevant consideration, the assured's post-contract duties were governed primarily by the policy. In Longmore L.J's words, "where a contract has been made, it is somewhat perverse to apply to it principles of good faith which are traditionally applicable mainly in pre-contract situations" and the starting point was thus the policy itself.'[646] Longmore LJ then considered the situations in which the continuing duty of utmost good faith had been considered, and ruled that such a duty did exist but that it was limited.[647]

(1) The duty had no application to fraudulent claims, as the right to refuse to make payment following a fraudulent claim rested upon the rule of law that the assured could not profit from his own wrong and, further: "There is no evidence that Sir Mackenzie Chalmers had this line of authority in fire insurance cases in mind when he drafted s 17 of his marine insurance code. The concept, would in any event, be alien in a field, such as marine insurance, where most, if not all, policies, were "valued" policies.

(2) A duty of good faith arose when the assured (or indeed the insurer) sought to vary the contractual risk, in which case the right of avoidance applied only to the variation and not to the original risk itself.

(3) A duty of good faith arose on the renewal of a contract. The duty was prospective and did not allow insurers to avoid the earlier policy even though the breach took place during its currency.

(4) A duty of good faith arose in "held covered" cases, although insofar as there was authority for the proposition that there was any such duty where the assured was exercising rights which he had under the original contract, such authority was "puzzling".

(5) Where the insurer had a right to information by virtue of an express or an implied term in the policy — which was of particular significance in liability insurance and reinsurance — there was a duty of good faith in the provision

[646] At para 9.
[647] At para 22.

of such information. However, there was no duty of utmost good faith simply because the policy contained a cancellation clause exercisable by the insurers on notice and for any or no reason.[648]

(6) A particular illustration of the continuing duty arose under a liability policy where the insurers exercised their right to take over the assured's defence, as the insurers were required to act in good faith and to take into account the assured's interests in deciding whether to settle with the third party, although the assured's primary remedy in such a case was breach of contract.[649]

Analysing these various possibilities, Longmore LJ concluded that only the situations in (5) and (6) were true illustrations of the continuing duty of utmost good faith, as situations (2) to (4) were in effect pre-contractual matters and were governed by pre-contractual principles. As far as disclosure by the assured was concerned, therefore, the duty existed only where there was a contractual obligation to disclose (situation (5)); and it remained to consider exactly when there would be a breach of the continuing duty of utmost good faith as well as a breach of contract. In considering this question, Longmore LJ held that the concepts of breach of contract and breach of the continuing duty of utmost good faith were closely connected. An obligation to provide information was generally to be construed as an innominate term; and insurers would have the right to treat the policy as repudiated only if the assured's breach was such as to show that he regarded himself as no longer bound by the policy.[650] Given that the requirements for treating a policy as having been repudiated were strict; and given also that the consequences of a breach of the duty of utmost good faith were more severe, in that the policy would be avoided *ab initio* and would thus deprive the assured of all rights under the policy, including accrued rights, it followed that insurers were unable to sidestep the terms of the policy by relying on the continuing duty of utmost good faith in circumstances in which they could not have repudiated the policy. In short, there had to be "at least the same quality of conduct as would justify the insurer in accepting the insured's conduct as a repudiation of the contract". On this approach, the disproportionate effects of avoidance *ab initio* were mitigated, as they were confined to the case in which the insurers in any event had a right to terminate the policy as from the date of breach. The words "at least" are also important, as Longmore LJ does not appear to be saying that every case of repudiation amounts to a breach of the continuing duty: it remains necessary for insurers to demonstrate that the assured's

[648] Following *New Hampshire Insurance v MGN Ltd* [1997] LRLR 24.

[649] *Cox v Bankside* [1995] 2 Lloyd's Rep 437. See, however, the judgment of Mance LJ in *Gan Insurance Co v Tai Ping Insurance Co (Nos 2 and 3)* [2000] Lloyd's Rep IR 667, where the obligation of an insurer to take into account the interests of the assured in negotiating with third parties was specifically classified as a matter of contract and not a consequence of the continuing duty of utmost good faith.

[650] At the time that *K/S Merc-Skandia* was decided, the accepted view of the breach of a policy condition, based on *Alfred McAlpine Plc v BAI (Run-off) Ltd* [2000] Lloyd's Rep IR 352, was that insurers who had been seriously prejudiced by a breach of a policy term had the right to treat the claim as repudiated, leaving the policy itself untouched. It was unclear whether there could he repudiation of a claim in circumstances where there was no repudiation of the policy itself, and, accordingly, it was also unclear whether the parallel right to avoid applied to repudiation of a claim as well as repudiation of the policy. This is all now academic, as a majority of the Court of Appeal in *Friends Provident Life & Pensions Ltd v Sirius International Insurance Corp* [2006] Lloyd's Rep IR 45 denied the existence of the concept of repudiation of a claim: insurers can refuse to pay a claim only where they are entitled to treat the policy as a whole as having been repudiated.

failure to disclose was material to the issue in that it had some effect on the insurers' ultimate liability and also that the insurers had been induced to alter their behaviour by reason of the assured's presentation of facts. However, it might be thought that, in general, conduct which is repudiatory will fulfil the requirements of materiality and inducement, given that most insurance conditions have to be assessed in relation to their consequences for the insurers, so it is likely that in most cases repudiation and breach of the duty of utmost good faith in the context of failure to disclose will be coterminous.

The recognition that the continuing duty operates alongside the right of the insurers to treat the policy as repudiated for breach disregards the possibility that the contractual duty amounts to an exhaustive statement of the assured's obligations which overrides the continuing duty of utmost good faith. This was indeed held to be the position in *Hussain v Brown (No 2)*.[651] In that case, it was decided that a contractual obligation on the assured to notify any circumstance which might increase the risk superseded the continuing duty of utmost good faith, so that the insurer's only remedy was breach of contract and that, as a general principle, an insurer who wished to maintain that duty in existence despite the presence of an express term would have to make clear provision for that in the policy.

Two further points are noteworthy here. First, Longmore LJ rejected the proposition that fraud per se was enough to trigger a breach of the continuing duty: fraud was a necessary but not a sufficient requirement, and insurers were required to prove that there had been an unfair presentation of information was material which induced their reliance. Second, given that there was no obligation on the assured to disclose information in the absence of an express term, then should the insurers ask for information other than under an express term the only duty of the assured was not materially to misrepresent the facts in anything he did say to insurers: there was no duty of disclosure and in the event of misrepresentation then insurers would have their ordinary common law and statutory remedies for misrepresentation.

The application of this reasoning to the actual facts in *K/S Merc-Skandia* was straightforward. While there had been fraud, that fraud made no difference to the liability of the insurers under the policy and in any event was not directed at them: the worst that had happened was that the insurers' solicitors had maintained their legal proceedings opposing English jurisdiction longer than would otherwise have been the case. The insurers thus had no right to treat the policy as repudiated. It followed that they had no right to rely upon the continuing duty of utmost good faith.

The Aegeon.[652] In *Agapitos v Agnew, The Aegeon,* the assured's vessel became a total loss. The underwriters denied liability on the basis of various breaches of warranty relating to the date at which "hot works" had been carried out on the vessel, and the assured commenced proceedings. The underwriters in the present application sought **6.112**

[651] (Unrep, 1996).

[652] [2001] Lloyd's Rep IR 191, affirmed [2002] Lloyd's Rep IR 573.

s 148 of the Act, an insurer is not permitted to plead any policy defence (including any rateable proportion clause) to a claim by the third-party victim of the assured, as was the situation here. Consequently, it could not be said that LG's payment of 100 per cent of the loss was "voluntary". However, the Court of Appeal pointed out that under s.151(4) of the Act, LG had a right of recourse against the assured in respect of any sums which it had been obliged to pay to the third party for which it was not liable under the policy. By its failure to exercise the right of recourse, LG had converted its 100 per cent payment into 50 per cent voluntary payment, which it was not able to recover from DI.

The *Legal & General* approach was followed by David Steel J in *Bovis Construction Ltd v Commercial Union Insurance Co Ltd*.[280] In this case, the assured had concurrent claims under his own public liability policy and also under a joint names policy procured by a third party. The full amount of the assured's loss was paid by the assured's public liability insurers, who sought to exercise a right of contribution against the joint names insurers. David Steel J, relying on a rateable proportion clause in the public liability policy, held that the public liability insurers had paid half of the loss as volunteers and accordingly there was no right of contribution. The learned judge refused to countenance the possibility that, as only half the payment had been voluntary, contribution ought to exist in respect of the other half. The same suggestion had been rejected in *Legal & General*.

Legal & General v Drake Insurance was, crucially, distinguished by the Court of Appeal in *Drake Insurance Co v Provident Insurance Co*[281] on facts very similar to those in *Legal & General*. Both insurers faced liability in respect of a motor insurance claim. The defendants purported to avoid the policy for non-disclosure and obtained an arbitration award confirming their entitlement to do so. The claimants ultimately agreed to pay the claim and throughout the process sought to involve the defendants although they were ultimately unsuccessful in doing so. The Court of Appeal, having ruled that the arbitration award was not binding on the claimants and that the claimants had established that the avoidance was invalid so that there was double insurance, held that the claimants were able to recover on the basis that they were not volunteers. This was so for two reasons: the arbitration award itself provided an insuperable difficulty to asserting that the defendants were liable to indemnify the assured; and the claimants' protests to the defendants were inconsistent with any suggestion that their payment had been voluntary. It would be easy to assume that, in light of *Drake v Provident*, little can remain of *Legal & General* as it would appear that the paying insurer can overcome the suggestion that it has paid as a volunteer despite the presence of a rateable proportion clause where the paying insurer has sought—unsuccessfully—to persuade the other insurer to honour its own obligations towards the assured prior to the paying insurer's own payment. It is only where the paying insurer makes payment without ascertaining

[280] [2001] Lloyd's Rep IR 321.

[281] [2004] Lloyd's Rep IR 277. The approach taken in this case reflects that in Australia, namely that an insurer who pays more than its rateable share following denial of liability by another insurer is not a volunteer and is entitled to contribution: *GRE Insurance Ltd v QBE Insurance Ltd* [1985] VR 83; *Limit (No.3) Ltd v ACE Insurance Ltd* [2009] NSWSC 514.

whether there is concurrent insurance in place, or without attempting to persuade the concurrent insurer itself to make payment, that the paying insurer can be said to be a volunteer. Although the point did not arise for consideration, the Court of Appeal in *Drake v Provident* was extremely critical of the notion adopted in *Legal & General* that a motor insurer who was obliged to make full payment under s 151 of the Road Traffic Act 1988, despite the existence of a rateable proportion clause in the policy was nevertheless to be regarded as a volunteer by failing to exercise the statutory right of recourse against the assured under s 151(7) of the 1988 Act. As the Court of Appeal pointed out, in the vast majority of cases the statutory right of recourse will as a matter of fact prove to be worthless, and it was difficult to see why the paying insurer should be prevented from recovering a contribution from a concurrent insurer by the existence of a theoretical right of recourse.

The wider view of contribution has also found favour in Singapore, in *SHC Capital Ltd v NTUC Income Insurance Co-operative Ltd*.[282] The claimant was the liability insurer of EIN under a policy which contained a clause excluding the claimant's liability in the event that any other policy covered EIN's liability. EIN was also co-assured under a policy issued by the defendant insurer; there was no equivalent escape clause in the defendant's policy. Following an injury to a workman for which EIN faced liability, the defendant refused the claimant's request to take over the defence of EIN: as a result, the claimant defended the proceedings and indemnified EIN for the workman's claim. The present proceedings were for an indemnity. It is to be noted that no question of contribution could arise on these facts, as the claimant's assertion was that it had faced no liability at all and that the defendant was solely liable. The court noted, however, that the principles applicable to contribution were equally applicable to the present action, and the sole question was whether the claimant had paid as a volunteer. Following *Drake Insurance Plc v Provident Insurance Plc* in preference to *Legal & General Assurance Society v Drake Insurance Co Ltd*, the court noted that "there is much to be said for encouraging insurers to pay out expeditiously, leaving disputes on liability between different insurers to be resolved at a later date, without the paying insurer's right of recourse being removed on the ground that he had acted as a volunteer", and held that a payment was not to be regarded as voluntary if it was paid as a matter of "practical necessity".

The volunteer principle has similarly not found favour in Australia.[283] In *Limit (No 3) Ltd v ACE Insurance Ltd*[284] the primary layer insurer denied liability, and the excess layer insurers, having paid on the basis that they were the only insurers on risk, sought contribution. The Supreme Court of New South Wales ruled that there was no contribution on the facts of the case, because at the date of the loss the excess layer insurers were not liable, in that their liability arose only after the primary layer insurer had refused to pay. There could be contribution only if both insurers were liable at the date of the loss. Also, there was no contribution because the excess layer insurers

[282] [2010] SGHC 224.

[283] *Sydney Turf Club v Crowley* (1972) 126 CLR 420; *GRE Insurance Ltd v QBE Insurance Ltd* [1985] VR 83.

[284] 2009 NSWSC 514. See also *Zurich Australian Insurance v GIO General* [2011] NSWCA 47.

were seeking 100% indemnity and not contribution as such. However, the court found for the excess layer insurers by applying the equitable concept of recoupment based on unjust enrichment, in that if the primary layer insurer was not bound to provide indemnity then it would have made a profit from its own wrongdoing.

11.060 *The subrogation rights of a contributing insurer.* Sometimes both subrogation and contribution are applicable in the same case. Thus, if the owner of premises insures them with two insurers, each of whom pay him in respect of a loss, they will be entitled to contribution between themselves with regard to any subrogation rights against a tenant in respect of repairs. One insurer cannot proceed against the tenant in the assured's name and retain the whole of the proceeds.[285] Contribution, in fact, applies not only to the liabilities, but also to the benefits to which an insurer is entitled, under a policy.

However, it is only the paying insurer who has direct subrogation rights against the wrongdoer responsible for the loss. If that insurer does not exercise those rights, the insurer from whom contribution is sought remains liable for contribution and does not have subrogation rights itself. This was so held by the Supreme Court of Western Australia, in *Speno Rail Maintenance Australia Pty Ltd v Metals & Minerals Insurance Pte Ltd*.[286] In this case Speno, a rail grinding contractor, entered into a contract with Hamersley. Under the agreement Speno was to provide services to Hamersley and to indemnify Hamersley for common law liability for personal injury to any of Speno's employees. Two of Speno's employees were injured by the negligence of Hamersley. Speno was insured against liability under a policy issued by Zurich, the policy also extending to Hamersley as a co-assured. Hamersley was separately insured by MMI. The Zurich policy did not extend to personal injury claims brought against Speno. The two employees made a claim against Hamersley, and recovered. Zurich made payment to Hamersley and ought contribution from MMI. MMI in turn commenced a subrogation action against Speno seeking to exercise Hamersley's right of indemnity against Speno. The Supreme Court ruled that MMI, who were merely contributing insurers, had no right of subrogation, because MMI had not meet the threshold requirement for subrogation, that of providing an indemnity to the person whose rights it sought to enforce. That indemnity had been provided by Zurich and any subrogation rights against Speno belonged to Zurich alone, rights which had under the policy been waived. Although the facts of this case are somewhat convoluted, the principle is straightforward. If A has policies from U1 and U2, and A suffers a loss at the hands of T which is paid for by U1, only U1 has subrogation rights against T. If U1 chooses not to exercise those subrogation rights, or has waived them, and seeks contribution from U2, then on the basis of *Speno* U2 has no subrogation right against T. The case was appealed to the High Court, where the appeal was dismissed on the separate ground that there was no double insurance at all, because Speno was merely a beneficiary under the MMI policy and not a co-assured.

[285] See Lord Wright in *Boag v Standard Marine Insurance* [1937] 2 KB 113, 123.
[286] (2009) 253 ALR 364.

Determining the amount of contribution

11.061 *The methods of calculation.* Insurers who are under co-ordinate liabilities to make good the one loss must share the burden pro rata but the question that immediately arises is what is meant by "pro rata"? The established principle is that all persons liable to satisfy the same debt should contribute towards its payment in a way which is equitable when it has been discharged by one of them – in other words, contribution should be based on reason, justice and fairness – and a court is entitled to take into account all matters which go towards ensuring a just result, including the circumstances giving rise to the claim. That may mean that the court can depart from one of the established modes of calculation in order to achieve a just result.[287] It should be noted that the principles of contribution require a consideration of the number of the insurers involved, and not the number of insurance contracts entered into.[288]

The cases in which the basis for assessment of a rateable proportion has been considered by the courts are few in number. There is of course s 80(1) of the Marine Insurance Act 1906 which provides that, where an assured is over-insured by double insurance, each insurer is bound, as between the assured and the other insurers, to contribute rateably to the loss in proportion to the amount for which he is liable under the contract. However, this takes the matter little further. If it is assumed that there are two policies, each covering precisely the same subject matter to precisely the same maximum limit, or if the policies are unlimited in amount,[289] it is apparent that each insurer will bear one half of the assured's loss, up to the maximum liability figure of each. However, matters become more complex where the maximum sum insured by the two policies is different. Market practice has evolved three distinct rules.

First, the respective proportions to be provided by each insurer may determined by the "maximum liability" rule. Under this principle, the maximum possible liabilities of the insurers are added together, and each insurer pays the proportion of the loss which accords with the proportion which its own maximum liability figure bears to the total maximum liability figure. For example, insurer A has issued a policy under which its maximum liability is to be £50,000, and insurer B has issued a policy under which its maximum liability is £100,000. Losses would be apportioned in the following ways:[290]

Loss	*Insurer A*	*Insurer B*
(1) £25,000	$\frac{50{,}000 \times 25{,}000}{150{,}000} = £8{,}333$	$\frac{100{,}000 \times 25{,}000}{150{,}000} = £16{,}667$
(2) £75,000	$\frac{50{,}000 \times 75{,}000}{150{,}000} = £25{,}000$	$\frac{100{,}000 \times 75{,}000}{150{,}000} = £50{,}000$

[287] *Zurich Australian Insurance Ltd v Metals & Minerals Insurance Pte Ltd* [2007] WASC 62.
[288] *John v Rawlings* (1984) 36 SASR 182; *Mercer v Petroleum Drilling Services (Aust) Pty Ltd* (1985) 39 SASR 277.
[289] *Weddell v Road Transport & General insurance* [1932] 2 KB 563; *Austin v Zurich Insurance* [1945] 1 KB 250.
[290] Cf *Unitarian congregation of Toronto v Western* (1866) 26 UCQB 175.

The second possibility is the "independent liability" test, whereby the liability of each insurer is determined as if it stood alone, and the ratios that those independent liabilities as determined bear to each other fix the proportion of each loss that the insurers have to bear. The examples given above would give rise to the following results under the independent liability principle:

Loss	*Insurer A*	*Insurer B*
(1) £25,000	Liable for £25,000 thus pays:	Liable for £25,000 thus pays:
	$\frac{25{,}000 \times 25{,}000}{50{,}000} = £12{,}500$	$\frac{25{,}000 \times 25{,}000}{50{,}000} = £12{,}500$
(2) £75,000	Liable for £50,000 thus pays:	Liable for £75,000 thus pays:
	$\frac{50{,}000 \times 75{,}000}{125{,}000} = £30{,}000$	$\frac{75{,}000 \times 75{,}000}{125{,}000} = £45{,}000$

The third approach, the "common liability" method, is something of a hybrid. Under this method, the parties are equally liable up to the limits of the lower-valued policy, and if there is any surplus then it is to be borne by the higher-valued policy. Thus, using the above example, if policy A is is capped at £50,000 and policy B is capped at $100,000, a loss of £50,000 would be divided equally between them but a loss of £75,000 would be divided equally up to $50,000 but insurer B would pick up the excess $25,000, making its liability £50,000 as opposed to insurer A's liability of £25,000. The common liability method of assessment has been considered in only one case, *O'Kane v Jones*,[291] a marine decision in which it was rejected because the Marine Insurance Act 1906, s 80, contemplated only an apportionment of some kind.

The merits of these various methods of calculation are not always obvious. A number of variables may exist. The two insurances may be:[292] similar in form but with different policy limits; different in form, with each covering the actual loss in question in full; or different in form with all of the loss covered by one policy and only part of it being covered by the other.

11.062 *Property insurance.* As far as fire policies are concerned, the advantage of maximum liability is that the limits of liability under each policy are based upon the value of the insured subject matter and accordingly each insurer's responsibility for damage to it. In Australia, however, the Full Court of Victoria in *GRE Insurance Ltd v QBE*

[291] [2005] Lloyd's Rep IR 174.
[292] Many other variations may be devised.

Insurance Ltd[293] adopted the independent liability measure.[294] Insurer A insured premises against loss of or damage by fire to a maximum amount of $700,000 while insurer B insured the same premises in respect of the same risk to a maximum figure of $1,500,000. Damage to the extent of $800,000 occurred. McGarvie J held that the court was entitled, on looking at the relevant considerations, "to apportion the loss in a way that does justice amongst those liable to meet it". The basic justification which underlay the principle of contribution was equality – that one should not bear the burden in ease of the rest – and the relief given by way of contribution to the paying insurer was given because otherwise that insurer would alone be bearing the cost of easing the burdens of the other insurers. The court concluced that the amount which had been paid should be borne in proportion to the burden of liability which that payment lifted from the respective insurers, that is, that the "independent liability" method of determining contribution should be adopted. McGarvie J added that in some cases there might be other considerations which could lead a court to allocate the burden in some other way, while there could be a difference in approach between a court with the responsibility of fairly allocating the burden in the one specific case before it and methods used in the insurance industry, perhaps as the result of long-established practice or as a result of arrangements made to regulate the industry or part of it.[295]

The approach to be adopted as between marine policies was considered by in England by Deputy High Court Judge Richard Siberry QC in *O'Kane v Jones*.[296] The policies in this case were both on the hull and machinery of a vessel: the first policy was in the sum of US$2.5 million and the second policy was in the sum of US$5 million. A total loss occurred. The application of both the independent liability method and the maximum liability method produced the same outcome, that of a 1:2 ratio between the policies, and the court was thus not required to choose between them and indeed did not do so.[297] The alternative possibility of common liability was mooted by the insurers of first policy. The suggestion was that each of the insurers should be liable equally up to the amount for which they were independently liable. Thus the first US$2.5 million would be divided equally between the insurers, and the surplus would be borne by the second insurer, giving a ratio of 1:3.[298] The court's view in *O'Kane* was that wording of s 86(1) of the Marine Insurance Act 1909 required a rateable apportionment of liability and that while that wording was apt to encompass both the maximum and independent

[293] [1985] VR 83 FC.
[294] In *North British and Maritime Insurance v London, Liverpool and Globe Insurance Co* (1877) 5 QBD 569 the insurers agreed that the independent liability principle was to be applied in a dispute between two property insurers, although the Court of Appeal made no comment upon this assumption. The case cannot, therefore, be taken as authority for the proposition that the independent liability principle is to be applied as a matter of law.
[295] [1985] VR 83 FC at 103-104. Cf *Placer v Dyno* [2000] NSWSC 142. See also *Drayton v Martin* (1996) 67 FCR 1 at 38, a case of liability insurance, The matter was not considered on appeal—see *HRH Casualty v General Insurance Ltd v FAI General Insurance Co Ltd* (1997) 9 ANZ Ins Cas 61-358. For comment on the appropriateness of this measure to property insurance, see [1977] Camb LJ 231 and also ALRC, *Report No 20* "Insurance Contracts" (1982), pp 180–181, paras 293–294.
[296] [2005] Lloyd's Rep IR 174.
[297] In *Tai Ping Insurance Co v Tugu Insurance Co Ltd* [2001] HKEC 506, the independent liability method was adopted in Hong Kong for marine insurance.
[298] Tbat had been the preferred approach of Lawton LJ in [1977] QB 804.

liability approaches, it could not apply to common liability as that method did not operate by apportionment.

11.063 *Liability insurance.* The position of liability insurance where the two policies are of the same type was discussed by the Court of Appeal in *Commercial Union Assurance Co Ltd v Hayden*.[299] The policies in each case specified a maximum liability in relation to any one occurrence, being £100,000 and £10,000 respectively. A claim in respect of a loss covered by both policies was, by agreement between the insurers, settled by the assured for £4,425, leaving the question of apportionment still to be decided. The claimant asserted that the proper basis for contribution was "independent" On this basis, any claim up to £10,000 would be borne equally, but for larger claims the ratio would be 4:1. The defendant argued for the "maximum liability" test, so that his liability was limited to 10/110 of the claim. Cairns LJ regarded the matter as primarily one of construction of the policies concerned but found the language used in the relevant clauses of no help in deciding the issue, since it was equally capable of either suggested interpretation. He found no English authority which was directly in point, while he regarded the authorities on apportionment between insurers decided in England, Scotland, Canada and the United States which had been cited to the court, as of limited assistance. His Lordship pointed out that the views of certain text writers favoured the independent actual liability approach, while their discussion of authorities showed that in property insurance the usual basis of contribution was the maximum liability test except where the policies contained pro rata average clauses, in which case the measure of contribution was based on the independent liability test. He noted that there appeared to be no settled basis for contribution under liability insurance. After examining authority, Cairns LJ said that he was not persuaded that the same basis of apportionment should apply to liability insurance as to property insurance, nor that any reliable guide could be provided by an analogy with contribution between co-sureties. He pointed out that in property insurance the insurer insured the property for a stated sum, which was normally supposed to represent the value of the property, but that in liability insurance there was no corresponding "value" to which the limit of the insurer's liability was related. Further, premiums for the two types of insurance were quite differently assessed, being based on the sum insured in the case of property insurance, while questions of general policy, underwriting experience, and the view of the risk, loomed largely in establishing the rate in liability insurance. The bulk of claims in liability insurance fell within a low limit and premiums were fixed on the assumption that the risk of a claim anywhere near the maximum was extremely small.[300]

In the result, Cairns LJ held that, in the absence of authority. The policies should be given the meaning more likely to be intended by reasonable businesspeople. When the policy was issued by each insurer, it was not to be supposed that each insurer knew that there was or was going to be another policy covering the same risk. Accordingly, each limit of liability must be taken to be fixed without knowledge of the limit under

[299] [1977] QB 804.
[300] [1977] QB 804 at 814-815.

any other policy, and using those limits as the basis for contribution was arbitrary. Cairns LJ felt that the independent actual liability basis was much more realistic in its results. The obvious purpose of a limit of liability was to protect the insurer from the effect of an exceptionally large claim, and it seemed artificial to use the limits under two policies to adjust liability in respect of claims which were within the limits of either policy.

Stephenson and Lawton LJJ gave judgments similar in effect. Lawton LJ pointed out that the principle underlying the law of contribution was that burdens should be shared and that the burden under an indemnity liability policy was the claim that was made, not the claim that could be made. To ascertain the proportions of contribution by reference to the limits of indemnity would be an odd way of sharing the burden in equity between insurers; and would be an almost impossible task where there was a limit under one policy but not under another.[301]

The decision of the English Court of Appeal is authority for the view that, in the field of liability insurance, where there is double insurance with two co-insurers having differing upper limits for claims, the inference is that they are accepting the same level of risk up to the lower of these limits and that there is an equal division of liability up to that lower limit. That approach was also followed by the Supreme Court of Western Australia in *Zurich Australian Insurance Ltd v Metals & Minerals Insurance Pte Ltd*,[302] although the ruling that there was double insurance was reversed on appeal and so the matter was not tested before a higher court. The same approach may also apply where one insurer specifies a limit and the other does not, for it is a practical impossibility to assess the maximum cover in the latter case, and hence the maximum potential liability test is inoperable. Reliance must be placed therefore on actual liability as opposed to potential limits of liability. The advantage of the independent liability approach in disregarding maximum liability figures in liability policies is that such figures may be arbitrary bear no relation to the maximum amount for which the insurer is likely to be called upon to provide indemnity. Again, there may be different approaches to aggregation in the two policies. It is the case that the function of a maximum liability figure is not to serve as a basis for the apportioning of losses should double insurance happen to exist, but rather to limit the insurer's liability in respect of any one claim as defined in the policy.

11.064 *Non-concurrent policies.* Where the two policies cover different losses but happen to have a single loss in common, the potential maximum liability of the insurers might be thought to have little relevance to the amounts that each ought to bear for the common loss. That approach was adopted in England in *American Surety Co of New York v Wrightson*.[303] Here, the New York company had agreed to indemnify the assured bank for losses caused to it by the dishonesty of its employees, up to a maximum figure of $2,500 for each employee, and Lloyd's underwriters had issued a more general

[301] [1977] QB 804 at 822.
[302] [2007] WASC 6.
[303] (1910) 103 LT 663.

The Insurance Authority may exercise powers under ss 27 to 32, 34(1) or 35(1) even where none of the grounds specified in ss 26(1), (2) and (3) exist, if that power is exercised before the expiration of five years ("the relevant period") beginning on the latest date on which the insurer was authorised to carry on any class of insurance business or the date on which the person became a controller[198]. However these requirements shall not continue after the expiration of the period of 10 years from the beginning of the relevant period.

12.066 *Recession, variation and publication of requirements.* The Insurance Authority may rescind a requirement imposed in the exercise of any power of intervention[199] if it is no longer necessary, and may from time to time vary such a requirement.[200] No requirements imposed under s 26(4) can be varied after the expiration of the "relevant period" mentioned in the subsection, unless there is a relaxation of such requirement.[201] A rescission under s 38(1) of a requirement imposed under a restriction on a new business[202] may be limited so as to apply only to contracts of a specified description.[203] The Insurance Authority must publish a notice of the imposition, and of the rescission or variation of any such requirement, in the Gazette and in such other ways as may be expedient to notify the public.[204]

12.067 *Civil proceedings on behalf of insurers.* The Financial Secretary is empowered to bring civil proceedings in the name of an insurer. Such proceedings may be brought against third parties or against directors or officers of the insurer itself, so that the action is akin to a derivative action. The proceeds of a successful action are to be held for the company, and if the proceeds relate to a loss from the long-term fund then they must be allocated to that fund.[205]

12.068 **Failure to maintain solvency margin.** As seen above, an insurer has to maintain an excess of the value of its assets over the amount of its liabilities of such amount which is required or prescribed under s 59(1)(aa). The amount of the required solvency margin is set out in the Insurance Companies (Margin of Solvency) Regulation (Cap 41F). If the insurer fails to maintain the requisite solvency margin, the Insurance Authority may require him to submit a plan for the restoration of a sound financial position,[206] or if a plan has been submitted, to propose modification,[207] or give effect to any such plan accepted by him as adequate.[208] If an excess of the value of its assets

[198] Insurance Companies Ordinance, s 26(4)(a) and (b). A controller of an insurer in relation to a company ("the applicant") means: (i) a person whose directions or instructions the directors of the applicant or of a body corporate of which it is a subsidiary, are accustomed to act; or (ii) who alone with any associate or nominee, is entitled to exercise or control 15 per cent or more of the voting power at any general meeting of the applicant or body corporate which it is a subsidiary: Insurance Companies Ordinance, s 9(1)(c).

[199] Pursuant to ss 27 to 35A of the Insurance Companies Ordinance.

[200] Insurance Companies Ordinance, s 38.

[201] Insurance Companies Ordinance, s 38(2).

[202] Insurance Companies Ordinance, s 27.

[203] Insurance Companies Ordinance, s 38(3).

[204] Insurance Companies Ordinance, s 38(4).

[205] Insurance Companies Ordinance, s 39, applying s 147 of the Companies Ordinance.

[206] Insurance Companies Ordinance, s 35AA(1)(a).

[207] Insurance Companies Ordinance, s 35AA(1)(b).

[208] Insurance Companies Ordinance, s 35AA(1)(c).

over the amount of its liabilities maintained by an insurer falls below the amount[209] prescribed or determined under s 59(1)(aa), then the Insurance Authority may submit a short-term financial scheme,[210] where such a scheme has been submitted, propose modification to the scheme,[211] and give effect to the scheme accepted by him as adequate.[212]

When determining the value of the assets and amount of the liabilities of an insurer[213], the insurance authority may take into account unpaid share capital, future profits and hidden reserves of the insurer.[214]

Offences. An offence is committed by any person[215] who:[216] **12.069**

(1) defaults in complying with any of the requirements imposed under ss 27 to 34, 35(1) or 35AA of the Insurance Companies Ordinance;[217]

(2) in purported compliance with the requirements to furnishes information that he knows to be false in a material particular or recklessly furnishes information which is false in a material particular;[218]

(3) acts or continues to act as a chief executive, director or controller of an insurer where the appointment is deemed revoked;[219]

(4) fails without reasonable excuse to comply with any of the requirement of an insurer's Manager to submit information;[220] or

(5) wilfully obstructs, resists or delays an insurer's Manager in the lawful performance of his function or exercise of his powers,[221] or any other person lawfully assisting the Manager in such performance of such functions or exercise of such powers.[222]

An offence is also committed by any person who, by any statement, promise or representation which he knows to be false, misleading or deceptive, or by any dishonest concealment of material facts, or by the reckless making (dishonest or otherwise) of any statement, promise or representation which is false, misleading or

[209] The prescribed amount can be found in s 10(2) of the Insurance Companies Ordinance.

[210] Insurance Companies Ordinance, s 35AA(2)(a).

[211] Insurance Companies Ordinance, s 35AA(2)(b).

[212] Insurance Companies Ordinance, s 35AA(2)(c).

[213] Under s 35AA(1) to (2) of the Insurance Companies Ordinance.

[214] Insurance Companies Ordinance, s 35AA(3).

[215] If the offence is committed by a company, there is a similar criminal sanction against any controller, director or member who has by his consent, connivance or neglect caused the offence to be committed: Insurance Companies Ordinance, s 57.

[216] Insurance Companies Ordinance, s 41(1)(i) and (ii).

[217] Insurance Companies Ordinance, s 41(1)(a).

[218] Insurance Companies Ordinance, s 41(1)(b).

[219] Insurance Companies Ordinance, s 41(1)(c).

[220] Insurance Companies Ordinance, s 41(1)(d).

[221] Insurance Companies Ordinance, s 41(1)(e)(i).

[222] Insurance Companies Ordinance, s 41(1)(e)(ii).

deceptive, induces or attempts to induce another person to enter into or offer to enter into any contract of insurance commits an offence.[223]

A further offence is committed by any person who causes or permits to be included in any notice sent, or any document deposited, under the Ordinance, a statement which he knows to be false in a material particular or recklessly causes or permits to be so included a statement which is false in a material particular.[224]

There is a two-year limitation period, running from the date of discovery, or six years from the date of commission (whichever is earlier) for the institution of criminal proceedings under the Ordinance.[225]

12.070 **Duties and liabilities of institutions.** No liability shall be incurred by the Government or any public officer, Advisor or Manager as a result of anything done or omitted to be done by any public officer, Advisor or Manager *bona fide* in the performance or purported performance of the functions, or the exercise or purported exercise of the powers, imposed or conferred by or under the Insurance Companies Ordinance.[226] Those persons are nevertheless under a duty of confidentiality with regard to information obtained in the course of their duties, punishable as a criminal offence.[227] Information may, however, be disclosed for specified statutory regulatory purposes.[228]

12.071 *Secrecy, Disclosure and Examination by outside authorities*. Except in the exercise of any function under the Insurance Companies Ordinance or for carrying into effect of the provisions under the Insurance Companies Ordinance, every person to whom this subsection applies shall:[229] (1) preserve and aid in preserving secrecy with regard to all matters relating to the affairs of any insurer that may come to his knowledge in the exercise of any function under this Ordinance;[230] (2) not communicate any such matter to any person other than the person to whom such matter relates;[231] and (2) not suffer or permit any person to have access to any records in his possession, custody or control or in the possession, custody or control of any other person so appointed or employed[232].

An Insurance Authority may disclose information to an authority in a place outside of Hong Kong where (1) that authority exercises functions in that place corresponding to the functions of: (a) the Insurance Authority; or (b) an authorised statutory office within the meaning of s 53A(3B);[233] and (2) in the opinion of the Insurance

223 Insurance Companies Ordinance, s 56(1).
224 Insurance Companies Ordinance, s 56(2).
225 Insurance Companies Ordinance, s 58.
226 Insurance Companies Ordinance, s 55A.
227 Insurance Companies Ordinance, s 53A.
228 Insurance Companies Ordinance, s 53B to E.
229 Insurance Companies Ordinance, s 53A(1).
230 Insurance Companies Ordinance, s 53A(1)(a).
231 Insurance Companies Ordinance, s 53A(1)(b).
232 Insurance Companies Ordinance, s 53A(1)(c).
233 Insurance Companies Ordinance, s 53B(1)(a)(i) and (ii).

Authority: (a) that authority is subject to adequate secrecy provisions in that place; and (b) it is desirable or expedient that the information should be so disclosed in the interests of existing or potential policyholders or the public interest; or (c) such disclosure will enable or assist the recipient of the information to exercise his functions and it is not contrary to the interests of existing or potential policyholders or the public interest that the information should be so disclosed.[234]

Any office or agency of an insurer, carrying on any class of insurance business in or from Hong Kong, shall permit the insurance supervisory authority of a place outside Hong Kong to examine its books, accounts and transactions on Hong Kong.[235]

12.072 *Communication by prescribed person with the Insurance Authority*. No duty which a prescribed person[236] may be subject to shall be regarded as contravened by reason of his communicating in good faith to the Insurance Authority, whether or not in response to a request made by an Insurance Authority, any information or opinion on a matter:[237] (a) of which he becomes aware in his capacity as a prescribed person; [238] and (b) which is relevant to any function of the Insurance Authority under the Insurance Companies Ordinance.[239]

Where a prescribed person becomes aware of any matter which in his opinion adversely affects the financial condition of the insurer to a material extent, he must as soon as practicable send to the Insurance Authority a report in writing of the matter.[240]

Where a prescribed person[241] become aware of any situation[242] which in his opinion: (a) creates a material risk that a fund maintained by the insurer in respect of its longterm business may be insufficient to meet the liabilities attributable to that fund;[243] or (b) has resulted or may result in the insurer failing to satisfy an obligation in respect of its long-term business to which it is or was subject to under the Insurance Companies Ordinance.[244]

Where a prescribed person, during the performance of his duties in that capacity in respect of the insurer concerned, becomes aware of evidence: (a) of a failure by the

234 Insurance Companies Ordinance, s 53B(1)(b)(i), (ii) and (iii).
235 Insurance Companies Ordinance s 53C(1) and (2). This section applies to Lloyd's.
236 "Prescribed person" means: (1) an auditor, former auditor, actuary or former actuary of an insurer or a former insurer and appointed under s 15 or Sch 3, Pt 1, para 4(1A); or (2) an accountant, former accountant, actuary or former actuary of an insurer or a former insurer and appointed by the insurer or former insurer, as the case may be, in compliance with a requirement under s 35(1); or (3) an auditor or former auditor of an insurance broker or a former insurance broker appointed under s 72: see s 2(1) of the Insurance Companies Ordinance.
237 A matter may be a matter which relates to a person other than an insurer or a former insurer: Insurance Companies Ordinance, s 53D(2).
238 Insurance Companies Ordinance, s 53D(a).
239 Insurance Companies Ordinance, s 53D(b).
240 Insurance Companies Ordinance, s 53E(1).
241 Other than an auditor, former auditor, accountant or former accountant.
242 Including, in the case of a former actuary referred to in the definition of "prescribed person", a situation of which he became aware when he was an actuary referred to in that definition.
243 Insurance Companies Ordinance, s 53E(2)(a).
244 Insurance Companies Ordinance, s 53E(2)(b).

insurer to comply with any conditions;[245] (b) that there exists a ground on which the Insurance Authority would be prohibited from authorising the insurer if the insurer were to make application in that behalf;[246] (c) of a failure by the insurer to comply with certain provisions;[247] or (d) of any default of the insurer in complying with certain requirements,[248] the prescribed person shall as soon as practicable send to the Insurance Authority a report in writing of the failure, ground and default.

12.073 *Service of Notice*. Any notice or other document to be given to or served on any other person under the Insurance Companies Ordinance may be served by post, and without prejudice to s 8 of the Interpretation and General Clauses Ordinance (Cap 1), a letter containing that notice or other document shall be deemed to be properly addressed if it is addressed to that person at his last known residence or business address.[249]

12.074 *Notification of cessation of place of business in Hong Kong.* If an insurer incorporated or formed outside Hong Kong shall cease to have a place of business in Hong Kong, the insurer shall give not less than three months prior written notice or shorter period permitted by the Insurance Authority, to the Insurance Authority of such cessation.[250] Failure to comply is an offence and any insurer is liable to a fine of HK$200,000 and, in the case of an individual, to imprisonment for two years, together with a fine of HK$2,000 for each day on which the failure to give the notice continues after the expiry of the period prescribed or such shorter period as may be permitted, as the case may be.[251]

5. Winding-up of Insurance Companies

12.075 **Grounds for winding-up.** Any company may be wound-up by the Court of First Instance[252] under the general provisions of the Companies Ordinance on any one of eight grounds. These grounds extend to insurance companies:[253]

(1) The company has by special resolution resolved that the company be wound-up by the court;[254]

(2) The company does not commence its business within a year from its incorporation, or suspends its business for a whole year;[255]

(3) The company has no members;[256]

[245] Under s 8(1)(a) of the Insurance Companies Ordinance, s 53E(a).
[246] Prohibited by s 8(3)(a), (b), (d) or (f): Insurance Companies Ordinance, s 53E(b).
[247] Sections 22, 22A or 23 of the Insurance Companies Ordinance: see s 53E(c).
[248] Sections 27, 28, 29, 30, 31, 32, 33, 34 or 35(1) of the Insurance Companies Ordinance: see s 53E(d).
[249] Insurance Companies Ordinance, s 55(a), (b) and (c).
[250] Insurance Companies Ordinance, s 55B(1).
[251] Insurance Companies Ordinance, s 55B(2).
[252] Henceforth, "the Court".
[253] Insurance Companies Ordinance, s 43.
[254] Companies Ordinance (Cap 32), s 177(1)(a).
[255] Companies Ordinance, s 177(1)(b).
[256] Companies Ordinance, s 177(1)(c).

(4) The company is unable to pay its debts.[257] In the case of an insurance company this includes the failure of the company to maintain its solvency margin;[258]

(5) The event, if any, occurs on the occurrence of which the memorandum or articles provide that the company is to be dissolved;[259]

(6) The court is of the opinion that it is just and equitable that the company should be wound-up.[260]

(7) On a petition by the Official Receiver or by any other person authorised to present a winding-up petition,[261] the court is satisfied that an existing voluntary winding up cannot be continued with due regard to the interests of the creditors or contributories;[262] or

(8) It appears to the Financial Secretary from any inspectors' report[263] or from any books and papers obtained under certain provisions of the Companies Ordinance[264] that it is expedient in the public interest that the company should be wound up, and the court thinks it is just and equitable for it to be wound up.[265]

In addition, the court may order a winding-up on the petition of 10 or more policyholders. However, such a petition has to be presented with leave of the court and will only be granted if a *prima facie* case has been established and security for costs for such amount as the court may think reasonable has been given.[266]

12.076 **Prohibition on voluntary winding-up of insurer.** An insurer shall not be wound-up voluntarily unless the Court of First Instance[267] otherwise orders, and no order can be made until notice has been served on the Insurance Authority who is entitled to be heard on the application and to call, examine and cross-examine any witnesses and, if he thinks fit, support or oppose the making of the order.[268]

Petitioner

12.077 *Winding-up on petition of Insurance Authority.* The Insurance Authority may present a petition for the winding-up[269] of an insurer, which is a company, in the following cases:

[257] Companies Ordinance, s 177(1)(d).
[258] Insurance Companies Ordinance, s 42.
[259] Companies Ordinance, s 177(1)(e).
[260] Companies Ordinance, s 177(1)(f).
[261] Companies Ordinance, s 179(1).
[262] Companies Ordinance, s 179(2).
[263] Companies Ordinance, s 146.
[264] Companies Ordinance, s 152A to B.
[265] Companies Ordinance, s 147(2)(a).
[266] Insurance Companies Ordinance s 43.
[267] Henceforth, "the Court": see the Insurance Companies Ordinance, s 43.
[268] Insurance Companies Ordinance s 45(1).
[269] In accordance with the Companies Ordinance.

(1) The company is unable to pay its debts. This includes a failure to maintain its margin of solvency.[270] In any proceedings on a petition to wind-up an insurer presented by the Insurance Authority, evidence that the company was insolvent either: (a) at the close of the period to which the accounts and balance sheet of the company last deposited in compliance with s 20 of the Insurance Companies Ordinance relate;[271] or (b) at any date or time specified in a requirement imposed in the exercise of regulatory powers under ss 32 or 34,[272] shall be evidence that the company continues to be unable to pay its debts, unless the contrary can be proved;

(2) The company has failed to satisfy an obligation to which it is or was subject by virtue of the Companies Insurance Ordinance or Ordinance repealed by it;[273]

(3) The company has failed to comply with the obligation[274] to keep or preserve proper books of accounts or produce books kept in satisfaction of that obligation;[275] or

(4) If the Insurance Authority thinks that it is expedient in the public interest that a company should be wound up, he may, unless the company is already being wound up, present a petition for it to be so wound up if the Court thinks just and equitable for it to be so wound-up.[276]

12.078 *Other petitioners.* Where a petition for winding-up of an insurer is presented by a person other than the Insurance Authority, a copy of the petition shall be served on him and he shall be entitled to be heard on the petition and to call, examine and crossexamine any witness and, if he so thinks fit, support or oppose the making of a winding-up order.[277]

12.079 **Winding-up of insurers involved in transfer of business.** Where an insurance business or part of the insurance business of an insurer has been transferred to an insurer under an arrangement in pursuance of which the transferor or its creditors has or have claims against the transferee insurer, then, if the transferee company is being wound-up by the court, the court must order the transferor company to be wound up in conjunction with the transferee company, and may by the same or any subsequent order appoint the same person to be liquidator for the two companies, and make provision for such other matters as may seem to the court necessary, with a view to the companies being wound-up as if they were one company.[278] The commencement of winding up of the transferee company is, unless otherwise ordered by the court, the commencement of the winding up of the transferor company.[279]

[270] Insurance Companies Ordinance, ss 42 and 44(1)(a).
[271] Insurance Companies Ordinance, s 44(2)(a).
[272] Insurance Companies Ordinance, s 44(2)(b).
[273] Insurance Companies Ordinance, s 44(1)(b).
[274] Under s 16 of the Insurance Companies Ordinance.
[275] Insurance Companies Ordinance, s 44(1)(c).
[276] Insurance Companies Ordinance, s 44(3).
[277] Insurance Companies Ordinance, s 44(4).
[278] Insurance Companies Ordinance, s 47(1).
[279] Insurance Companies Ordinance, s 47(2).

When the court is adjusting the rights and liabilities of the members of the several companies between themselves, the court is to have regard to the constitution of the companies, and to the arrangements entered into between the companies, in the same way as the court has regard to the rights and liabilities of different classes of contributories in the case of the winding-up of a single company, or as near to as circumstances admit.[280]

An application may be made in relation to the a winding-up of any transferor company in conjunction with a transferee company by any creditor of or person interested in, the transferee or transferor company.[281] Where an insurer stands in the relation of a transferee company to one company, and in relation of a transferor company to some other company, or where there are several companies standing in the relation of transferor companies to one transferee company, the court may deal with any number of such companies together or in separate groups, as it thinks most expedient by applying principles from this section.[282]

Winding-up of insurers involved in long-term business

Application of funds. Where there is a winding-up of an insurer engaged in long-term business, then under the Insurance Companies Ordinance s 45(2)(a), the assets representing the fund maintained by that insurer in respect of its long-term business are to be available only for meeting the liabilities of the insurer attributable to that part of the business to which the fund relates; and under the Insurance Companies Ordinance, s 45(2)(b), the other assets of the insurer shall be available only for meeting the liabilities of the insurer attributable to its other business. Where the value of the assets exceeds the amount of the liabilities mentioned, the restrictions imposed are not to apply to so much of those assets as represents the excess.[283] However, this has to be read subject to s 47(4A) which states that: **12.080**

(1) if in respect of any other fund maintained by the insurer in respect of its long-term business the amount the value of the assets mentioned in s 45(2)(a) exceeds the amount of the long-term liabilities mentioned therein, then the excess must be available for meeting:

(a) if there is only one such other fund, the liabilities of that fund to the extent to which they exceed the assets of that other fund;[284]

(b) if there are two or more such other funds, the respective liabilities of those other funds prorate to the extent to which they exceed the respective assets of those other funds; and

(2) if s 45(2)(a) is not applicable, or part of the excess remains after the operation of that paragraph, the liabilities of the insurer attributable to its other business.

[280] Insurance Companies Ordinance, s 47(3).
[281] Insurance Companies Ordinance, s 47(5).
[282] Insurance Companies Ordinance, s 47(6).
[283] This has to read subject to s 45(4A) of the Insurance Companies Ordinance.
[284] Insurance Companies Ordinance, s 45(4A)(a)(i).

15.017 **The obligation to indemnify.** In the absence of any contrary provision,[115] the reinsured must satisfy two conditions before the reinsurers' become liable to provide an indemnity: the reinsured must establish that as a matter of law it faced liability to the assured; and the reinsured must show that the reinsurers were liable under the terms of the reinsurance agreement.[116] The second condition is a matter of construction, although in the case of a facultative agreement it is likely that the insuring and reinsuring provisions are to the same effect. The first condition may be satisfied in one of three ways: the reinsured may have been sued to judgment; the reinsured may have been subject to an adverse arbitration award; or the reinsured may have entered into a binding settlement with the assured.

A judgment, whether of an English court or of a foreign court, is to be given recognition in English law as a conclusive disposition of the issues which it decides. In principle such a judgment is binding only between the parties, ie, the assured and the reinsured. It was said in *Commercial Union Assurance Co v NRG Victory Reinsurance Ltd*[117] that a judgment was nevertheless binding on the reinsurers, and conclusively established the liability of the reinsured, so that if the reinsured has been sued to judgment by the assured, the reinsured's loss is established as a matter of law. The Court of Appeal recognised that there may be exceptional circumstances in which a foreign judgment may not be binding, eg, where the court was not of competent jurisdiction or had not acted in contravention of an exclusive jurisdiction or arbitration clause, where there was a manifest error of law, where the judgment was perverse or where the reinsured had failed to defend itself properly, but these remote possibilities aside a judgment is conclusive. However, in *Wasa International Insurance Co v Lexington Insurance Co*[118] Lord Mance expressed the view that the Court of Appeal's analysis in *Commercial Union* was *obiter* and that a foreign judgment was not necessarily binding in the absence of a follow the settlements clause (see below).

Arbitral awards give rise to the same issues. Although an arbitration award is only binding as between the parties to the arbitration, and indeed is confidential to them, it has been held that reinsurers are under an implied obligation to indemnify the reinsured in the event of an arbitration award in favour of the assured,[119] although in the light of Lord Mance's comments in *Wasa* this may be true only where the reinsurers have agreed to follow the reinsured's settlements.

A settlement between the assured and the reinsured is not, however, automatically binding on the reinsurers. A settlement is merely the first stage in establishing the reinsurers' liability, and the reinsured must go on to establish that, had it been sued to judgment by the assured, there would have been a finding of liability under the law applicable to the insurance contract[120] of at least the amount provided for in the settlement. It is not enough for the reinsured to prove that the settlement was a reasonable

[115] *Ie*, a follow the settlements or follow the fortunes clause: see *infra*.
[116] *Hill v Mercantile and General* [1996] LRLR 341.
[117] [1998] Lloyd's Rep IR 439.
[118] [2009] UKHL 40.
[119] *Sun Life Assurance Co of Canada v Lincoln National Life Insurance Co* [2005] 1 Lloyd's Rep 606.
[120] *Enterprise Oil Ltd v Strand Insurance Co Ltd* [2007] Lloyd's Rep IR 186.

one or that it was made in the face of foreign legal proceedings and removed the risk of punitive damages being awarded against the reinsured. The position is illustrated by *Commercial Union Assurance Co v NRG Victory Reinsurance Ltd*.[121] The reinsured was the insurer of the Exxon Valdez, which ran aground in 1989. The assured incurred substantial losses, including clean-up costs, and sought to recover those costs from the reinsured under a policy which covered first and third party liability for losses caused by the cleaning up of "debris". Proceedings were commenced against the reinsured in Texas, which the reinsured settled on favourable terms when faced with legal advice that the Texas jury would be likely to find in favour of the assured. The Court of Appeal rejected the reinsured's claim for summary judgment against the reinsurers, and held that the reinsured had not proved its loss simply by relying on the advice of local lawyers: it was necessary for the reinsured to go further and to demonstrate that there was legal liability as a matter of law. In subsequent proceedings the reinsured sought a declaration that it had faced liability to the assured, but failed on the ground that under New York law – the law governing the insurance contract – the word "debris" did not include an oil spill, so that there had never been any liability under the policy.[122]

Proof of loss under treaties

15.018 In the case of a treaty, and particulary an excess of loss treaty where the reinsured cannot recover unless aggregate losses reach the given trigger figure, it is impractical to prove that every claim made against the reinsured. In that situation it has been held that loss under a settlement may be proved by appropriate evidence. In *Equitas Ltd v R&Q Reinsurance Company (UK) Ltd*[123] a case involving an excess of loss reinsurance treaty, losses had been presented and paid in the LMX Spiral (a system involving successive layers of excess of loss reinsurance) on two major claims: the *Exxon Valdez* grounding as discussed in *Commercial Union v NRG Victory*, and the loss of aircraft following the invasion of Kuwait, as discussed in *Scott v Copenhagen Re Co (UK) Ltd*.[124] In each situation, losses had been paid before the courts had reached the conclusions that the pollution damage (in *Commercial Union)* was not covered (affecting about 6% of the claims) and that the aircraft losses (in *Scott*) had been wrongly aggregated so that additional deductibles should have been borne (affecting about 12.5% of the total claim). There was no obligation on the reinsurers to follow the reinsured's settlements, so that proof of actual loss was required. The dispute between the parties was what had to be proved. Gross J held that the mere fact that wrongly-paid claims had entered the LMX spiral was not of itself enough to preclude any recovery from the reinsurers. Gross J drew a distinction between; the requirement for the reinsured to prove *as a matter of law* that there were losses falling within both the insurance and the reinsurance, which was clearly the case on the facts; and the requirement for the reinsured to establish the amount of correctly paid losses *as a matter of fact*, in order to show that excess attachment points had been reached. In the words of Gross J; "Although it is a requirement of law that Equitas must satisfy Lord Mustill's first rule or fail, it is not a requirement of law that Equitas can only do so by proving a loss at each underlying level

[121] [1998] Lloyd's Rep IR 421.
[122] *King v Brandywine Reinsurance Co (UK) Ltd* [2005] Lloyd's Rep IR 509.
[123] [2009] EWHC 2787 (Comm).
[124] [2003] Lloyd's Rep IR 696.

of the LMX spiral. The question of how Equitas attempts to do so is, instead, one of fact or evidence." Given that there were reinsured losses, Gross J held that the reinsured had on the balance of probabilities proved its loss by relying upon an actuarial model which, although incapable of replicating the LMX Spiral exactly, was sufficiently close to the operation of the LMX Spiral to satisfy the reinsured's burden of proof.

This approach was followed in *IRB Brasil Resseguros SA v CX Reinsurance Company Ltd*[125] which involved a claim under 25 excess of loss treaties in force between 1976 to 1983 each of which required the reinsured to prove its loss as a matter of law. Class actions were brought against a number of assureds in respect of silicon breast implants, contaminated blood products, asbestos and chemical products, and these claims were settled by the reinsured in a series of global settlements. The claims presented to the excess of loss reinsurers totalled US$489,958.73 million. In such cases it is inevitable that the settlements can at best be an approximation: included in any class action will be invalid claims, overvalued claims and undervalued claims, so the question posed by *IRB Brasil* was whether excess of loss reinsurers were bound by a global settlement or whether it was incumbent on the reinsured to prove is loss in respect of each of the individual claims comprised in the class action. The arbitrators hearing the claim accepted that the settlement had been reached on the basis that it inevitably encompassed some invalid claims, but that the approach was commercially advantageous and the question was whether the reinsurers had reasonable grounds for contesting the basis of the reinsured's payment. Despite some loose language in the award, Burton J was satisfied that the arbitrators had not proceeded by asking whether the settlements were reasonable, but rather they had asked whether the reinsured had discharged its burden of proof on the balance of probabilities. The logic of *IRB Brasil* is undoubted, in that it is plainly impossible for a reinsured under a treaty to prove the validity of every individual claim comprised in a settled class action. The legal solution adopted by Burton J, following the reasoning of Gross J in *Equitas*, is that the question is not legal liability but rather the burden of proof that the loss was covered by the direct policy, and that a global settlement reached on reasonable investigation satisfies the burden of proof. The outcome is undoubtedly correct, in that any other conclusion would render recovery under an excess of loss contract all but impossible. It might be added, however, that in both *Equitas* and *IRB* the claims were under excess of loss treaties and not facultative contracts: in the case of a facultative contract proof of the reinsured's liability can be established in a single set of proceedings, so that other evidence is not relevant.

'Follow the settlements'

15.019 *Meaning of "follow the settlements".* The difficult position in which a reinsured may find itself in establishing liability at law to the assured after[126] a settlement[127]

[125] [2010] EWHC 974 (Comm).

[126] The reinsured and the reinsurers may agree on a liability figure under the reinsurance agreement in advance of any settlement between the reinsured and the assured, in which case the reinsurance settlement is binding and the problems discussed in this paragraph do not arise. See *National Company for Co-operative Insurance v St Paul Reinsurance Co* 1996, unreported.

[127] It was held by Colman J in *Lumberman's Mutual Casualty Co v Bovis Lend Lease Ltd* [2005] Lloyd's Rep IR 74 that an agreement under which various liabilities were settled for a global sum without any attempt to specific parts of the that sum to individual claims did not qualify as a "settlement" at all. That view was rejected by Aikens J in *Enterprise Oil Ltd v Strand Insurance Co Ltd* [2007] Lloyd's Rep IR 186, although the position of reinsurance in this regard remains uncertain.

has been reached with the assured is ordinarily mitigated by the use of "follow the settlements" and "follow the fortunes"[128] clauses. These clauses originally appeared in facultative agreements in the 1930's, in order to extend the reinsurers' liability to bona fide settlements,[129] preventing the reinsurers from questioning the basis on which the settlement had been made, and now appear as the second part of the full reinsurance clause which provides "as original[130] and follow the settlements" In *Insurance Co of Africa v Scor (UK) Reinsurance*[131] the Court of Appeal held, *obiter*,[132] that the reinsured is to be taken to have established its own liability under a settlement unless the reinsurers can establish[133] that the settlement was not entered into in a "bona fide and businesslike fashion". For this purpose the reinsurers are entitled to put the reinsured to proof of its loss by receiving information from the reinsured as to how the settlement was reached.[134] Once these conditions have been satisfied, the reinsurers are liable to indemnify the reinsured even though it subsequently proves that the reinsured was not as a matter of strict law liable to the assured, eg, by reason of fraud on the part of the assured having subsequently been established[135] or that the claim was otherwise bad.[136]

There are two aspects to a bona fide and businesslike settlement.[137] First, the reinsured must determine whether there is, on reasonable interpretation of the direct policy, a serious possibility that the policy covers the assured's claim and that there are no available defences to it:[138] if the policy covers a foreign risk, this may involve taking advice from local lawyers. Secondly, the reinsured must determine ascertain the facts to ascertain whether the claim is a good one and the amount sought is justified, and if necessary the advice of loss adjusters and other experts is to be obtained and given

[128] The authorities are all concerned with follow the settlements. There is no decided English case on "follow the fortunes", although it was common ground in *CGU International Insurance Plc v AstraZenica Insurance Co Ltd* [2006] Lloyd's Rep IR 409 that these words were narrower than "follow the settlements" and did not have the effect of binding reinsurers to the reinsured's bona fide and businesslike settlements.

[129] Replacing the earlier "pay as may be paid thereon" wording. The phrase was held to mean that the reinsurers were liable to indemnify the reinsured only on proof of legal liability (*Chippendale v Holt* (1895) 65 LJQB 104; *Merchants' Marine Insurance Co Ltd v Liverpool Marine and General Insurance Co Ltd* (1928) 31 Ll LR 45; *Excess Insurance v Matthews* (1925) 21 Com Cas 43; *Traders and General Insurance v Bankers & General Insurance* (1921) 38 TLR 94) although there was a view that once liability had been established reinsurers were bound by the settlement quantum figure (*Western Assurance Co of Toronto v Poole* [1903] 1 KB 376, a view doubted in *Gurney v Grimmer* (1932) 44 Ll LR 189 but subsequently approved in *Hong Kong Borneo Services Ltd v Pilcher* [1992] 2 Lloyd's Rep 593).

[130] See *supra* for the effect of these and similar words.

[131] [1985] 1 Lloyd's Rep 312. Cf *Excess Liability Insurance Co Ltd v Mathews* (1925) 31 Com Cas 43; *New Hampshire Insurance Co v Grand Union Insurance Co Ltd* [1995] 2 HKC 1.

[132] In that case the reinsured had been sued to judgment, so the point did not arise.

[133] *Insurance Company of the State of Pennsylvania v Grand Union Insurance Co* [1990] 1 Lloyd's Rep 208; *Hellenic Reliance Insurance SA v Grand Union Insurance Co Ltd* [1989] 2 HKC 533.

[134] *Charman v Guardian Royal Exchange Assurance* [1992] 2 Lloyd's Rep 607; *Württembergische Aktiengesellschaft Versicherungs-Beteili Gungsesellschaft v Home Insurance Co (No 1)* 1994, unreported; *Hill v Mercantile and General Reinsurance Co Plc* [1996] 3 All ER 865.

[135] *Insurance Co of Africa v Scor (UK) Reinsurance* [1985] 1 Lloyd's Rep 312.

[136] *Assicurazioni Generali SpA v CGU General Insurance Plc* [2004] Lloyd's Rep IR 457.

[137] Although the reinsured's conduct may be dictated by a claims clause: see *infra*.

[138] *Municipal Mutual Insurance Ltd v Sea Insurance Co Ltd* [1996] LRLR 265. See also *English and American Insurance Co Ltd v Axa Re SA* [2007] Lloyd's Rep IR 359, where it was held that there was no evidence that the reinsured had acted other than in a bona fide and businesslike fashion by entering into a settlement based on US court judgments which represented the at least the reinsured's potential actual liability.

Compensation Ordinance, s 31) and compensation is neither assignable nor subject to set-off (Employees' Compensation Ordinance, s 46). The Employees' Compensation Ordinance applies to any employee, defined by the Employees' Compensation Ordinance, s 2 as any person who works under a contract of service or apprenticeship[281] by way of manual or clerical labour. The Ordinance is extended, with appropriate modifications, to employees who are masters, seafarers and crew of a Hong Kong ship, that is, a ship registered or licensed in Hong Kong (Employees' Compensation Ordinance, s 29). Seafarers recruited or engaged in Hong Kong but who are injured outside Hong Kong on a ship which is not a Hong Kong ship are covered by the Ordinance if the employer submits to the jurisdiction of the Hong Kong courts (Employees' Compensation Ordinance, s 30). It also applies to an employee injured outside Hong Kong as long as the contract of employment is entered into in Hong Kong with an employer who is carrying on business in Hong Kong (Employees' Compensation Ordinance, s 30B).

Employees excluded from cover are:

(1) a person whose employment is casual and who is employed otherwise than or the purpose of the employer's trade;

(2) an outworker;[282] and

(3) a member of the employer's family.[283]

Independent contractors are excluded from the legislation. The distinction between an employee and an independent contractor is not always straightforward, but in essence it rests in part upon the degree of control exercised over the person in question and in part upon whether that person is to be regarded as being in business for his own account.[284]

A contract of employment which is illegal may be treated by the court as valid for the purposes of the legislation (Employees' Compensation Ordinance, s 2(2)),[285] so that insurers remain liable to indemnify the employer for any liability under the contract.[286] An employer includes the Government[287] and any body of persons corporate or unincorporate and the legal personal representative of a deceased employer, and where

[281] Defined as including a contract of improvership or learnership: Employees' Compensation Ordinance, s 3.

[282] Defined as a person to whom articles or materials are given to be worked on or processed at his home or other premises not controlled by the employer: Employees' Compensation Ordinance, s 3.

[283] Defined in Employees' Compensation Ordinance, s 3 as: (a) a spouse or cohabitee; (b) a child; (c) a parent or grandparent; or (d) a grandson, granddaughter, stepfather, stepmother, stepson, stepdaughter, son-in-law, daughter-in-law, brother, sister, half-brother, half-sister, father-in-law, mother-in-law, brother-in-law, sister-inlaw, and child of a brother or sister of the whole blood, any of whom has been living with the employee as a member of the same household and has been so living for the period of 24 months immediately preceding the accident concerned.

[284] *Wong-Man-Luen v Hong Kong Wah Tung Stevedore Co* [1971] HKLR 390; *Pan Wen Tsai v Wing Luen Universal Laundry Ltd* [1998] HKLRY 352; *Lee Ting-Sang v Chung Ki-Keung* [1990] 1 HKLR 764.

[285] See *Chan Cheuk-Ting v Analogue Engineering Co Ltd* [1986] HKLR 935, which decides that the provision applies whether the contract is illegal as formed or illegal in its performance.

[286] *Chan Cheuk-Ting v Analogue Engineering Co Ltd* [1986] HKLR 935.

[287] Although Government employees in the form of the armed forces or persons employed outside Hong Kong are excluded: Employees' Compensation Ordinance, s 4.

an employee has been loaned then the original employer remains the employer for the purposes of the Ordinance (Employees' Compensation Ordinance, s 3).

Liability for injury. As far as statutory liability under the Employees' Compensation Ordinance is concerned, an employer[288] is required to pay compensation to any employee who suffers personal injury by accident arising out of and in the course of[289] employment (Employees' Compensation Ordinance, s 5(1)).[290] The following injuries are excepted (Employees' Compensation Ordinance, s 5(2)): any injury (other than partial incapacity of a permanent nature) which does not incapacitate the employee from earning full wages at the work at which he was employed; any incapacity or death resulting from a deliberate self-injury; any incapacity or death resulting from personal injury if the employee has at any time represented to the employer that he was not suffering or had not previously suffered from that or a similar injury, knowing that the representation was false; or any injury, not resulting in death or serious and permanent incapacity, caused by an accident which is directly attributable to the employee's addiction to drugs or his having been at the time of the accident under the influence of alcohol. These exceptions aside, liability is strict.[291] **18.056**

Assessment and payment of compensation for injury. The formalities of the making of a claim are set out in the Employees' Compensation Ordinance itself and in supplementary regulations. Notice of an accident to be given by the employee to the employer within 24 months (Employees' Compensation Ordinance, s 14) in the form required by the Employees' Compensation Regulations (Cap 282A).[292] If an accident results in the death of an employee within three days, the employer must report the death to the Commissioner within seven days (Employees' Compensation Ordinance, s 15(1)). Incidents leading to total or partial incapacity must be notified within 14 days (Employees' Compensation Ordinance, s 15(1A)). The employer may require the injured employee to undergo a medical examination (Employees' Compensation Ordinance, s 16). **18.057**

In the case of death arising from personal injury, compensation is to be paid to eligible family members (Employees' Compensation Ordinance, s 12[293]), the sum if necessary

[288] The Employees' Compensation Ordinance is without prejudice to the right of an injured employee to sue any third party who is liable to him as a matter of law as well as, or instead of, the employer: Employees' Compensation Ordinance, s 25. For indemnities between persons jointly liable, see Employees' Compensation Ordinance, s 27.

[289] An accident arising "in the course of" employment is deemed to have arisen "out of" the employment unless the contrary is proved: Employees' Compensation Ordinance, s 5(4)(a).

[290] For the meaning of "course of employment", see: *Yuen Wai Ling v Ocean Shipping and Enterprises* [1984] HKLR 425; *Lau Kam Nui v Sau Kee Co Ltd* [1999] 1 HKLRD 163. The common law has recognised that an employee may be acting in the course of his employment even though he was disobeying his employer's instructions: *Rose v Plenty* [1976] 1 Lloyd's Rep 263. Employees' Compensation Ordinance, s 5(3) provides that there is protection even though the employee was acting in breach of a statutory or other regulation, or was engaging in rescue work, or was travelling to or from his place of work by arrangements made with the employer.

[291] *Lau Kwok-Keung v Evergo Electric Manufacturing Co Ltd* [1989] 2 HKDCLR 40.

[292] The rules of court have been adapted for compensation claims: Employees' Compensation (Rules of Court) Rules (Cap 282B). For evidence as to injuries occurring outside Hong Kong, see Employees' Compensation Ordinance, s 30A.

[293] Application may be made to the court for an apportionment of compensation amongst family members where distribution is not otherwise provided for by the Ordinance: Employees' Compensation Ordinance, s 13.

to be determined by the Commissioner for Labour (Employees' Compensation Ordinance, ss 6A, 6B, 6D),[294] and interim payments may be made to the deceased's spouse (Employees' Compensation Ordinance, s 6C). The amount of compensation payable in a fatal accident case is on a sliding scale based upon the age of the employee and his earnings (Employees' Compensation Ordinance, s 6), and funeral expenses are included (Employees' Compensation Ordinance, s 6E), subject to an aggregate cap on liability not exceeding the maximum sum payable (Employees' Compensation Ordinance, s 6G).

Where the injury results not in death but in permanent total incapacity, there is similar sliding scale for the calculation of compensation (Employees' Compensation Ordinance, s 7), with additional sums payable where the employee requires subsequent care (Employees' Compensation Ordinance, s 8 and Sch 6). In the case of partial permanent incapacity, compensation is based upon the nature of the injury (Employees' Compensation Ordinance, s 9 and Sch 1), and in the case of temporary incapacity the employee is entitled either to period payments or to a lump sum based upon the probable duration of such incapacity (Employees' Compensation Ordinance, s 10) – the employer and the employee may agree the amount of compensation under this latter provision, although the agreement may be cancelled by the Commissioner if the agreement is not in accordance with the Ordinance or based on mistake or misleading information (Employees' Compensation Ordinance, ss 16CA and 16CB).

In all cases the Employees' Compensation Ordinance defines earnings and how they are to be calculated for the purposes of compensation payments (Employees' Compensation Ordinance, ss 3 and 11). The Commissioner may assess the compensation payable under these provisions, by issuing a certificate setting out the sums payable (Employees' Compensation Ordinance, s 16A). This is subject to an appeal to the court where the certificate was erroneous, outside the Ordinance or based on false information (Employees' Compensation Ordinance, s 16B). The Commissioner operates through Employees' Compensation (Ordinary Assessment) Boards appointed for the purpose (Employees' Compensation Ordinance, s 16D), and claims relating to partial permanent incapacity may be referred by such a Board to an Employees' Compensation (Special Assessment) Board (Employees' Compensation Ordinance, s 16E). The Board in question may require the employee to attend for medical examination (Employees' Compensation Ordinance, s 16I). The Board is ultimately to issue a certificate, and this is subject to review by the Commissioner (Employees' Compensation Ordinance, ss 16F and 16G) or by the Board on its own initiative where the assessment is shown to have been based on mistake or false information (Employees' Compensation Ordinance, s 16GA). There is an appeal to the court from determinations of a Board (Employees' Compensation Ordinance, s 18, 18A and 20),[295] and a periodic payment may be reviewed by the court if circumstances

[294] For information to be supplied to the Commissioner, see Employees' Compensation Ordinance, s 6F. An appeal lies to the court from the Commissioner's determinations: Employees' Compensation Ordinance, s 6H.

[295] With a further appeal to the Court of Appeal on a point of law only: Employees' Compensation Ordinance, s 23. A point of law may also be referred to the Court of Appeal: Employees' Compensation Ordinance, s 22.

have changed (Employees' Compensation Ordinance, s 19).[296] A certificate free of appeals and challenges is deemed to be conclusive evidence of the sums owed to the employee (Employees' Compensation Ordinance, s 16H).

An employer is liable also for medical expenses incurred both inside and outside Hong Kong for the treatment of any injury (Employees' Compensation Ordinance, ss 10A, 10AA, 10AB and 10B). He is also liable for the cost of fitting prostheses or surgical appliances (Employees' Compensation Ordinance, ss 36A to 36O).

The employment rights of an injured employee are preserved by the Ordinance. An employer commits a criminal offence if, without the consent of the Commissioner, he terminates or give notice to terminate the contract of an employee who has suffered incapacity before compensation has been assessed (Employees' Compensation Ordinance, s 48(1)–(2)) or, in the case of temporary incapacity not exceeding three days, before the period of temporary incapacity has expired (Employees' Compensation Ordinance, s 48(1A)–(2)).

Liability for occupational disease. The Employees' Compensation Ordinance deals separately with occupational disease. If an employee suffers total or partial incapacity, or dies, from an occupational disease, compensation is payable as if the loss was caused by an injury (Employees' Compensation Ordinance, s 32). Compensation is recoverable from the last employer during the period immediately preceding the incapacity (Employees' Compensation Ordinance, s 32(1). To protect against a claim for a latent occupational disease sustained in a previous employment, an employer in any specified trade or profession[297] may require a potential employee to undertake a medical examination, and if the employee fails to do so then the employer is immune from any subsequent claim (Employees' Compensation Ordinance, s 33). There are statutory presumptions as to cause of death from specified occupational diseases (Employees' Compensation Ordinance, s 34). Diseases not covered by the Ordinance[298] may nevertheless result in compensation if the disease also constitutes a personal injury (Employees' Compensation Ordinance, s 36), asbestos-related diseases and deafness excepted, as these have their own compensation regimes which are funded by the Government.[299] **18.058**

Obligation to insure

Scope of obligation. The Employees' Compensation Ordinance, s 40(1) provides that no employer shall employ any employee in any employment unless there is in force in relation to such employee a policy of insurance[300] issued by an insurer for an amount not **18.059**

[296] An agreed period payment may not be varied unilaterally by the employer: Employees' Compensation Ordinance, s 20.

[297] Employees' Compensation Ordinance, Sch 3, sets out the relevant employments.

[298] As to which, see Sch 2, which under Employees' Compensation Ordinance, s 35, may be amended from time to time.

[299] Pneumoconiosis and Mesothelioma (Compensation) Ordinance 2006 (Cap 6); Occupational Deafness (Compensation) Ordinance 1994 (Cap 21).

[300] The policy must be one which is issued in respect of liability under the Ordinance. See *Chan Chu Ngan v Woon Poon Pui* [1992] 2 HKC 193, where it was held that a policy issued to the employer was one which had been