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# Insurance in commercial transactions

**by Practical Law Commercial with assistance from Melanie Quixley, Principal, Barry Nilsson, and based on original material by Rehana Box, Partner, Ashurst and Philip Hopley (formerly Ashurst), Partner, Hall&Wilcox**

Status: **Maintained** | Jurisdiction: **Australia**

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This note provides an overview of some of the general insurance issues in commercial transactions. It discusses the nature and type of insurances commonly required in commercial contracts, terminology used in insurance contracts, the statutory duties of disclosure and the duty to act with utmost good faith, the extension of the unfair contract terms regime to insurance contracts, what to think about when reviewing an insurance policy, how to make a claim and issues to be aware of when making a claim. It summarises the issues to consider when drafting or assessing proposed insurance requirements in commercial contracts. This note also highlights some of the insurance contract issues that arose as a result of COVID-19 and considers what businesses should do moving forward.

## Scope of this note

This note provides an overview of some of the main issues to be aware of when dealing with insurance in commercial transactions. It considers:

- The nature and type of the most common general insurances.
- Terminology used in insurance contracts.
- Third-party claimants' right to access monies under insurances policies.
- The statutory duties of disclosure and the duty to act with utmost good faith.
- The extension of the unfair contract terms regime under the *Australian Securities and Investments Commission Act 2001* (Cth) (**ASIC Act**) to insurance contracts governed by the *Insurance Contracts Act 1984* (Cth) (**ICA 1984**) to protect consumers from unfair contractual terms in standard form contracts.
- How to review an insurance policy.
- Issues to be aware of when making a claim to an insurer.

This note also highlights some of the insurance issues that arose out of COVID-19 and considers what businesses should do moving forward (see box, Insurance issues: lessons from COVID-19).

It also discusses some of the issues to be aware of when drafting or assessing insurance requirements in a contract for the supply of goods or services between businesses within Australia.

This note does not deal with:

- Life insurance, medical indemnity insurance, health insurance or specialist insurance, such as, for example, cyber, product guarantee, marine or aviation insurances. For further information about cyber insurance, see Practice note: overview, Cybersecurity: Cyber insurance.
- Parametric insurance. This is a novel type of insurance that has grown in popularity. The Insurance Council of Australia (**Insurance Council**) defines parametric insurance as a product that involves contracts where a claim is defined with reference to a pre-determined index. Under parametric insurance, no damage to insured property needs to be assessed. For further information, including an example, see Letter from the Insurance Council to the Australian Treasury, Appendix A.
- Warranty and indemnity (or transaction) insurance (W&I insurance), which is used in merger and acquisition transactions to insure or replace seller warranties and indemnities. For the key features of W&I insurance for buyers and sellers in the context

of private share sale and asset acquisitions, see Practice note, Warranty and indemnity insurance.

## Types of insurance contracts

There are many different types of insurance contracts available to manage risk in commercial contexts. When dealing with general insurance issues in commercial contracts, you should understand:

- What a particular insurance policy covers (see First party loss insurance and third-party liability insurance).
- How the insurance policy is intended to respond to an insured event (see Occurrence and claims made insurance contracts).

### First party loss insurance and third-party liability insurance

Insurance can generally be divided into the following two main categories:

- **First party loss insurance,** which provides cover for losses suffered by the insured usually as a consequence of an insured peril (such as fire, wind, illness, flood and theft) (see Examples of first party loss insurance).
- **Third-party liability insurance,** which insures the liability of the insured to a third-party for loss or damage caused by the insured's acts or omissions (see Examples of third-party liability insurance).

However, a single insurance policy may contain both types of cover under different insuring clauses. For example, most liability insurances will contain an element of first party loss cover where they provide an indemnity for the insured's legal expenses incurred in defending a claim brought by a third-party. Policies are also often given different names by insurers or are packaged together, so you should always review the policy terms to determine what is in fact covered (see Unfair contract terms in insurance contracts).

Insurance products continuously evolve to reflect society's changing interactions and business practices. New insurance products will likely become available to address any coverage gaps in existing products; for example, policies that are designed to provide cover to businesses and individuals arising from climate-related risks or AI systems.

#### Examples of first party loss insurance

- **Property insurance.** This covers loss or damage to the insured's property.
- **Business interruption insurance.** This is a policy that is effected with property insurance to cover lost revenue and other losses, such as increased costs of working, that flow from the destruction of insured property.
- **Transit insurance.** This covers loss or damage to goods in transit.
- **Contract works insurance.** This is a type of property insurance that covers property under construction.
- **Advance consequential loss insurance.** This covers economic losses caused by the delay of, or loss or damage to, construction works, including expediting costs.
- **Motor vehicle property.** This covers loss or damage to, or theft of, the insured's motor vehicles.
- **Cyber insurance.** This covers economic loss caused by cyber events such as hacking, denial of service attacks or ransomware.
- **Industrial special risks.** This covers material damage and business interruption and is suitable for large/complex business with high value assets.

#### Examples of third-party liability insurance

- **Public liability insurance.** This covers the insured's liability to third parties for injury, death, or loss or damage to property.
- **Products liability insurance.** This covers the insured's liability to third parties for injury, death, or loss or damage to property caused by the insured's products.
- **Professional indemnity insurance.** This covers the insured's liability for professional negligence. This policy also covers the insured's liability for unintentional breaches of confidentiality, privacy and intellectual property rights.
- **Cyber liability.** This covers the insured's liability for cyber events such as the introduction of a virus into a customer's network or theft of information.
- **Workers' compensation insurance.** This covers the insured employer's liability to its employees for injury or death.

- **Compulsory third-party and motor vehicle liability insurance.** This covers the insured's liability to third parties for injury, death, or loss or damage to property arising from the use of a motor vehicle.

There are many other types of insurance than those listed above, one or more of which may be relevant in any particular situation, for example, pollution liability insurance, warehousemen's cover or asbestos removalist's liability insurance.

## Occurrence and claims made insurance contracts

Insurers will generally offer cover on an **occurrence basis** (see Occurrence basis) or on a **claims made basis** (see Claims made basis). The basis on which an insurance policy responds to provide an indemnity varies and will depend on whether it is written on an occurrence basis or a claims made basis. This is an important distinction to understand when:

- Deciding the period for which an insurance must be maintained.
- Making a claim for indemnity.
- Assessing which insurance policy held at a particular time will respond to a claim for indemnity that has been made.

In determining the basis on which an insurance policy may respond to provide an indemnity, a court will look to the substance of the contract instead of its prescribed form. For example, a court will place more weight on the **real effect** of the policy rather than any descriptive labels attached to it (see, for example, *Burnie v Dr Leslie Blackstock* [2020] NSWDC 452 at [21]-[22], applying the majority decision *FAI General Insurance Co Ltd v Australian Hospital Care Pty Ltd* [2001] HCA 38).

### Occurrence basis

An occurrence basis contract of insurance refers to the insurer's promise to indemnify the insured for any loss or liability arising out of a defined event, accident, occurrence or circumstance. These terms are generally defined in the insurance contract. This means that for an insurer to be liable under the policy, the defined event or circumstance must have occurred during the insurance policy's period. For example, a company that suffers property damage and loss of profits as a result of an insured event should be able to claim under its property damage and business interruption policy, provided the insured event occurred during the period of cover. The fact that the insured may make a claim after the contract has expired is not relevant. Insurers may face claims where the damage caused by the insured event does not materialise during the period of cover, but arises or is discovered many years later.

The general rule is that first party loss insurances are usually written on an occurrence basis, whereas a third-party liability policy can be written on either a claims made or occurrence basis (see Claims made basis). However, there are exceptions and the policy wording must always be checked. Typical examples of insurance contracts written on an occurrence basis include property damage insurance and motor vehicle property, motor vehicle liability, public and products liability and cyber insurance.

### Claims made basis

In contrast to an occurrence basis contract of insurance, a claims made contract of insurance refers to a promise by the insurer to indemnify the insured for any claim that is made within the duration of the policy, regardless of when the insured event took place. For example, a professional who faces claims from third parties should be able to claim under their professional liability policy provided the third-party claims were made against them during the period of cover (see Professional indemnity insurance).

Typical examples of claims made insurance include professional liability insurance and directors' and officers' insurance.

## Policyholders, insured, beneficiaries, noting and loss payees

### Policyholder

The policyholder is the contracting party that enters into the insurance policy. A policyholder will usually be an insured party but that is not always the case. For example, under builders warranty and lenders mortgage insurances, the policyholders (the builder and the borrower, respectively) are not insured parties and have no entitlement to make a claim for indemnity.

## Insured

An insured is the person or entity that is covered for its loss or liability under the insurance. A policy may have multiple insureds, in which case each insured will usually have an independent right to make a claim for indemnity. Being identified in an insurance policy as a named insured or an **additional insured** does not determine whether that party is a party to the contract of insurance. It will depend on the construction of the policy and surrounding facts, including any agency relationship, and can involve complex issues of fact and law (see, for example, *Lambert Leasing Inc v QBE Insurance (Australia) Ltd* [2016] NSWCA 254 (**Lambert Leasing v QBE Insurance**)).

## Third-party beneficiaries

A third-party beneficiary generally refers to a class of persons who are described as having the benefit of the insurance cover but who are not parties to the contract of insurance.

The distinction between an insured person and a third-party beneficiary is not usually a significant one in practice because:

- Third-party beneficiaries have both a common law and statutory right to make a direct claim for indemnity (see *Trident General Insurance Co Ltd v McNiece Bros Pty Ltd* [1988] HCA 44; (1988) 165 CLR 107; section 48, ICA 1984).
- An insurer is entitled to raise the same defences to a claim by a third-party beneficiary as it could in response to an identical claim by an insured, including the conduct of the insured.

The classification of the party as a third-party beneficiary can have consequences for insurers seeking contribution by the operation of section 45 of the ICA 1984 (see Lambert Leasing v QBE Insurance and *Zurich Australian Insurance Ltd v Metals & Minerals Insurance Pte Ltd* [2009] HCA 50; see also Contribution).

## Noting a person's interest on a policy

Policies sometimes **note** the interest of third parties. This is generally done to put the insurer on notice that a party other than the insured has a beneficial interest in the subject matter of the insurance; for example, where a mortgagee or financier's interest is noted on a property policy.

Noting a third party's interests on a policy may give that party the status of a third-party beneficiary under section 48(1) of the ICA 1984. This, in turn, provides the third-party beneficiary with a right to recover from the insurer. Whether this will occur will depend on both:

- The terms of the policy, in particular the insuring clause and any clauses dealing with the rights of a party not named in the policy, such as an "interests of other party" type clause.
- The contract requiring the noting of the interests.

(See *Insurance Australia Ltd (t/as CGU Insurance) v MOS Beverages Pty Ltd* [2021] FCAFC 165.)

## Loss payee

A loss payee is a person to whom insurance proceeds are directed to be paid, even though that person may not be an insured party or otherwise have any rights under the insurance policy. The insurer will discharge its liability to indemnify the insured by paying the loss payee.

Incorporating a loss payee provision for the mortgagee or financier of an insured is often done in preference to (and sometimes in addition to) noting that person's interests under a policy.

# Direct rights of third-party claimants to access insurance proceeds

Australian law provides a limited basis for third-party claimants to access monies under insurance policies directly without reference to the insured.

## Commonwealth legislation

Section 51 of the ICA 1984 provides recourse where an insured (or third-party beneficiary) defendant is dead or cannot be found, and where the insurance provides cover in respect of the liability of the insured or third-party beneficiary to the claimant.

Section 601AG of the *Corporations Act 2001* (Cth) provides a means of recovery against insurers of companies that are deregistered, where the insurance provided cover for the company's liability to the claimant before deregistration. The relevant time to consider the merits of a claim under section 601AG is immediately before deregistration (see *Esined No 9*

*Pty Ltd v Moylan Retirement Solutions Pty Ltd (No 2)* [2020] NSWSC 359 at [456]).

### State legislation

In addition to the rights under section 51 of the ICA 1984, in New South Wales (**NSW**), a claimant may also be able to recover directly from an insurer pursuant to section 4 of the *Civil Liability (Third Party Claims Against Insurers) Act 2017* (NSW) (**CLTPCAI Act**). This provision provides as follows:

- If an insured person has an insured liability to a person (the claimant), the claimant may, subject to the CLTPCAI Act, recover the amount of the insured liability from the insurer in proceedings before a court.
- The amount of the insured liability is the amount of the indemnity (if any) payable pursuant to the terms of the contract of insurance in respect of the insured person's liability to the claimant.
- In proceedings brought by a claimant against an insurer under this section, the insurer stands in the place of the insured person as if the proceedings were proceedings to recover damages, compensation or costs from the insured person. Accordingly (but subject to the CLTPCAI Act), the parties have the same rights and liabilities, and the court has the same powers, as if the proceedings were proceedings brought against the insured person.
- This section does not entitle a claimant to recover any amount from a re-insurer under a contract or arrangement for reinsurance.

Leave of the court is required before proceedings are commenced or continued under this section (section 5, CLTPCAI Act; see *Avant Insurance Ltd v Burnie* [2021] NSWCA 272 at [8] and *Clark v Avant Insurance Ltd* [2022] NSWCA 175 at [27]). Leave must be refused under section 5(3) of the CLTPCAI Act if the insurer can establish that it is entitled to disclaim liability under the contract of insurance (see *Chubb Insurance Australia Ltd v Giabal Pty Ltd; Catlin Australia Pty Ltd v Giabal Pty Ltd* [2020] NSWCA 309).

The insurer stands in the place of the insured, and is able to rely on any defences or answers to the claim that the insured would have had recourse to (section 7, CLTPCAI Act).

## Duty of disclosure and duty of utmost good faith

Two important duties govern the conduct of parties to insurance contracts. The most important is the duty of utmost good faith that the parties owe each other in their dealings with one another, both pre-contractually and post-contractually (see Duty of utmost good faith). The duty of disclosure, which is a function of the duty of utmost good faith, is that before the relevant contract of insurance is entered into, each insured person has a duty to disclose information about the risk to the insurer (see Duty of disclosure).

Although both duties have a common law basis, the law in Australia is now codified under Parts II and IV of the ICA 1984.

### Duty of disclosure

From 18 December 2020, in general terms, the duty of disclosure requires each insured to disclose to the proposed insurer, before the contract of insurance is entered into, every matter that is known, or a reasonable person in the circumstances could be expected to know, as being relevant to the insurer's decision whether to accept the risk, and if so on what terms (section 21, ICA 1984). This duty applies to contracts of insurance that are not, or would not be, consumer insurance contracts (section 20E, ICA 1984; see below). For a discussion of what is required to establish a breach of an insured's duty of disclosure, see *Carter v Chubb Insurance Australia Ltd* [2024] FCA 1312.

This duty applies not only when a policy is first entered into but also when it is renewed, extended or varied (sections 11(9) and 21(1), ICA 1984).

The duty of disclosure does not apply to every matter known to the insured. For example, there is no duty to disclose matters that decrease the insured risk or of which an insurer is already aware (section 21(2), ICA 1984).

A consumer insurance contract is a contract obtained wholly or predominantly for the personal, domestic or household purposes of the insured (that is, a retail contract) (section 11AB, ICA 1984). The insured's obligation is to take reasonable care not to make a misrepresentation to the insurer before a consumer

insurance contract is entered into (section 20B, ICA 1984). This will be determined by considering all of the relevant circumstances, including the type of consumer insurance contract and how clearly the insurer communicated to the insured the importance of answering those questions and possible consequences of failing to do so.

### Remedies for breach

For a general insurance contract, an insurer's remedies for a breach of the duty of disclosure through an omission or misrepresentation by the insured are confined to those contained in sections 28 and 60 of the ICA 1984. In summary:

- If the non-disclosure/misrepresentation is fraudulent (that is, if the non-disclosure is made intentionally, or recklessly without regard to its accuracy), the insurer may be entitled to avoid the policy. Avoidance will result in the policy being treated as if it had never existed and so will also extinguish the rights of any other **innocent** insureds to claim under it.
- If a non-disclosure/misrepresentation is not intentional or reckless (a so-called **innocent** non-disclosure), or if an insurer does not wish to (or has agreed in the policy not to) exercise any right of avoidance it has, then the insurer:
  - may reduce its liability for the claim proportionately to place it in the same position it would have been in had the correct disclosure been made; and
  - the insurer may cancel the policy and extinguish the insurance cover from the date of cancellation, but not retrospectively so the rights of an insured with a claim that arose before the date of cancellation will be preserved.

An insurer may be found to have waived its right to rely on an insured's non-disclosure under section 21 of the ICA 1984 where there has been partial disclosure by an insured of a relevant matter and the insurer does not seek further particulars (see *J&J Richards Super Pty Ltd ATF The J&J Richards Superannuation Fund v Nielsen* [2024] FCA 1472).

## Duty of utmost good faith

The duty of utmost good faith essentially requires the parties to an insurance policy to act honestly and deal fairly with each other at all times, including when a claim is made and determined (*Allianz Australia Insurance Ltd v Delor Vue Apartments CTS 39788* (2022) 277 CLR 445; *CGU Insurance Ltd v AMP Financial Planning Pty Ltd* [2007] HCA 36; (2007) 235 CLR 1; *Sayseng v Kellogg Superannuation Pty Ltd* [2003] NSWSC 945*; Edwards v Hunter Valley Co-op Dairy Co Ltd* (1992) 7 ANZ Ins Cas 61-113).

Some specific points to note are that:

- In practical terms, the duty imposes on an insurer an obligation to consider claims promptly and only decline claims on a reasonable basis. Where an insurer conducts the defence of a claim against the insured, the insurer must have regard for the insured's interests as well as its own, consistent with commercial standards of decency and fairness (see also the General Insurance Code of Practice 2023). In the decision in *ASIC v Youi Pty Ltd* [2020] FCA 1701, Allsop CJ found that the duty of utmost good faith when handling claims is characterised by "full and frank disclosure, clarity, candour, and timeliness" (at [9]).
- The duty of utmost good faith applies to third-party beneficiaries and to insureds who are not parties to the insurance policy.
- The duty of utmost good faith continues to apply with respect to honesty in claims handling.
- Breach of the duty may give rise to a claim for damages for breach of contract (the duty is implied as a term into every contract of insurance by section 13 of the ICA 1984). However, an insured may also rely on general contractual principles in seeking damages for consequential loss arising out of, for example, an unreasonable delay in determining a claim for indemnity (*Brescia Furniture Pty Ltd v QBE Insurance (Australia) Ltd* [2007] NSWSC 598).

# Unfair contract terms in insurance contracts

Since April 2021, the unfair contract terms regime under the ASIC Act has applied to new or renewed insurance contracts governed by the ICA 1984 (see the Financial Sector Reform (Hayne Royal Commission Response - Protecting Consumers (2019 Measures)) Act (No 2) 2020 (Cth) (**Amending Act**)).

## What is the unfair contract terms regime?

The unfair contract terms regime was introduced in 2010 to protect consumers from unfair contract terms

in standard form contracts. The regime was extended to small business contracts in 2016 and to insurance contracts governed by the ICA 1984 in April 2021.

A term in a relevant standard form contract is void if it is unfair. In addition to being void, from 9 November 2023 the inclusion of, or reliance upon, unfair contract terms in consumer and small business contracts is prohibited and a court may order significant civil pecuniary penalties for violations of the prohibition (section 12BF of the ASIC Act, as amended by the Treasury Laws Amendment (More Competition, Better Prices) Act 2022 (Cth)).

A term of a **consumer contract** or **small business contract** is void if three central elements are met:

- The term is unfair.
- The contract is a standard form contract.
- The contract is a financial product, or a contract for the supply, or possible supply, of services that are financial services.

(Section 12BF, ASIC Act.)

Generally, the rest of the contract continues to bind the parties if it can operate without the unfair term.

For a guide to Practical Law's resources dealing with the unfair contract terms regime under the Australian Consumer Law, see Toolkit, Unfair contract terms.

## Applying the unfair contract terms regime to insurance contracts

The central elements of the existing unfair contract terms regime apply to insurance contracts governed by the ICA 1984 under the Amending Act.

A term is unfair if it:

- Would cause a significant imbalance in the parties' rights and obligations arising under the contract.
- Is not reasonably necessary to protect the legitimate interest of the party who would be advantaged by the term.
- Would cause detriment (whether financial or otherwise) to a party if it were to be applied or relied on.

(Section 12BG, ASIC Act.)

A court will determine whether unfairness arises in a particular contract on a case-by-case basis and may take into account such matters as it thinks relevant. However, a court must take into account the extent to which the term is transparent and the contract as a whole.

Not all terms of a contract are captured by the regime. The regime does not apply to terms of a contract that:

- Define the main subject matter of the insurance contract. The main subject matter of an insurance contract will be limited to the description of what is being insured.
- Set the upfront price payable under the insurance contract.
- Define the quantum or existence of the excess or deductible of the insurance contract if they are disclosed upfront and are transparent.

Third-party beneficiaries of an insurance contract covered by the regime are able to bring a claim under the unfair contract terms regime. Third parties to other kinds of contracts continue to be unable to bring claims under the unfair contract terms regime.

The duty of utmost good faith continues to apply to insurance contracts concurrently with the unfair contract terms regime (see Duty of utmost good faith). The decision of *Australian Securities and Investments Commission v Auto & General Insurance Company Ltd* [2025] FCAFC 76 indicates that the court will assess the contractual term in the context of the legal environment in which it operates (see box, Australian Securities and Investments Commission v Auto & General Insurance Company Ltd [2025] FCAFC 76). This means that the court will first consider the term in the context of the ICA 1984 and the duty of utmost good faith. The decision suggests that it will be difficult to establish that a term in an insurance contract is unfair.

### Australian Securities and Investments Commission v Auto & General Insurance Company Ltd [2025] FCAFC 76

In this case, the Full Federal Court of Australia (**Full Federal Court**) considered the interaction of the unfair contract terms regime with the regulation of insurance contracts by the ICA 1984.

ASIC had brought proceedings against Auto & General Insurance Company Ltd (**A&G**)

alleging that the notification term in A&G's home and contents insurance contracts was an unfair term under section 12BG(1) of the ASIC Act and therefore void. Under the term, the insured was required to tell A&G "if anything changes" about the insured's home or contents. A failure to notify entitled A&G to certain consequences, including that A&G may refuse to pay a claim. ASIC was unsuccessful at first instance and appealed the finding that the notification term was not an unfair term under the provision.

On appeal, A&G's arguments included that the primary judge was correct to conclude that there was a meaningful relationship between the notification obligation and the protection of the insurer's interests, and that the insurer's rights upon breach were qualified by the operation of sections 13 and 54 of the ICA 1984. Section 13 implies into all insurance contracts a duty of utmost good faith and section 54 imposes restrictions on the exercise of contractual rights to refuse to pay claims.

The Full Federal Court dismissed ASIC's appeal. The majority of the court upheld ASIC's construction of the term to qualify the notification requirement "with a criterion of materiality" about the risk insured. Nevertheless, the court held that ASIC had failed to demonstrate that the notification clause, properly construed (on ASIC's own construction) and taking into account its transparency, caused a significant imbalance in the parties' rights and obligations even before the provisions of the ICA 1984 were considered.

Although it was not necessary to decide, the court also held that ASIC had failed to demonstrate that the notification term was not reasonably necessary to protect A&G's legitimate interests. The obligation being imposed on the insured was proportionate to the interests being protected. While the term lacked transparency in some respects, overall that lack of transparency didn't detract from a conclusion that it was reasonably necessary to protect those interests.

## Reviewing an insurance policy

An insurance policy is first and foremost a commercial contract and it should be interpreted like any other commercial contract by being given a business-like interpretation. Attention should be given to the language used and to the commercial circumstances and objectives of the policy (*McCann v Switzerland Insurance Australia Ltd* (2000) 203 CLR 579; [2000] HCA 65 at [22]; *Australian Casualty Co Ltd v Federico* (1986) 160 CLR 513; [1986] HCA 32 at CLR pages 520-521 and 525, cited in *McCann* at [74]; see also *Zhang v ROC Services (NSW) Pty Ltd* [2016] NSWCA 370 at [95]).

Insurance policies should be drafted in plain language but, even so, they can often be difficult to understand. When reviewing a policy, lawyers should ensure that they have the following documents:

- The policy wording, which contains the main body of the terms and conditions of the insurance.
- The policy schedule, which contains important information about variable terms such as:
  - the identities of the insureds (see Insured);
  - the period of insurance cover;
  - the limit of indemnity;
  - the applicable deductible or excess (the first part of a loss that has to be borne by the insured party), noting there may be more than one; and
  - any endorsements (a written change or addition to the policy). However, the practice in the insurance industry is to vary policies by issuing an endorsement instead of directly amending and re-issuing the policy wording or schedule. Given that multiple variations can result in multiple endorsements that can override each other, it is important to make sure that a complete set of endorsements is supplied so that the policy can be read by reference to them.
- Where relevant to confirm that an insurance policy remains current, a certificate of currency. This is a document confirming that an insurance policy is current and in force as at a particular date. It does not form part of the policy. To the extent that the certificate refers to the policy terms, it should not be relied on without corroboration. The terms of the policy itself will prevail over any inconsistency with a certificate of currency.

For statutory policies, only a certificate of insurance or registration and, possibly, a certificate of currency is required because the terms of cover are prescribed by statute.

An insured can make a request in writing to an insurer to provide a statement in writing that sets out all the provisions of the insurance contract (section 74, ICA 1984). This can be a useful means for third-party beneficiaries to obtain details of insurance taken out by others that may benefit them.

## Structure of an insurance policy

The insuring clause, exclusion clauses and conditions form the essential structure of an insurance policy, and these should guide its interpretation.

### Insuring clause

The insuring clause sets out the scope of the insurance cover by specifying the risks covered by the insurance. While insuring clauses are generally very broadly worded, and are written back by the policy exclusions and conditions (and sometimes the definitions) that follow, the essential first step is to determine whether the insuring clause, on its face, responds to the occurrence or claim in question.

Policies commonly include extensions to the insuring clause that provide additional insurance cover for particular circumstances. These are generally set out underneath the main insuring clause but can also be in the endorsements or elsewhere.

### Exclusion clauses

A policy's exclusion clauses identify the specific circumstances, events or losses that are carved out of the insurance. As a result, careful attention is required to determine whether an otherwise insured occurrence or claim is excluded from cover. Exclusions can significantly reduce the value of insurance cover.

Consistently with the general principles of interpretation referred to above, the courts will generally give effect to exclusion clauses where the language is clear, having regard to their natural and ordinary meaning and read in the context of the contract as a whole, and will only construe them against the interests of the insurer in the event of ambiguity or where this would render the insurance cover largely illusory (*Alex Kay Pty Ltd v General Motors Acceptance Corporation* [1963] VR 458 at 462-463; *Ashmere Cove Pty Ltd v Beekink* [2009] FCA 564 at [104]; *Hakea Holdings Pty Ltd v Neon Underwriting Ltd for and on behalf of the Underwriting Members of Lloyds Syndicate 2468* [2023] FCAFC 34).

### Conditions

Policies include a separate section that sets out the conditions that regulate the manner in which the policy operates. Examples of issues that may be dealt with in conditions include:

- The insured's obligations when making a claim.
- The insurer's obligations where it assumes the conduct of the defence of a claim on behalf of an insured.
- Any agreed restrictions on the insurer's rights (such as in relation to issues of severability and non-imputation where there are multiple insureds, to protect each insured from being prejudiced by the conduct of other insureds).
- The effect of a change of control of the insured on the insurance cover.
- Rights of the insured to assign or cancel the policy.
- Boilerplate clauses, such as those dealing with governing law and jurisdiction.

# Making a claim or notifying a circumstance to an insurer

The insurance policy will set out the steps an insured must take when notifying a claim or circumstance to the insurer, and these should be consulted and followed. This process often benefits from the involvement of insurance lawyers to review the policy terms to confirm that the claim falls within the insurance cover or to ensure that the notification of the circumstance maximises the potential for the insurance cover to respond.

Particular issues arise in relation to the making of claims and the notification of potential claims under claims made insurance policies. Lawyers should be aware of the following issues.

## Know your policy type

For claims made policies (see Claims made basis), determine the type of claims made policy involved by reference to the policy wording, as these vary as follows:

- A simple **claims made** policy provides cover for claims that are made against an insured during the period of the insurance cover.
- A **claims made and notified** policy goes further than this in requiring both the claim to be made and the notification to the insurer to occur during the policy period.
- A **claims made and circumstances notified** policy requires a claim to be made, or the notification to the insurer of circumstances that the insured considers may give rise to a later claim to be made, during the policy period. If a notification is made in time, then any later claim that arises will be covered under the policy.

That said, it is still possible to notify an insurer of a circumstance that the insured believes may give rise to a future claim against it under a **claims made** or a **claims made and notified** policy. This is because:

- Some policies that are described as being **claims made** contain what is referred to as a **deeming provision**, which permits the insured to notify its insurer of circumstances that may give rise to a claim. (The effect of this is the same as for a **claims made and circumstances notified** policy, in the third bullet above.)
- Section 40(3) of the ICA 1984 provides a statutory right to insureds to notify their insurers of circumstances that may give rise to future claims. This is less beneficial than a contractual right to notify circumstances because section 40(3) requires the notification to be made before the period of insurance ends. Section 54 of the ICA 1984 cannot forgive a failure to comply with section 40(3) (see Late notification of claims). Care should be taken when drafting a notification. It must not be so broad and lacking in detail that it does not identify **facts** that would allow the insurer to identify the **claim** that might follow, as that may prevent section 40(3) of the ICA 1984 from operating (see *Esined No. 9 Pty Ltd v Moylan Retirement Solutions Pty Ltd* (No.2) [2020] NSWSC 359).

### Late notification of claims

What happens if an insured becomes aware of a claim or a circumstance during the period of cover but omits to notify its insurer before the expiry of the insurance, perhaps for several years?

Where an insurer has a contractual right under the policy to refuse a claim that is notified outside the period of cover, section 54 of the ICA 1984 prevents an insurer from doing so, except to the extent that the insurer's interests have been prejudiced or where the loss has been caused by this omission (*FAI General Insurance Co Ltd v Australian Hospital Care Pty Ltd*[2001] HCA 38; (2001) 204 CLR 641).

In practical terms, section 54 of the ICA 1984 will frequently, but not always, operate to **forgive** the late notification of a claim. This is because it is generally difficult for insurers to identify any prejudice that flows from a late notification.

While this can be a complex area of law, it is possible to give the following general guidance on the application of section 54 of the ICA 1984 to the late notification of claims:

- Where an insured first becomes aware of a claim against the insured during the policy period, a failure to notify that claim to the insurer during the policy period will generally be forgiven by section 54.
- Where a claim (of which the insured had no prior knowledge) is made outside the policy period, section 54 will not assist the insured (there being no **failure** by the insured to notify the claim for section 54 to remedy) (see *DIF III – Global Co-Investment Fund LP v DIF Capital Partners Ltd* [2020] NSWCA 124).
- Where an insured is aware during the policy period of a circumstance that may give rise to a claim, but fails to notify the insurer of this circumstance, section 54 should apply unless the policy in question is a **claims made** or **claims made and notified** policy with no deeming provision. Section 54 does not forgive a failure to comply with section 40(3) of the ICA 1984, which requires a circumstance to be notified before the insurance policy period ends (see Know your policy type) (see *Gosford City Council v GIO General Ltd* [2002] NSWSC 511).

Further, insurance coverage rights may depend on other relevant policy provisions, such as those dealing with discovery periods, extended notification periods, run-off rights and continuous coverage clauses as well as prior and pending claim exclusions and retroactive coverage dates.

## Subrogation

Where an insurer has fully paid out on its indemnity to an insured under an indemnity insurance policy, the equitable rules on subrogation enable the insurer to

recoup all or some of that money from a third party who caused or contributed to the loss.

The rules on subrogation mean that once an insurer has fully paid out under an insurance contract, the insurer can "step into the shoes" of the insured and assume any rights the insured has against a third party that was responsible for causing the loss. The rationale of subrogation is to ensure that the insured does not recover the same loss twice, first against its insurer, and second against the third party.

Where rights of subrogation arise and are exercised by an insurer, the third-party claim will be brought in the insured's name, and the insured must cooperate with the policy terms to assist the insurer to recover its loss. Insureds should take care not to jeopardise or restrict an insurer's rights of subrogation in their dealings with third parties. Similarly, insureds should ensure that their rights with respect to recovery of any uninsured losses (such as the deductible) are not prejudiced by the insurer when exercising its right of subrogation.

Sections 64 to 68 of the ICA 1984 contain provisions that deal with subrogation.

For a legal update that considers the decision by the Federal Court of Australia (**Federal Court**) in *Technology Swiss Pty Ltd v AAI Ltd* [2021] FCA 95 in relation to subrogated recoveries when an insurer and insured retain a significant interest in the proceeds, see Legal update, Upholding insurers' right to subrogated recoveries: plan ahead or suffer the consequences!.

## Contribution

The issue of contribution arises where an insured has two or more separate contracts of insurance that both respond to the same loss. The principles governing contribution are outside the scope of this note, but be aware that:

- If the relevant insured loss arises, the general principle is that the insured is free to claim payment under whichever policy it chooses. However, this will be subject to the terms of the particular insurance contract.
- An insurer that pays out a claim under an insurance policy may be able to claim a contribution from another insurer (or insurers) that provide identical cover (section 76, ICA 1984). However, some insurers attempt to avoid the issue of having to contribute by inserting provisions that exclude loss where the insured has entered into another contract of insurance that also responds to the loss. These clauses are not always enforceable or effective (see *Allianz Australia Insurance Ltd v Certain Underwriters at Lloyd's of London Subscribing to Policy Number B105809GCOM0430* [2019] NSWCA 271). The insurer's ability to rely on an "other insurance" clause is regulated by section 45 of the ICA 1984, and may only be enforceable in relation to statutory insurances, specified policies or as against a non-party insured (see *Zurich Australia Insurance Ltd v Metals & Minerals Insurance Pty Ltd* [2009] HCA 50; (2009) 240 CLR 391).

## Insurance and risk allocation in commercial contracts

Commercial contracts (in particular those between a principal and contractor) frequently require a party to procure or hold insurances. The main reasons for doing this are to:

- Effectively allocate risk under the contract.
- Increase the contractor's ability to sustain losses and liabilities, remain in business and satisfy its contractual obligations (the greater the contract length and the more difficult it is to replace the contractor, the more important this is).
- Transfer the payment of a liability to a third-party insurer to reduce or avoid any conflict between the contract parties that could interfere with the contract performance and the parties' commercial relationship.

For further information on how to identify common types of risks and choosing the right strategy to mitigate and negotiate risks in commercial contracts, see Practice note, Limitation and exclusion of liability in commercial contracts.

### What insurances should be considered?

While the particular insurance requirements will vary depending on the nature of the commercial contract, the parties involved and the commercial bargain, typically the choice of insurance will be influenced by an assessment of:

- The risks arising under the contract.
- Which of the risks should be borne by the contractor and which should be insured on commercially effective terms.

- Any limitations on a party's liability.
- Which party is best placed to effect the insurance. It does not always have to be effected by the party to be insured (for example, sometimes a principal effects the insurances for the benefit of contractors).
- Cost considerations.

It will fall on the parties themselves to make these decisions, with the assistance of insurance advisers and specialist lawyers, if necessary. In many cases, the party required to take out insurances will already have this cover in place for its business. In others, the insurance cover will need to be taken out on a contract specific basis.

Note that many insurances will not cover risks assumed by a party by way of contract. For example, if a party releases another party from liability, the resulting risk to the first party may not be insured. Similarly, a contractual indemnity that alters the general law position may not be insured. For further information on how to review a party's insurance coverage as part of the assessment and negotiation of the contractual allocation of risk in a commercial contract and types of insurances often required, see Practice note, Limitation and exclusion of liability in commercial contracts: Reviewing a party's insurance coverage.

## Guidance when drafting insurance procurement requirements

It is often the case that commercial contracts contain short-form insurance procurement requirements that do little more than state the type of insurance and the limit of cover required. While this may be appropriate in some cases, you should always consider whether a more fulsome and prescriptive insurance procurement clause should be used, particularly when drafting this clause for the benefit of a client principal.

For more information, see Standard clause, Insurance.

The court will interpret these contractual clauses by giving them a businesslike interpretation in accordance with the ordinary principles of contractual interpretation, and consideration should be given to their meaning in the context of the whole contract (see *McCann v Switzerland Insurance Australia Ltd* (2000) 203 CLR 579; [2000] HCA 65).

Examples of some common practical issues to be aware of when drafting such clauses are set out below.

### Public liability insurance

The following issues should be considered in relation to public liability insurance:

- Where a principal is engaging a contractor to arrange public liability insurance, it may not be necessary to include the principal as an insured where the principal has its own public liability cover. In many cases, at most, it should be a requirement that the principal be included as an insured party solely for the purpose of covering its potential vicarious liability for the contractor's conduct. This is also known as **principal's liability cover**.
- The insurance should extend to cover damage to any property that belongs to the principal that will be under the contractor's care, custody or control.
- The limits of indemnity for public and products liability insurance are often misdescribed:
  - public liability insurance limits should be expressed as "$[AMOUNT] each and every occurrence"; and
  - product liability insurance limits should be stipulated to be "$[AMOUNT] each occurrence and in the aggregate for all occurrences in any 12-month policy period".

### Professional indemnity insurance

In relation to professional indemnity insurance:

- It is prudent to require the insurance cover to have a definition of professional services that is broad enough to include all professional services that are to be provided, including those supplied by any subcontractors.
- Consider the need to expressly require the insurance cover to extend to software and IT risks and unintentional breaches of trade practices laws.
- Policies commonly include a **retroactive date**. This date sets the limit on how far back in time conduct can occur that will give rise to an insured claim. Consider requiring that any retroactive date is no later than the first commencement of work that is to be covered. This may predate the contract.

- The limit of indemnity should be expressed as "$[AMOUNT] per claim in the aggregate for all claims in any 12-month period". It is not uncommon also to request that the limit of indemnity include a right of reinstatement, if the limit is exhausted by claims made during the policy period.

## Property and business interruption insurance

In relation to property and business interruption insurance:

- Where goods are being provided, the contractor should insure the goods and the principal's property (unless otherwise insured) for its full replacement or reinstatement value, as well as its own property that is material to the contractor's ability to perform its obligations under the contract.
- Business interruption insurance may be required to be taken out in conjunction with the property cover (where they are taken out together the package policy is known as an Industrial Special Risks policy). This insurance can provide cover for any loss of profit or increased costs of working that occur to the contractor's business following insured property damage.

## Period of insurance

While both occurrence and claims made insurances should be effected and maintained for the duration of the services being provided under the contract, claims made policies also need to be maintained for a further **run-off** period of between seven to ten years. This is intended to ensure that any claims that arise out of conduct occurring during the contract's life, but which do not materialise for several years, will be covered.

## Multiple insureds

Policies involving multiple insureds should prompt the parties to consider the need for them to include clauses that:

- Protect the position of innocent insureds from being prejudiced by the knowledge and conduct of other insureds (known as a **non-imputation** and **severability** clause).
- Provide that the policy covers claims between the parties (known as a **cross-liability** clause).

## Policy limits

Policy limits apply in different ways to different policies. The required minimum limit should be expressed as is appropriate to the policy. For example, some policies have limits that apply to each occurrence or claim (or series of related occurrences or claims); some have an aggregate limit for all claims and occurrences during the policy year, and others have limits set by time.

Be aware that policies will often stipulate sub-limits of cover for certain events where the full policy limit is not available. You should identify any relevant sub-limits of cover within the available insurance and ensure that the limits of insurance comply with the contractual terms by either obtaining increased insurance cover (if needed) or ensuring the contract contains matching sub limits.

Practitioners are often asked to comment on or suggest a particular limit of cover for insurances. While lawyers are able to comment on their experience of what they see as being a usual limit for this type of risk, practitioners are not qualified to give advice on an appropriate limit of indemnity for liability insurances and this question should always be referred to an insurance broker.

## Deductible and self-insured retentions

There should be some oversight of monetary and time deductibles, self-insured retentions and co-insurance terms to ensure that they are reasonable and do not undermine the intended cover.

## Insurer ratings

It is common practice to require that any insurer selected to provide insurance has a specified financial security rating by a recognised ratings agency. The contract may allow for the insurer to be other than as specified, with the principal's approval (generally, with agreement that the principal's approval will not be unreasonably withheld). External ratings are not always appropriate, such as, for example, when dealing with Lloyd's Syndicates (where the Lloyd's market itself is rated) or for statutory insurances.

## Self-insurance and captives

A party may seek to self-insure. This may mean:

- It has no insurance, in which case consider matters such as the party's balance sheet.

- It is a regulated self-insurer, for example, for workers' compensation. This is usually acceptable.
- It has a related body corporate that insures it (known as a captive). If so, there will be various risks as, for example, the captive will likely not be rated, may be wound up or domiciled in a jurisdiction with light regulatory supervision. Additional assistance from an insurance adviser or insurance law specialist should be sought.

## Evidence of insurance

When seeking evidence of compliance with the insurance requirements in a contract, the party that is taking out the required insurance should be obliged to provide a certificate of currency and in many cases also a complete copy of the policy wording, including the schedule and endorsements.

## Insurance issues: lessons from COVID-19

The outbreak of COVID-19 impacted various industries in different ways. The resulting disruption to travel, events, supply chains and operations meant that many businesses incurred significant costs and financial losses.

In general, when a business suffers losses, it is necessary to identify whether it has an insurance policy or policies that might respond to those losses (see First party loss insurance and third-party liability insurance). If it does, the business needs to review the policy wording carefully to see whether there is an extension of coverage or, conversely, a specific exclusion (see Reviewing an insurance policy).

Several types of insurance were potentially available to businesses that suffered losses due to the COVID-19 pandemic, and various coverage issues arose, with test cases litigated in the courts to determine them. The relevant types available were, in summary:

- **Business interruption insurance.** This is a policy that is effected with property insurance to cover lost revenue and other economic losses that flow from destruction of insured property by an insured peril. In most cases, business interruption insurance covers loss of income caused by physical damage to insured property, such as a building damaged by flood or fire. Some policies may include an extension of coverage for interruption caused by non-physical events. They may also have an extension for limited coverage for closure of premises on the order of a government or public authority due to health, safety or infectious disease concerns.

  Businesses previously affected by severe acute respiratory syndrome (**SARS**), Ebola disease or bird flu may have specific extensions included in their policies such as interruption by infectious/contagious diseases, interruption by mandatory closure for pandemic diseases or contingent business interruption or supply chain insurance. The terms of such extensions can vary greatly and may be subject to separate sub-limits and deductibles. However, some businesses may have limited coverage due to policy exclusions. Exclusions broadly applicable to pollutants or specific to viruses and/or bacteria have become more prevalent since SARS, Ebola virus and bird flu as insurers try to exclude coverage for losses from infectious diseases. In August 2020, a test case was heard in the NSW Court of Appeal to determine the effectiveness of certain infectious diseases exclusions in business interruption policies. Those exclusions referred to the *Quarantine Act 1908* (Cth), which was repealed and replaced in June 2016 by the *Biosecurity Act 2015* (Cth) (**Biosecurity Act 2015**). In November 2020, the test case decision was handed down (*HDI Global Specialty SE v Wonkana No. 3 Pty Ltd* [2020] NSWCA 296 (**HDI Global Specialty SE v Wonkana No. 3**)). The NSW Court of Appeal unanimously found that references in the policies to "diseases declared to be quarantinable diseases under the *Quarantine Act 1908* (Cth) and subsequent amendments" could not be construed to extend or refer to "diseases determined to be listed human diseases under the *Biosecurity Act 2015* (Cth)". The court held that, as a result, the diseases

exclusions included in those policies did not apply. In June 2021, an application for leave or special leave to appeal the decision was rejected by the High Court (for more information, see Insurance Council of Australia, BI test cases). In December 2020, in *Rockment Pty Ltd (t/a Vanilla Lounge) v AAI Ltd (t/a Vero Insurance)* [2020] FCAFC 228, the Full Federal Court considered the construction and effectiveness of an exclusion clause in the applicant's (the insured's) business insurance policy. The Full Federal Court unanimously rejected the insured's narrower interpretation of the exclusion clause in favour of the insurer's broader interpretation. The Full Federal Court determined (at [31]) that the cause of the claim necessary to trigger the exclusion is an emergency declared under the Biosecurity Act 2015. Policies containing similar or identically worded exclusions may have been more likely to exclude coverage for losses associated with the impacts of COVID-19. In February 2021, the Insurance Council announced the commencement of proceedings in the Federal Court to test the application of further issues regarding pandemic coverage in business interruption policies. This test case consisted of ten COVID-19 related business interruption insurance claims lodged by various small businesses (*Swiss Re International Se v LCA Marrickville Pty Ltd* [2021] FCA 1206). In contrast to the first test case, which contemplated the application of exclusion clauses (HDI Global Specialty SE v Wonkana No. 3), this test case marked a return to first principles in determining the threshold question of whether certain insurance clauses or policy extensions would provide cover to policyholders. In particular, this test case was concerned with determining the application of certain policy wordings in the context of the COVID-19 pandemic, including:

- infectious disease clauses, which generally provide cover for loss arising from the outbreak of an infectious disease at the insured premises or within a specified radius of the insured premises;
- prevention of access clauses, which generally provide cover for losses arising from certain government mandates preventing or restricting access to the insured premises because of a threat of damage to property or persons (often within a specified radius of the insured premises); and
- hybrid clauses, which generally provide cover for losses arising from government mandates preventing access to premises, but only where those mandates are made in response to the outbreak of infectious disease within a certain specified radius of the insured premises.

On 8 October 2021, the Federal Court found in favour of the insurers, concluding that policyholders were not entitled to cover in nine out of the ten insurance claims. In each of the nine cases, prevention of access clauses and hybrid clauses were found not to be applicable in the circumstances. This was primarily because the requirement for government mandates to be made in response to an outbreak of infectious disease was not satisfied given that none of the Commonwealth or state government orders were made as a result of the specific presence or outbreak of COVID-19 at the relevant policyholder's insured premises (or within a specified radius of the insured premises). In the remaining case, the court found that Victorian Government orders to stay at home were made in response to the spread of COVID-19 across Victoria (including within the specified radius of the insured premises) and concluded that an infectious disease clause did apply under a policy of insurance held by Meridian Travel. However, the court noted that there were other substantial hurdles for the policyholder to overcome in proving that it was entitled to any indemnity, such as whether its losses could be attributed to business interruptions caused solely by COVID-19. Five of the ten cases heard as a part of the test case were appealed. In November 2021, the Full Federal Court heard the five appeals together (see *LCA Marrickville Pty Ltd v*

*Swiss Re International SE* [2022] FCAFC 17) with the addition of a sixth appeal case (see *Star Entertainment Group Ltd v Chubb Insurance Australia Ltd* [2022] FCAFC 16, an appeal from a first instance decision that diseases declared under the Biosecurity Act 2015 were excluded and therefore coverage did not apply in the case of business interruption due to COVID-19). On 21 February 2022, the Full Federal Court delivered its judgment on the test cases appealed. In each case, the Full Federal Court substantially agreed with the findings of the Federal Court and dismissed the appeals, save for allowing minor points of appeal and cross-appeal, with the effect that:

- where no entitlement to coverage was found, it was unnecessary for the primary judge to answer the further questions posed by the parties (such as, whether interest was payable or third-party benefits should be accounted for when determining loss); and
- if Meridian Travel established an entitlement to recover under the infectious disease clause, then interest was payable under section 57 of the ICA 1984 from the date on which it became unreasonable for the insurer to withhold payment, and third-party benefits received (such as JobKeeper and the Victorian Government's Support Fund) were not to be accounted for when calculating the indemnity as the causal requirement of the methodology set out in the policy had not been met.

On 14 October 2022, the High Court refused an application for special leave to appeal these decisions. For further information, see Insurance Council of Australia, BI test cases.

- **Trade credit insurance.** This insures against the risk of non-payment by a contractual counterparty or guarantor. However, the cover may not have been available for financial loss arising out of COVID-19 if the debtor was excused from payment by a force majeure clause (for more information on force majeure, see Practice note, Force majeure).
- **Event insurance.** This is a bespoke policy that should be considered where an event is cancelled or postponed.
- **Travel insurance.** This should be considered where business travel plans are cancelled, and associated bookings lost. Travel insurance policy terms vary greatly. There may be no cover if the trip is cancelled voluntarily and out of precaution, rather than due to official restrictions on travel. Further, any travel arrangements that were made after the broad awareness of COVID-19 may not have been covered as the outbreak of COVID-19 was then considered a **foreseen event**. However, some types of travel insurance may cover **cancel for any reason** or **change of mind**.
- **Liability insurance.** These are policies that cover the insured's liability to third parties for injury, death or loss of or damage to property. These policies were relevant for business owners that faced liability claims brought by individuals who alleged they were infected with COVID-19 on the business's property or because of some action or inaction by the business. Those claims may have been faced by businesses operating in the hospitality and healthcare industries.

The experience of COVID-19 has highlighted the variation in policy, extension and exclusion wording in insurance contracts in the context of business interruption. Moving forward, it is critical for businesses to undertake a careful review of the insurance contracts they have in place. Many policies now expressly exclude cover for losses arising from COVID-19.

Insurance commonly has strict provisions requiring notification to insurers of actual or potential claims, and duties to mitigate loss. If there is actual or potential coverage for losses, the policy will require the insured to act promptly to notify the insurer and take steps to mitigate its loss or damage (see Making a claim or notifying a circumstance to an insurer).

As financial losses accrue over time, it is crucial to keep records to prove the direct causal

link between the insured peril and financial losses. Businesses should keep records of what happened, what was done to mitigate the impact, and relevant dates and timeframes. Some businesses, such as restaurants, may suffer an immediate impact, while others, such as retailers, may experience a delayed impact, for example, from delayed international shipments. Businesses should consider how their operations have changed since the insured peril and keep a record of all costs.

For further information, see Practice note, In-house lawyer's guide to assessing a company's insurance coverage and using insurance strategically.