PRACTICE OF CLAIMS AND LOSS ADJUSTING

CIP-07

V3

Technical contributors

Since it was first published, a number of technical contributors have updated, reviewed and verified specific and specialised sections of this textbook. Their work has been invaluable in producing such a comprehensive textbook and is much appreciated.

The following is a list of these contributors:

- **Niall Coppinger** ACII, Chartered Insurer
- **John Higgins** ACII Dip Inf Tech, Chartered Insurance Practitioner
- **Aoife Mc Kenna** FCII, Chartered Insurer
- **Sinéad Nolan** ACII, Chartered Insurer
- **Dr. Marc Sweeney** DBA MBA MSc FCII FCILA BSc (Hons) Psych

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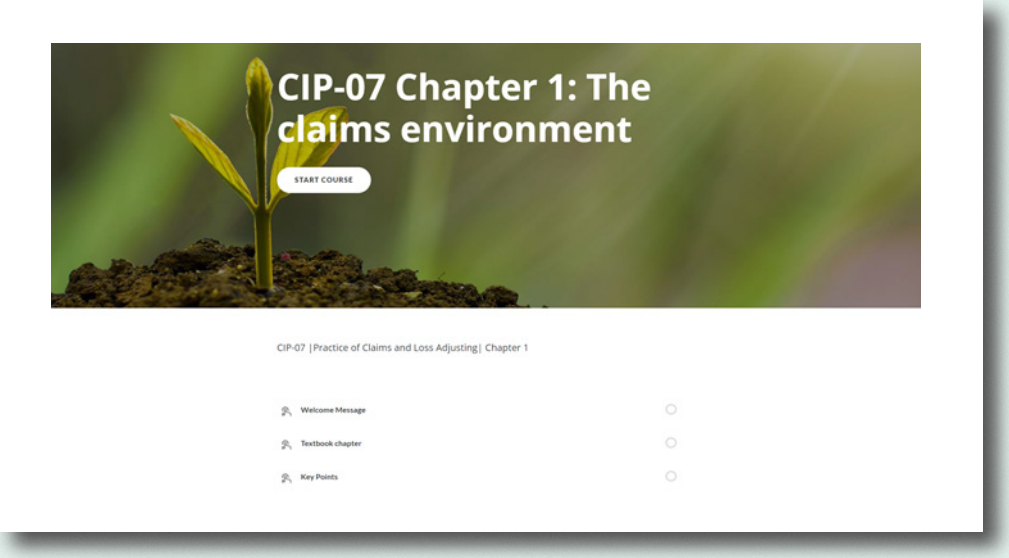

This section welcomes you to the module, identifies how you learn best, provides you with your learning plan and gives you invaluable study skills tips.

Your Guide to Success

Your guide to success is essential in getting you started on this module as it shows you how to plan your study and cover all the material ahead of your exam. It will help you find the best way to approach your study, give you advice on how to manage you time and ensure you give yourself the best chance of exam success.

Online study supports

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- an e-book
- an exam countdown timer
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Textbook

All of the questions that feature in your exam are based on the content in this textbook. The online supports listed on the previous page are there to aid your study of the textbook, not replace it. The textbook includes key features designed to help you break down and remember the material, as well as to understand central concepts. These features work as follows:

Examples: These indicate how theories operate in simple day-to-day situations.

Just thinks: These offer you an opportunity to interact with the material by applying your learning.

Key terms: These appear in the page margins and at the end of the textbook, and explain the meaning and context of insurance terms you may not have come across before.

Quick questions: These appear throughout the textbook and are designed to test your knowledge as you go. You can check your answers at the end of each chapter.

Reminder: These are reminders of or references to concepts, definitions or topics previously outlined or studied and outline how a topic works in practice.

End of chapter questions: These provide a great opportunity to test your learning and understanding of chapter topics. You can check your answers at the end of the chapter.

Case law: These outline the background to and details of relevant legal cases, illustrating the application of the rule of law being examined.

Claims scenario: This claims scenario was developed to provide you with a practical scenario, illustrating the application of the textbook material. This problem-based approach to learning supports easier study and practical application in your workplace.

Sample exam questions: These can be found at the end of each chapter and are examples of the types of questions that may appear on your exam paper. You should familiarise yourself with the types of questions asked, the key terms used (e.g. 'state', 'explain'), the amount of marks and time to be allocated to each question, and the examiner's suggested answers. These questions and answers are provided to help you to focus your study and prepare for your exam.

Insurance policy (and other) extracts: Throughout this textbook you will see references to insurance policies and other relevant sources, such as reports and legislation. The textbook summarises and abbreviates key information. You should be aware that policy extracts are not necessarily actual wordings, nor should they be taken as applying across the entire market. There are many variations of wording and ranges of exclusions. You are strongly advised therefore to acquire a number of policy wordings to see what exists in the market.

Websites: Throughout the textbook we refer to websites that can be used to provide additional context to your study material and keep you up to date with current trends and developments.
It is important to note, that you will only be examined on the information contained in this textbook.

Index: At the end of the textbook, there is an index of websites, legal cases, legislation, acronyms, key terms and formulae that provide a quick and easy reference to the material featured in this textbook.

Microlearning resources: These could be in the form of an infographic, an eLearning activity, a video or a publication. They have been developed to help you with challenging areas/topics. To access these, just log into the Member Area of www.iii.ie, click on the Connect logo, go into Your Learning Centre and select the microlearning section of the relevant chapter.

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Claims scenario 1

As an introduction to some of the topics covered throughout this textbook, a sample motor claims scenario is outlined below. Although the circumstances are more complex than most motor claims, they highlight some of the issues that claims handlers need to address at the different stages of the claims process.

The accident circumstances

Paddy, a van driver, is making a delivery for his employer, Jiffy Couriers. While driving the company van, he encounters road works being carried out by the Pothole Contractor Co. These works are poorly marked, forcing Paddy to swerve at the last moment, and causing his van to cross onto the opposite side of the road and collide with a car driven by Mary. After this impact, Paddy's van crashes into the gable wall of a house owned by Joseph.

Paddy's van is badly damaged because of the accident and he suffers injury to his knee and back.

Mary's car is also badly damaged. She and her passenger Jane suffer whiplash injuries.

Joseph's house is extensively damaged and is in a dangerous condition.

What are the potential claims in this scenario?

This is a complex accident, likely to involve many claims under different policies.

Some will be first-party claims, involving a person or company making a claim under their own policy. Others are third-party claims, where a person or company holds a policyholder responsible for injury or damage to property. We will see more about these distinctions in Chapter 1B.

The potential first-party claims are:

- Mary – for damage to her car under her comprehensive motor policy.
- Jiffy Couriers – for damage to their van under their comprehensive motor policy.
- Joseph – for damage to his property under his household insurance policy.

The potential third-party claims are:

1. Claims against Jiffy Couriers:
    - Mary, Jane and Joseph are likely to blame Paddy for the accident and make claims against Jiffy Couriers.
    - These claims will be dealt with by Jiffy Couriers' motor insurance policy.
    - Mary's claim will be for personal injuries and for her uninsured losses (e.g. the policy excess that was deducted from her claim under her own motor insurance policy).
    - Jane's claim will be for personal injuries.
    - Mary's motor insurer and Joseph's household insurer are likely to exercise their subrogation rights (Chapter 7C) and seek recovery of their claim payments (for the damage to Mary's car and to Joseph's house) from Jiffy Couriers and their insurers.

2. Claims against Pothole Contractor Co.:
    - Paddy is likely to blame Pothole Contractor Co. for the accident and allege that they created an emergency avoidance situation by not having a proper system of signage and traffic management.
    - His personal injuries claim will be dealt with by Pothole Contractor Co.'s public liability policy.
    - Jiffy Couriers may make a claim against Pothole Contractor Co. for their uninsured losses. Their motor insurer may seek recovery of their claim payments.
    - Although the claims from Mary, Jane and Joseph will be made against Jiffy Couriers initially, Pothole Contractor Co. is likely to become involved in the cases.

Initial actions

Each policyholder notifies the incident to their insurer under their respective policies (see Chapter 2A), so that the notification processes can start.

Because of the serious damage to Joseph's house, his insurer appoints a loss adjuster (see Chapter 4C1) to inspect the damage, arrange emergency repairs and prepare a report.

Mary's insurer arranges for her car to be towed and repaired by an approved repairer. The claims handler decides that the investigation may be conducted by a desktop claims handler (see Chapter 4B1) as things seem straightforward from her viewpoint. The handler is briefed by phone to complete enquiries from the office.

Jiffy Couriers' insurer also arranges for the vehicle to be towed and repaired. The claims handler considers the injuries and the potential dispute about who was at fault. Because of the serious potential of the claims, they appoint a claims investigator (see Chapter 4C4). The claims handler requests a site visit and photographs to assist investigations.

All the insurers involved will calculate a preliminary estimate of the cost of the claims that may be made under their policies. This is known as a claims case reserve (see Chapter 2E).

What happens next?

The first-party claims will be verified and investigated by the insurers. Assuming there are no policy cover issues, they will be eventually settled under policy terms.

All parties that sustained personal injury (Paddy, Mary and Jane) or damage to their property (Jiffy Couriers, Mary and Joseph) have a potential claim against another party. They must prove that this other party is legally liable (responsible) for their loss. They must also follow the correct legal procedures (see Chapter 6E); including notifying the Personal Injuries Assessment Board (PIAB) of their claim (see Chapter 6C).

The insurers acting for Jiffy Couriers and Pothole Contractor Co. will undertake detailed investigations to find out who was at fault. Following suggestions that the road works were not properly marked or managed, this may involve them using experts, such as consulting engineers (see Chapter 4C9a). The insurers will also seek information about the claims made against their policyholders. This will include medical evidence of injuries suffered and documentary evidence of loss of earnings or other losses.

It is likely that the parties will disagree on who was at fault. This may mean that one or more of the injured parties issues legal proceedings, allowing a judge to determine liability for wrongdoing (see Chapter 6). Other parties may agree to allow one case to run in court so that liability can be decided for all of the injury, damage and subrogation claims.

What's the likely outcome?

A judge will consider whether the accident was due to Paddy's negligent driving, or to the emergency created by Pothole Contractor Co.'s poorly marked roadworks. Let us assume that the court hearing decided that both parties were equally to blame, with liability apportioned on a 50/50 basis. Let us also assume that the insurers for both parties agree that this apportionment will apply to all other claims.

We will now consider what this means for each of the claims.

- Paddy's personal injury claim will be settled by Pothole Contractor Co.'s public liability insurer. Since Paddy was 50% at fault for the accident his compensation will be reduced by this percentage. This reduction is on the basis of his contributory negligence.
- The subrogation claim from Jiffy Couriers' motor insurer will be settled the same way. The insurer will recover 50% of their outlay and 50% of Jiffy Couriers' uninsured losses (e.g. their excess and other uninsured losses including car hire etc.).
- Mary, Jane and Joseph are innocent parties and their claims will be paid in full. These claims will be shared equally between Jiffy Couriers' motor insurer and Pothole Contractor Co.'s public liability insurer. The subrogation claims from Mary's and Joseph's insurer will also be settled this way.

Summary

This scenario is for illustrative purposes, designed to give you a flavour of some of the issues considered in this module and to aid your studies by referencing situations that can arise throughout the lifecycle of a claim. As we work through the textbook, we will see more about the issues mentioned here.

Claims scenario 2

Let us now look at a sample cyber claim scenario and examine the different stages of the claims process.

The incident circumstances

A hospital's computer system was the subject of a ransomware attack. The hospital incurred significant expenses attempting to restore the data from their computer systems. The hospital could not bill any of the health insurers, pay suppliers, arrange patient appointments, or communicate internally or externally while the system was affected. Additionally, the hospital could not access or safeguard the patient, staff, supplier, or government-linked data it managed. The malware completely corrupted the hospital's system.

What are the potential claims in this scenario?

This is a complex incident and there will be first-party claims, involving the costs the hospital will incur that are claimable under their own policy. There is also the potential for third-party claims to include data security and privacy, media liability, failure to supply etc.

The potential first-party claims are:

- Breach/attack response costs
- Network and business interruption
- System failure
- Data restoration
- Extortion payment etc.

The potential third-party claims are:

- Data security and privacy and costs in relation to any related GDPR breaches/exposures
- Brand reputation and possible media liability
- Failure to supply or operate as a result of the attack on the first-party IT infrastructure.

Initial actions

The policyholder (hospital) notifies the incident to its insurer. The cyber insurer will have a panel of specialist providers in place on a 24/7 basis that can immediately engage with the policyholder to secure the situation and engage with the threat actor.

What happens next?

The insurer will immediately engage its technology experts to work with the policyholder and the threat actor to block further deterioration of the threat posed. The insurer may deal directly with the threat actors with agreed settlement to cease the ransomware attack or the insurer may be in a position to manage data recovery and security independent of the threat actors' ransom.

What's the likely outcome?

The insurer will quantify and indemnify the hospital for its forensics costs (if there are additional costs), its data recovery, and any business interruption and costs associated with its crisis management.

Chapter

1

The claims environment

What to expect in this chapter

This chapter introduces you to the main stages of the claims process and the terminology used for different types of claims. It gives an overview of the 'journey' of a claim through this process, and considers the important regulatory provisions applying at the different stages. It also addresses the challenge posed by insurance fraud and actions insurers take to prevent, detect and combat fraud.

Contents

A Introduction to claims and the claims process

The claims department is often described as an insurer's 'shop window'. From a policyholder's perspective, the handling of a claim is the true test of their insurer and insurance policy. If the claim is not handled fairly or efficiently, it will not matter how inexpensive the policy was, or how good the service has been up to then. This is why insurers strive to deliver excellent customer service when a claim is made. A satisfied policyholder is more likely to renew their policy and recommend an insurer to others.

An insurer also has other very important responsibilities. We saw in The Nature of Insurance module that insurance operates as a common pool, where the premiums of many pay for the claims of few. The insurer must manage this pool effectively for its policyholders. It must make sure that claims are handled fairly and under the terms of the relevant policy, and that those making a claim comply with all the requirements for cover.

Insurers therefore devise detailed processes for handling claims. They also ensure that their claims department is structured and organised in a way that is right for the number and type of claims received, and that all procedures and activities comply with the relevant regulatory requirements (see Section C).

What is the difference between a policyholder, an insured and a claimant?

In claims correspondence and throughout this textbook, you will see the terms 'policyholder', 'insured' and 'claimant' used almost interchangeably.

Technically speaking, any party that makes a claim (either under its own insurance policy or as a third party) is a claimant. However, the term 'claimant' usually refers to the party who is making a claim as a third party against an insured (a person/organisation) for an alleged breach of the insured's legal liability towards them. The term 'policyholder' refers to the party in whose name the insurance policy (contract of insurance) was taken out while the term 'insured' refers to any party that is covered by the insurance policy.

What is meant by the terms first party, second party and third party?

You will see these terms used throughout this textbook and in claims correspondence if you have access to same.

The first party to an insurance contract is the person or party whose property or legal liability is insured under the policy. The second party is the insurer. Both of these parties have agreed to enter into the insurance contract.

A third party is a person or other legal entity who is not part of the insurance contract but who nonetheless may have a valid claim against the insured/first party. For example, a third party may allege that there has been a breach of a duty of care owed to them by the insured, resulting in injury or damage.

A1 The claims department

Irish insurers typically deal with claims through a separate claims department, headed by a senior figure such as a claims manager, or a head of claims.

The claims department can be structured in different ways. Some companies split claims handling between property damage and personal injury. Within the property damage area, there may be a further division between first-party and third-party claims (see Section B). There may also be further division into sections or work groups, with a section head or team leader overseeing and managing the work processes. The size of the organisation, the types or complexity of claims and the volumes involved normally decide the best approach. It is also common for insurance claims departments to outsource certain claims types such as travel, gadget or windscreen damage claims to an external claims service provider.

You will be aware of the many types of insurance policies. As Table 1.1 shows, these can be broken down broadly into two areas.

Table 1.1 Types of policy

Personal insurances	Commercial insurances
Household	Commercial property
Motor	Business interruption
Personal accident	Motor fleet
Pet insurance	Employers liability
Caravan and mobile home	Public liability
Mobile phone	Products liability
Guaranteed asset protection (GAP)	Professional indemnity
Legal expenses	Fidelity guarantee
Travel	Engineering, computer and cyber
Cyber	Contractors 'all-risks'
	Cyber

frequency (of losses)

how often an event will (or is likely to) happen

severity (of losses)

the seriousness (size / consequences) of an event (also referred to as 'impact')

Most claims departments deal with large numbers of relatively minor claims, and smaller numbers of claims involving large or complex losses. This is because of the usual relationship between **frequency** and **severity**. For every large loss, there will be many small ones. In practice, this means that a claims department will have a lot of claims handlers dealing with small and medium-sized property, household or motor damage claims, and a smaller number of more specialist claims handlers dealing with larger property losses, personal injury claims, professional indemnity claims, business interruption claims and other specialist losses such as cyber claims. We will examine the role of the claims handler in Chapter 4. The sheer variety of insurance policies creates major variations not only in the types of claim but also in the outcomes and costs of claims. Sometimes two seemingly identical events can result in very different payment outcomes. For example:

1. Two buildings of the same size catch fire. One is block-built with a tiled roof, but the other is built partly of wood with a corrugated iron roof.
2. Two people are involved in the same motor accident and suffer whiplash-type injuries. One recovers within 6 months, but the other takes 2 years to recover.

Given the range of claims circumstances and outcomes, how can insurers make sense of all this? How does the claims department maintain consistency, when many

hundreds of claims may be notified daily? They do so by having a robust process dictating how claims are handled. This process is typically contained in an insurer's 'claims best practice' document or 'claims handling manual'.

The claims process (see Section A3) should state the actions to be taken at each stage of a claim, i.e. from notification to settlement. The following are the main stages common to claims.

A2 The lifecycle of a claim

While claims differ, there are many common elements. Figure 1.1 outlines the main stages of the 'lifecycle' of a claim and we now look at the important questions at each point. All elements are examined in more detail later in this textbook.

Figure 1.1 Lifecycle of a claim

A2a Notification of the claim

The claims process begins when the policyholder or others, e.g. a broker or third party notifies the insurer about a claim or an accident that may lead to a claim. We consider the notification process in Chapter 2.

The insurer then requests some basic information, so that preliminary action can begin. This includes giving the claim to a claims handler with the appropriate experience and expertise, who will ensure that first steps are taken.

A2b First checks on the claim information

Following notification, the policyholder may be required by the insurer to complete a **claim form** or **accident report form**, or send other supporting documents. These documents (and other information) are checked to ensure that all is correct and to see if further enquiries are needed (see Chapter 3).

A2c Checking policy coverage

When initial checks are complete, the claims handler examines the claim in detail. This involves checking all aspects of cover and ensuring, for example, that the policyholder has complied with any relevant **policy conditions** and that no **exclusions** apply to the loss (see Chapter 3B1c).

claim form

document designed to elicit from the policyholder all relevant information surrounding the circumstances of a loss caused by an insured event

accident report form

preferred term for a claim form used in motor and liability insurance(s)

policy condition

a provision in an insurance policy that must be complied with

exclusion (exception)

policy provision that defines circumstances or types of loss that are not covered

A2d Investigating the claim

The initial gathering and checking of claim information and policy cover will direct further necessary investigations. This may involve a telephone follow-up, desktop handling, the use of in-house investigators, loss adjusters, or other experts. Chapter 4 looks at claims investigation. The investigation outcome determines if the insurer will pay the claim (and if it proceeds to the remaining stages described next).

A2e Quantifying the claim

When cover has been confirmed and investigations completed, the claims handler determines the value of the claim. As we will see in Chapter 5, this is based on the principle of **indemnity**, which ensures that the policyholder is compensated for their loss to the extent of the available cover. As we will see in Chapter 6, there are special considerations for quantifying third-party claims.

A2f Settling the claim

You will recall from The Nature of Insurance module that insurers have several options when settling claims. They may, for example, make a monetary payment or arrange for a damaged item to be repaired or replaced. For motor damage claims, they may instruct one of their approved repairers to rectify the damage. Chapter 7 examines the different options and considerations for the settlement.

indemnity

financial compensation sufficient to place the insured in the same financial position after a loss as they enjoyed immediately before the loss occurred

excess

first part of each and every claim that must be paid by the insured

Example 1.1

Conor accidentally crashes into a bollard causing damage to his car. He phones his insurer, XYZ Insurance to notify his claim. The claims handler asks a series of questions to check that Conor has comprehensive cover and that his car is covered on the accident date. Conor is also asked to complete an accident report form and send it to XYZ Insurance without delay.

The claims handler asks Conor to take his car to an approved repairer, where it will be inspected by a motor engineer. The engineer ensures that the damage to Conor's car is consistent with a vehicle damaged by a bollard and agrees the cost of repairs. When the repairs are complete, Conor collects his car from the garage and pays any **excess** that applies. The garage then sends an invoice to XYZ Insurance. The claims handler checks the invoice and settles the claim by electronically transferring payment to the garage.

A3 The claims process

An effective claims process increases customer satisfaction, fulfils consumer protection legislation and is cost-effective for the insurer. A top-performing claims service demonstrates delivery of the insurer's promise under a policy, and can be the most important selling point for the company's products.

As already noted, an insurer's claims process is typically written down on a step-by-step basis in a claims handling manual or claims best practice document.

Process maps or diagrams are also commonly used in claims departments. This is important where a claims handler may have a choice of actions, each leading to a different outcome. The direction taken in claims management can have cost implications, so all processes should be clear and unambiguous.

Devising first-party claims (see Section B1) processes is often straightforward, but must be done thoroughly and accurately. Complex claims involve multiple decisions and it is essential that processes and procedures are clearly set and followed. This provides clear steps for the claims handler, ensuring that best practice is observed, and allows time for making important decisions, e.g. engaging an expert.

In reality, the claims handling manual sets out what should be done at each stage in the lifecycle of a claim (see Section A2). It also covers other important areas, including the following:

- **'Fast track' claims:** Some claims can be settled at notification stage. Many motor windscreen claims or small household claims are notified in writing, enclosing an invoice for the loss. Windscreen claims may also be settled directly with an approved supplier, without any need for formal reporting by the insured. This allows the notification handler to register the claim, verify coverage and organise the settlement payment.
- **Reserving process:** As we will see in Chapter 2E, the claims handler must place a case reserve on each claim and must regularly review this amount. The claims handling manual will include the insurer's case reserving procedure and philosophy, including the monetary limit to which a handler can place a case reserve and what happens when a proposed reserve exceeds that level.
- **Negotiation process:** Each claims handler has authority up to an agreed settlement level. This is clearly documented in an authority letter, and a copy of this authority letter is issued to each individual claims handler.
- **Third-party experts:** The insurer's strategy for appointing experts will be set out together with guidelines on their appointment and management.
- **Issuing payment:** Each authority letter also confirms payment-issuing authority and the level to which payments may be issued by each claims handler. It also covers authority to approve and sign payment requisitions. This typically includes a requirement for a more senior handler to authorise large payments.
- **Audit process:** A robust audit or peer review process ensures that claims are handled in line with an insurer's standards and service levels. It also checks compliance with consumer protection, anti-money-laundering and **data protection** requirements. This audit includes examination of paper files, computer records and telephone interactions. For outsourced work, the process is applied to the activities of service providers engaged by the insurer.
- **Management information:** This covers both the ability to capture data for financial reporting and the capacity to analyse claims trends. For internal claims, it is used to identify claims volumes and costs.
- **Counter fraud management:** This enables claims handlers to look out for red flags or risk indicators indicating fraudulent behaviour.
- **Recovery process:** This sets out steps for claims handlers to take when recovering claims payments where subrogation applies.
- **Complaint management:** This sets out how claims handlers should react if a complaint is received and how to ensure that the complaint is handled in line with the CPC (see Chapter 7E).

data protection

term used to describe the individual's fundamental right to privacy of data kept in relation to them, and to their legal right to access and correct that data; also refers to the legal obligation by those who keep data to comply with data protection principles under the **Data Protection Acts** and **GDPR**

Quick question 1

Give two examples of claims that are typically settled through a 'fast track' claims process.

The answer is at the end of this chapter.

B First-party and third-party claims

We mentioned in Section A1 that claims departments can be structured differently. We referred to property damage and personal injury claims and **first-party** and **third-party claims**. This terminology may seem a little confusing if you do not work in a claims department.

Before we look at how first-party and third-party claims differ, let us think about some of the situations leading to claims. You should now re-read the claims scenario outlined at the start of this book. It describes a complex motor accident and how a number of different claims arise from the same incident. There are both first-party and third-party claims. Table 1.2 explains why these terms are used to categorise different claims.

first-party claim

any claim brought by the insured

third-party claim

a claim brought against the insured party by a person or entity (party) that was not connected with the original policy

Table 1.2 Parties to an insurance claim

First-party	The person insured under the policy (the policyholder).
Second-party	The insurer that issued the policy.
Third-party	Anyone else involved in a loss event. For example, in a motor accident, the third party might be another vehicle owner, property owner, a passenger or a pedestrian that suffered loss, damage or injury.

As we have already learned in the claims scenario, a single accident can give rise to both first-party and third-party claims.

B1 First-party claims

In general insurance, first-party claims typically involve damage to the insured's property. They include, for example, claims under:

- Commercial property and business interruption policies
- Household policies
- Motor (own damage)
- Personal accident policies
- Travel policies.

The first-party is a customer of the insurer and makes their claim under a contract of insurance (the insurance policy). When handling a first-party claim, the claims handler is aware of the insurer's service standards. These standards balance the need to deal with the claim fairly, efficiently and sympathetically while only paying valid claims. As we will see in Section C, the claims handler also observes the relevant regulatory requirements and deadlines.

In handling first-party claims, the claims handler often deals directly with the insured, or their intermediary (such as a broker or loss assessor). When checking and investigating a claim, the priority is to establish the existence and scope of cover. If cover is in order, the claim is settled according to the terms of the policy.

Microlearning resources

In the Member Area of www.iii.ie, via the Connect logo and in Your Learning Centre, select the microlearning section of this chapter to access a resource specifically developed to help you better understand this topic.

B2 Third-party claims

Third-party claims may be for property damage or personal injury. These claims are made against the negligent insured (the first party), for which a third-party motor or liability policy may provide cover. Table 1.3 provides some examples.

Table 1.3 Examples of third-party claims

Motor accident claims	• Damage to vehicles and other losses, such as excesses or car hire costs • Damage to other property (e.g. walls or fences) • Injury to drivers, passengers or pedestrians.
Public liability claims	• Injuries to visitors or customers • Damage to buildings caused by the insured's machinery • Damage to property caused by the insured's employees (e.g. fire damage during welding or other building work).
Employers liability claims	• Injury or death to the insured's employees (e.g. from a fall at work or when using machinery) • Work-related disease or sickness, e.g. occupational asthma, hearing loss, asbestos-related diseases • Vicarious liability (e.g. where an employer is deemed liable for a wrong committed by an employee).
Professional indemnity claims	• Financial loss to a client caused by the insured's negligent advice e.g. bad advice from an accountant leads to a client facing a large tax liability • Breach of confidence e.g. where private information is disclosed by the insured without the consent of the third party. • Loss of title documents e.g. lawyer has lost client's property title deeds.

It is important to note that where the first party has no legal liability, the third party's claim will not succeed. For example, the **Accidental Fires Act 1943** protects a property owner from third-party claims arising from an accidental property fire.

When handling third-party claims, the claims handler may deal directly with third parties, with the **Personal Injuries Assessment Board** (PIAB) and/or with the third party's legal representatives. They also deal with the insured, particularly at the notification and investigation stage. As with first-party claims, the claims handler must first establish the existence and scope of cover. Third-party claims need additional investigations to find out if the insured is liable (responsible) for the alleged injury, loss or damage.

When cover is confirmed, the claims handler begins either defending or negotiating settlement of the claim on the insured's behalf. As we will see in Chapter 6, this can be a complex process, possibly resulting in a court hearing.

Personal Injuries Assessment Board
independent statutory body set up to assess compensation due to an injured party when someone else is to blame for the injury

B2a How do third-party claims arise?

A third-party claim arises from the insured's breach (or alleged breach) of a legal duty. You will recall from The Nature of Insurance module that the law of **torts** specifies the legal duties we owe towards one another. Table 1.4 shows examples of some of the main torts.

torts
a civil wrong

Table 1.4 Examples of torts

Tort	Definition	Example
Negligence	A failure to exercise the care that a reasonable person would have shown in similar circumstances.	A motor accident caused by a driver's carelessness. Damage to a newly built property caused by the engineer's poor design.
Trespass to the person	Causing deliberate or reckless physical harm or restraint to another person.	A security person uses excess force when removing a customer from a bar, causing injury.
Trespass to goods	Wrongfully interfering with things that another person owns or is responsible for.	A tenant damages or removes their landlord's property.
Trespass to land	Unlawfully entering, refusing to leave or placing an object on another person's land.	A farmer allows their animals to stray onto a neighbour's land where they cause damage.
Private nuisance	Unlawfully interfering with a person's use or enjoyment of their land.	A person disturbs their neighbour by playing loud music every night, causing them nuisance and possibly injury.
Defamation	A false statement about a person that causes injury to that person's reputation.	A newspaper publishes false accusations against a politician which leads to a right for damages.

trespass
intentional interference with people, goods or land

negligence
failure to take reasonable care in certain circumstances

damages
financial compensation fixed by the court according to the seriousness of the injury or damage caused

Most third-party claims are based on the tort of **negligence**, making the third party prove that their injury, loss or damage was a direct and foreseeable result of the insured's failure to take reasonable care. If an insured fails to take reasonable care and causes injury, loss or damage to another, they may be liable to pay **damages**. A driver, for example, is responsible for injuries and damage to property caused by their negligent driving. An employer may also be responsible for injuries caused to employees because of faulty work equipment or inadequate training.

C Impact of the Consumer Protection Code

You will recall from the Compliance and Advice module that all stages of the insurance process are subject to the Consumer Protection Code (CPC).[1] We will now look at the CPC's impact on the claims process.

Students should note that the Central Bank of Ireland (Central Bank) are undertaking a substantial review of the CPC. There are 8 themes in the Discussion Papers including:

1. innovation and disruption
2. digitalisation
3. unregulated activities
4. pricing
5. informing effectively
6. vulnerability
7. financial literacy, and
8. climate matters.

It is expected that the new consumer protection framework will take the form of Regulations as opposed to a statutory code. It is likely to be in effect by the end of 2024. Until then, we will look at the current CPC's impact on the claims process.

C1 Claims handling procedures

Under the CPC, insurers must have written procedures for effective and proper claims handling. The CPC specifies minimum requirements, but we saw in Section A1 that insurers have more detailed procedure manuals for claims handling usually called the 'claims handling manual'. Under the CPC, this procedure must at least provide the following:

- Where an accident occurs and personal injury is suffered, a copy of the PIAB claimant information leaflet is issued to the **claimant** as soon as it is notified.
- If a motor accident involves an uninsured or unidentified vehicle, or a foreign-registered vehicle, the insurer must advise the potential claimant to contact the **Motor Insurers' Bureau of Ireland** (MIBI).
- A claim form (where required) must be issued within 5 business days of notification.
- The insurer must offer to assist the claimant in making a claim, highlighting any beneficial policy terms and conditions.

Claimant

person or entity making a claim

Motor Insurers' Bureau of Ireland

body set up between motor insurers and the government, which aims to ensure that innocent victims of road accidents are properly compensated in circumstances where no effective motor insurance is in force (uninsured or untraced vehicles)

[1] The Central Bank Consumer Protection Code is available at www.centralbank.ie.

- A record of all conversations with a claimant must be kept.
- While a claim is progressing, an insurer must provide updates of developments affecting the claim within 10 business days of each development.
- Any additional documentation or clarification must be requested from the claimant as soon as required and, if necessary, a reminder issued in writing.
- A claim must be paid within 10 business days of the claimant accepting an offer.

An insurance intermediary helping a consumer to make a claim must, on receipt of completed claims documentation, send such documentation to the relevant **regulated entity** within 1 business day.

In Section A2, we said that claims checking and investigation are important elements in the lifecycle of a typical claim. This is also a regulatory requirement, as shown in Extract 1.1.

regulated entity

a financial services provider authorised, registered or licensed by the Central Bank or other EU or EEA Member State that is providing regulated activities in the State

1.1 Extract CPC and claim validity

Provision 7.6 A regulated entity must endeavour to verify the validity of a claim received from a claimant prior to making a decision on its outcome.

We will see more about how claims handlers verify claims in Chapters 3 and 4.

C2 External (and internal) experts and the CPC

If an insurer engages the services of a **loss adjuster** and/or expert appraiser, it must notify the claimant of their contact details and the fact that the loss adjuster/appraiser acts in the interest of the insurer and maintain a record of this notification.

Extract 1.2 outlines the CPC's requirements regarding the use of loss adjusters and **external experts**.

loss adjuster

expert in processing claims from start to finish (and appointed by the insurer)

external expert

professional, e.g. solicitor, claims investigator or motor assessor, who is employed by an insurer on a per-claim basis but does not work directly for the insurer

1.2 Extract CPC requirements in relation to the use of third parties

Provision 7.9 Where a regulated entity engages the services of a loss adjustor and/or expert appraiser, it must notify the claimant of the contact details of the loss adjuster and/or expert appraiser it has appointed to assist in the processing of the claim and that such loss adjuster and/or expert appraiser acts in the interest of the regulated entity and the regulated entity must maintain a record of this notification.

Provision 7.10 In the case of motor insurance and property insurance claims, and other claims where relevant, the regulated entity must notify the claimant that the claimant may appoint a loss assessor to act in their interests but that any such appointment will be at the claimant's expense and the regulated entity must maintain a record of this notification.

Duty to deal with a third party instructed by a claimant

Provision 7.11 At the claimant's request and with the claimant's written consent, a regulated entity must engage with a third party which a claimant has appointed to act on his or her behalf in relation to a claim.

When the insurer uses a direct contractor to carry out repairs, they must tell the claimant what work will be done and at what cost. They may not ask the claimant to certify the work and must certify that it at least puts the claimant back in the position they were in before the loss.

1.3 Extract CPC requirements in relation to the use of third parties

Provision 7.13 Where an insurance undertaking appoints a third party to undertake restitution work in respect of a claim, the insurance undertaking must provide the claimant in advance and on paper or on another durable medium, with details of the scope of the work that has been approved and the cost.

Provision 7.14 Where a method of direct settlement has been used, a regulated entity:

a) must not ask the claimant to certify any restitution work carried out by a third party appointed by the insurance undertaking; and

b) must certify, on paper or on another durable medium, to the claimant that the restitution work carried out by the third party appointed by the insurance undertaking has been carried out to restore the claimant's property at least to the standard that existed prior to the insured event.

Quick question 2

Identify the document that must be issued to a claimant in a personal injury claim immediately on notification.

C3 Claims settlement

The regulatory requirements that apply to claims settlement were covered in The Nature of Insurance module. In summary:

- An insurer must investigate a claim thoroughly before making a decision on its outcome.
- An insurer must communicate its decision and any settlement offer to a claimant within 10 business days of making a decision. This communication must be in a **durable medium**, such as a letter or email.
- The claimant must be allowed at least 10 business days to accept or reject a settlement decision or offer, but the claimant may waive this period if they wish.
- A claim must be paid within 10 business days of the claimant accepting an offer.
- When a payment is made to someone other than the policyholder, the insurer must inform them in writing at the time of the settlement of the final outcome of the claim.

durable medium

any instrument that enables a recipient to store information addressed personally to the recipient in a way that renders it accessible for future reference, for a period of time adequate for the purposes of the information and which allows the unchanged reproduction of the information stored

C4 Complaints

A regulated entity must have a written procedure for the proper handling of complaints. This need not apply where the complaint has been resolved to the complainant's satisfaction within 5 business days, provided that a record of this fact is maintained. You will recall from the Compliance and Advice module that there are strict rules and timescales for responding to and dealing with complaints.

Insurers and intermediaries must keep an up-to-date log of all consumer complaints. They must also undertake regular appropriate analysis of consumer complaints patterns, including investigating whether complaints indicate an isolated or a more widespread issue. This analysis of consumer complaints must be communicated to the regulated entity's compliance/risk function and senior management.

Example 1.2

The importance of adherence to these provisions was clearly demonstrated by the Central Bank in January 2021 when it announced that Keystone Insurance had been fined €41,385 for overcharging customers and providing 'unclear' communication on fees to customers. The Central Bank's Director of Enforcement and Anti-Money Laundering, said that :

> "Insurance intermediaries are required to recommend the most suitable product(s) to meet their customers' needs and to always act in their best interests. The Central Bank expects that all regulated firms should have adequate processes, systems and controls in place to ensure compliance with the Code, ensure staff are trained on the Code's provisions, regularly check that they are in compliance with the Code and ensure that any failures that may occur are identified and rectified early"[2].

Example 1.3

In September 2022, the Central Bank imposed a record-level fine of just over €100 million on the Bank of Ireland. The fine was a culmination of breaches made by the firm under the following regulatory instruments:

- **European Communities (Unfair Terms in Consumer Contracts) Regulations 1995**
- **European Communities (Unfair Terms in Consumer Contracts) Regulations 1995 and**
- **Consumer Protection Codes 2006 and 2012.**

We will consider dispute resolution and the role of the **Financial Services and Pensions Ombudsman** (FSPO) in Chapter 7.

Financial Services and Pensions Ombudsman (FSPO)

an office that deals independently and impartially with unresolved complaints from consumers about the conduct of a regulated financial service provider

Just think

Think of your own firm's internal complaints procedures.

[2] Adapted from Central Bank of Ireland, 'Enforcement Action Notice: Keystone Insurance Limited reprimanded and fined €41,385 by the Central Bank of Ireland for breaches of the Consumer Protection Code 2012', online press release, 28 January 2021

C5 Vulnerable consumer

The Central Bank tries to protect **vulnerable consumers** by defining and making specific provision in the CPC. Regulated entities must specifically address these requirements within their claims process and ensure that the claims process does not take unfair advantage of a vulnerable consumer.

vulnerable consumer

a natural person who:

a. has the capacity to make their own decisions but who, because of individual circumstances, may require assistance to do so (e.g. hearing impaired or visual impaired persons)

b. has limited capacity to make their own decisions and who requires assistance to do so (e.g. persons with intellectual disabilities or mental health difficulties)

- Consumer Protection Code (Definitions)

1.4

Extract CPC and vulnerable consumers

Provision 3.1

Where a regulated entity has identified that a personal consumer is a vulnerable consumer, the regulated entity must ensure that the vulnerable consumer is provided with such reasonable arrangements and/or assistance that may be necessary to facilitate him or her in his or her dealings with the regulated entity.

The PIAB website (www.piab.ie) also recognises this category of consumer and provides special supports for 'identifiable vulnerable claimants'. Although legal fees do not form part of the standard assessment award, PIAB does generally allow some contribution for legal assistance for vulnerable consumers when making its awards.

Insurers must demonstrate that they have a policy in place that sets out how they deal with vulnerable consumers. They must also have written processes which outline the practical steps they take to support vulnerable consumers through the claims process.

C6 Central Bank themed inspections

The Central Bank regularly undertakes themed inspections to ensure regulated entities continue to comply with various statutory codes (e.g. CPC) and Directives. These themed inspections focus on a specific topic, product or practice as opposed to focussing on a particular regulated entity. The Central Bank has undertaken numerous claims-related themed inspections and details of these can be found on the Central Bank website (www.centralbank.ie). When the inspections are completed, the Central Bank communicates with the industry about its findings via an industry letter which is made publicly available.

D Insurance fraud

Most insurance claims are genuine and are settled by insurers under the terms of a policy. A minority of policyholders and third parties make false or exaggerated claims with the view of making a financial gain at the insurer's expense. The cost of insurance fraud in Ireland is estimated to be €200 million annually.[3] It is widely accepted that this adds approximately €50 to each insurance premium. This is a serious issue for the insurance industry, for society as a whole and for honest policyholders who ultimately pay for fraudulent claims through higher premiums.

Insurance fraud can also comprise money-laundering activities whereby criminal or terrorist organisations may seek to 'clean' or 'wash' money which is the proceeds of criminal activity through apparently legitimate channels, such as insurance policies. To tackle this, insurers are required to follow strict and comprehensive 'know your customer' procedures which include identity checks on the persons or corporations applying for insurance cover. A series of EU Anti-money laundering Directives place requirements on obliged entities (e.g. insurers) to have policies and procedures in place to prevent money-laundering.

You may recall from the Practice of Risk Control and Underwriting module that there are two main types of insurance fraud: opportunistic fraud and premeditated fraud.

- Opportunistic fraud is often committed by otherwise law-abiding citizens. It includes, for example, exaggerating the extent of a genuine incident by alleging that more items were stolen or damaged than was the case.
- Premeditated fraud is more calculated as it's a planned effort to submit a false claim. For example, a fraudster acquires a damaged vehicle, takes out an insurance policy, alleges that the car skidded into the wall damaging the vehicle and injuring the passengers – all with an intention of benefitting from the claim for the vehicle damage and personal injury claims made by the passengers.

[3] Insurance Ireland (www.insuranceireland.eu). 'Insurance Fraud'.

D1 Possible fraud indicators

All claims handlers must be alert to indicators that a claim is potentially fraudulent. Just as it is impossible to guarantee that all fraudulent claims will be identified, it is also impossible to provide a comprehensive list of all potential fraud risk indicators. However, some of the most common indicators include:

- Overstatement of claims
- Late notification of a claim
- Lack of original documents
- Altered documents
- Lack of evidence of ownership
- Multiple insurance policies covering the same risk
- Unusual changes to cover shortly before an alleged event (e.g. changes in sums insured or addition of specified items)
- Inconsistent, vague or changing accounts of the circumstances giving rise to a claim
- Multiple claims
- A claim occurring shortly after inception of a policy
- Changing attitude from friendly and helpful to aggressive and evasive.

The following sections look at some of these fraud indicators in more detail.

D1a Overstatement of claims

Not every overstatement of a claim is fraudulent. Some claimants may 'round up' a claim payment based on their inflated perception of an item's value to them – this is not considered fraud.

Major overstatement of a claim should raise suspicions that the inflated aspect of the claim is false and the claims handler should investigate further. A loss adjuster will look closely at the circumstances of the loss and the documentation submitted. If the insured cannot verify the full extent of their alleged loss, insurers may decline an aspect of their claim. The onus is on the insured to prove their loss. Most policy conditions include a fraud condition enabling an insurer to decline a claim if a false document is submitted by the insured. Note that such right can be enforced even if other aspects of the claim are genuine.

However, claims handlers need to be careful. In the Irish case, *Superwood Holdings v Sun Alliance & London plc and Others* (1995), also known as the 'Superwood case' the Supreme Court held that exaggeration is not conclusive evidence of fraud, 'for a man might honestly have an exaggerated idea of the value of the stock, or suggest a high figure as a bargaining price'. This confirmed the position previously established in UK case law.

The Civil Liability and Courts Act 2004 introduced standards in relation to the proving of fraud. Section 26 of the **Civil Liability and Courts Act 2004** prohibits plaintiffs from knowingly giving evidence that is false or misleading. If an application under Section 26 is successful, the plaintiff's entire claim is dismissed, even if there is a liability on the part of the defendants for a part of the claim. There is an exception where the court considers that a dismissal would result in an injustice.

Case law

The Court of Appeal case of *Platt v OBH Luxury Accommodation Limited & Anor (2017)* established certain principles required to bring a successful Section 26 application. It was held that the standard of proof that is required was the balance of probability but regard must be had to:

i. the seriousness of the matter being alleged

ii. the gravity of the issue

iii. the consequences in considering the evidence necessary to discharge the onus of proof and

iv. the fact that mere errors by the plaintiff were not enough to sustain a Section 26 application by the defendant.

D1b Late notification of a claim

The reasons for the late notification for a claim to an insurer could be entirely legitimate and reasonable. Nevertheless, a claims handler should always investigate late notification as it is possible that if the stated incident is said to have occurred some time ago, it may be difficult for the insurer to establish the circumstances and the extent of the loss. It could also be the case that a policyholder presents a claim which occurred some time ago in order to obscure the circumstances which gave rise to the loss, in which case this is considered to be fraud. However, it must be remembered that under the **Consumer Insurance Contracts Act 2019**, an insurer cannot decline a claim made under a consumer insurance contract for late notification unless there is evidence of prejudice to their position.[4]

D1c Lack of evidence of ownership

Frequently an insured cannot produce a purchase receipt to prove that they originally owned any property allegedly stolen, damaged or lost. This may not cause concern in itself, as many people do not routinely keep receipts. For valuable or large items, the insured should be able to produce some other evidence of ownership. For example, if it is part of a large inheritance, they might produce a copy of a will. Other examples are a photograph of the insured wearing the lost jewellery or showing the stolen or damaged antique furniture (or picture) in the background. If something was a gift, the donor may be prepared to verify the gift and its approximate value.

D1d Multiple insurance policies covering the same risk

If there are multiple policies of indemnity, e.g. fire policies, then an insured who successfully attempts to make more than one claim for the same incident will receive more than their entitlement. If this is done innocently and the insured declares the additional policies, then the question is dealt with by seeking contributions from all insurers involved. If the additional policies are concealed by the insured, this should suggest fraud. The problem arises less often in insurance classes such as personal accident policies, which are not policies of indemnity, so the insured may be claiming legitimately. If there is a large number of policies providing a substantial total benefit, this may indicate possible fraud and require full investigation.

[4] The **Consumer Insurance Contracts Act 2019** only applies to natural persons not acting in the course of business and sole traders, partnerships, trust clubs, charities or incorporated bodies (i.e companies) with an annual turnover of €3million or less. Therefore, insurers may generally continue to decline claims made under non-consumer insurance contracts for late notification without proving prejudice.

Example 1.4

Two separate claims for burglaries in the same geographic area amounted to €103,000 and both claims were very similar. Investigations discovered that the two claimants were good friends and it was proven that together they had staged their own burglaries. These cases were successfully prosecuted. One of the claimants was made pay €12,000 to the court, which was distributed between charities in the local area.

Quick question 3

List four possible indicators of a fraudulent claim.

D2 Fraud in third-party claims

The fraud indicators outlined in Section D1 apply mainly to first-party claims. Claims handlers must also consider the potential for fraudulent third-party claims. This can take a number of forms, including exaggeration of the injuries or financial losses suffered in an accident.

Another example is 'staged motor accidents' where criminal gangs either induce innocent motorists to hit their vehicle or deliberately cause crashes. This is a type of premeditated fraud, in which these crashes are used to generate fraudulent personal injury claims from allegedly injured passengers.

In some instances, the parties to a genuine accident allege that there were more passengers in the car in order to submit additional personal injury claims. These alleged passengers are referred to as 'phantom passengers'.

When investigating a third-party claim, an insurer probes all aspects of a case to ensure it is genuine. Where a plaintiff knowingly gives false evidence to mislead the court, Section 26 of the **Civil Liability and Courts Act 2004** allows the judge to dismiss the claim entirely, including the legitimate elements of it, unless the dismissal would result in an injustice. Fraud is a crime and those making fraudulent claims face a number of serious sanctions.

Judges can dismiss a claim in its entirety, because of alleged exaggeration. However, the argument to dismiss the claim in its entirety was not successful for the defendants in the case of *Dunleavy v Swan Park Ltd t/a Hair Republic* (2011).

Case law

The plaintiff's hair was damaged because of a colour treatment. It took 18 months to grow out. Her energy levels fell and she withdrew from social activities as a result of this incident. The defendant argued that the plaintiff failed to disclose a history of depression and a previous motor accident. It argued that she was exaggerating her income and effects on her social life and maintained that the claim should fail under Section 26 of the Civil Liability and Courts Act 2004. O'Neill J accepted the evidence of the plaintiff and awarded €30,000 general damages and €15,000 special damages. He commented that Section 26 could only be availed of to deter fraudulent claims and could not be relied on to dismiss a claim on the basis of mere anomalies or inconsistencies.

Visit www.insuranceconfidential.ie to read about more cases of insurance fraud.

D3 Fraud investigation

In all cases of suspected fraud, a balance must be struck between meeting honest claims fairly, equitably and promptly, while fully investigating possible fraudulent claims. The high burden of proof required has always made it difficult for insurers to prove and show that there was intent to commit fraud. Many insurance companies have dedicated teams that investigate potentially fraudulent claims. These are called Special Investigation Units (SIUs) or anti-fraud teams. If a claims handler suspects a claim may be fraudulent, they pass this claim to the SIU team. This team will examine and investigate the claim thoroughly, using social media, skilled interviewing techniques and sometimes private investigators.

witness

any person who is in a position to give evidence about the circumstances of an incident or the losses that the claimant has incurred (or not)

A detailed statement taken by an experienced investigator and promptly applied may be very useful when investigating a potentially fraudulent claim. The investigator explains to the policyholder why the investigation is being undertaken. This statement is very valuable if discrepancies are discovered in reviewing **witness** statements in subsequent discussions with Gardaí or if the statement made is very different to documentary evidence. If sufficient evidence is gathered to suggest the probability that a claim is fraudulent, then the insurer should also report the matter to the Gardaí or other appropriate authorities and cooperate with them in any prosecutions. Proving insurance fraud is difficult and many suspected frauds have to be settled due to lack of proof.

Working together, the Garda National Economic Crime Bureau and Insurance Ireland compiled *Guidelines for the Reporting of Suspected Fraudulent Insurance Claims* which defines what constitutes serious insurance fraud and outlines the process and documentation involved in referring a suspected fraud file to An Garda Síochána for investigation. These guidelines can be found on www.garda.ie.

In September 2021, the Insurance Fraud Coordination Office (IFCO) was launched in Ireland as part of continued efforts to tackle and eradicate insurance fraud. IFCO is a wholly dedicated unit of An Garda Síochána that operates under the remit of the Garda National Economic Crime Bureau (GNECB). It deals with complaints of insurance fraud and aims to secure more prosecutions against those committing insurance fraud. These prosecutions should create a deterrent, lead to less instances of insurance fraud and ultimately lower insurance premiums.

D4 Technology in fraud investigation

Fraud is a major concern across the financial services sector, prompting firms to seek a multi-disciplinary approach to its prevention and detection. Along with traditional methods used within a claims department and the various industry initiatives, insurers are also looking at the possible value of using digital and technological methods.

D4a Industry databases

InsuranceLink

a database of past claimants, maintained by Insurance Ireland

InsuranceLink is the industry database for recording both first and third-party claims. It assists in the detection and defence of exaggerated and fraudulent claims. It contains details of claims made by individuals against insurers, insurance policyholders or directly against self-insured members of the service (including local authorities and public bodies). It records both property damage and personal injury claims.

InsuranceLink is a key instrument in fraud prevention and detection. Members record new claims on the database and receive a match report if somebody has made a previous third-party claim (third-party claimant), first-party claim (first-party claimant), or had a third-party claim made against their policy (respondent). It is important to note that a match report does not necessarily mean a claim is fraudulent or exaggerated. It may prompt an insurer to carry out further investigations or arrange a medical examination.

The National Claims Information Database is managed by the Central Bank and was introduced by the **Central Bank (National Claims Information Database) Act 2018**. This Act allows the Central Bank to collect and analyse data provided by insurers in relation to:

- claims costs
- the income generated in relation to general insurance and
- the costs associated with managing claims.

Other databases used by insurers include:

- **National Fleet Database (NFD)** – This adds fleet and motor trader registration numbers to the existing Automatic Number Plate Recognition (ANPR) system, which holds the registration numbers of all privately-owned vehicles.
- **Fine Arts Loss Register** – This contains details of stolen or missing works of art.
- **Integrated Information Data Service (IIDS)** – Some insurers have an arrangement with the Department of Transport allowing them to verify the number of penalty points recorded on a driving licence. The service also allows insurers to verify the No Claims Discount entitlement.

D4b Fraud modelling

Fraud modelling uses data analytics to spot opportunities for fraud and to track potentially fraudulent activities. It also ensures that lessons are learned and incorporated into strategies to tackle fraud. This is already used in the banking sector to combat credit card fraud.

Fraud modelling also helps firms to identify possible weaknesses in their internal systems and controls by spotting trends and patterns that may not be apparent in other methods of analysis. This allows prompt action against threats and weakness. Although a relatively new development, this may play a major role in how insurers identify and tackle fraud in the future.

D4c Telematics

High insurance premiums; particularly for young and inexperienced drivers have led some insurers to introduce motor policies which require the policyholder's driving to be monitored either via a mobile phone app or via a 'black box' device installed in the vehicle. With the policyholder's consent, the vehicle's telematics data is reviewed by the insurer and the premium is adjusted to reflect poor or safe driving (e.g. speed, braking etc.). Vehicle telematics data can also be used by fraud investigators as it includes full global positioning system (GPS) data which details the vehicle's journeys (date, time, location). This can be compared against the statements from the policyholder and third parties in an event of a suspicious claim. Wider use of the vehicle telematics is one of the recommendations made by the Cost of Insurance Working Group.

D4d Social media

Many insurers use social media such as Facebook, Twitter, Instagram and YouTube to help spot fraudsters. Unless social media users have adjusted the privacy settings on their accounts, all information that is posted is considered public. This means that, where a legitimate interest exists under the **General Data Protection Regulation 2016** (GDPR), insurers have free access to any non-private posts. Insurers can also look for social media connections between multiple parties involved in a claim.

D4e Data matching software

This software is used to analyse the insurers' data. In the context of staged accidents, it can reveal links between the parties who allege they did not know each other e.g. parties using the same email address or phone number when seeking a policy quotation. When dealing with large volumes of data, it would be too time consuming for claims handlers or fraud investigators to check for all such links manually. Therefore, this software is an important tool to combat organised fraud as it may uncover wider links between numerous claims and lead to the discovery of a fraud ring. Due to data protection restrictions such data mining is not allowed between insurers; each insurer can only analyse their own data.

D4f Insurance Ireland initiatives

Insurance Ireland, the representative body for insurers, has overseen and collaborated with other parties to introduce a number of initiatives in the industry. They are:

- Insurance Confidential. This was established in 2003 and is a confidential fraud reporting service for members of the public, which also reports on the prevalence of fraud.
- *Guidelines of the reporting of suspected insurance fraud*. These were put in place in co-operation with An Garda Síochána in order to assist insurers in the referral of cases for criminal investigation.
- The Fraud Forum. This forum facilitates the sharing of expertise and information between insurers in order to deter fraud.

E Summary

In this chapter, we looked at the main stages of claims processing and introduced some of the typical terminology used when referring to different types of claims.

We also considered the regulatory issues applying to the different stages of the claims process, and the importance of fraud awareness and detection.

In later chapters, we will study each stage of the claims process in more detail.

E1 What's next?

In the next chapter we will look at claims notification, which is the first stage of the claims process. We will examine the information that insurers gather when a claim is notified and the important actions that are taken at this point.

E2 Online learning supports

Your Member Area includes a guide to success, an automated study planner, an exam countdown timer and study tips guide. These study supports are invaluable in reinforcing what you have learned so far. The webinars, chapter-by-chapter key points and other supports will help you to break down the chapter's content when revising.

Remember: This module is examined by mixed assessment, which includes:

- An online mid-semester MCQ assessment (20 questions)
- An end-of-semester written exam paper (9 questions)

Given that your online mid-semester assessment is a multiple-choice question test, completing the online practice paper is the ideal preparation for this. You can prepare for the end-of-semester written exam and test your knowledge by completing sample and past written exam papers.

To access these online learning supports, just log into your Member Area on **www.iii.ie** and click on the **Connect** logo.

End of chapter questions

Use these questions to test your understanding of what we've covered so far in Chapter 1. It should be noted that these end of chapter questions are revision questions to test your understanding of the material in the chapter just studied. They are not sample exam questions.

1. State how a claims department ensures a consistent approach to all types of claims notified on a daily basis.

2. Briefly outline what is involved in the claims investigation process.

3. Outline the CPC obligations of an insurer regarding consumer complaints.

4. Outline the three parties to an insurance claim.

5. State three types of policy where first-party claims typically arise.

6. Identify the persons or organisations a claims handler usually deals with when handling a third-party claim.

7. State the regulatory requirement for an insurer when an accident involves an uninsured, unidentified, or foreign-registered vehicle.

8. State the insurer's duty when dealing with a third party appointed by a claimant.

9. Explain the obligations that the CPC places on regulated entities in relation to their dealings with 'vulnerable consumers'.

10. Explain the role of an insurer's special investigation unit, or anti-fraud team.

Answers to end of chapter questions

Check your answers against those below and make a note of any points you left out. This will highlight some sections you may need to look at more closely during your revision.

1. The claims department can ensure consistency by having a robust process dictating how claims are handled. This is often contained in an insurer's 'claims best practice' document or 'claims handling manual'.

2. The initial gathering and checking of the claim information and policy cover will direct whatever further investigations are necessary. This may involve a telephone follow-up, desktop handling, the use of in-house investigators or using the services of loss adjusters or other experts. The outcome of the investigation will determine whether or not the insurer will pay the claim.

3. An insurer, as a regulated entity, must have a written procedure for the proper handling of complaints. Insurers and intermediaries must keep an up-to-date log of all consumer complaints. They must undertake regular appropriate analysis of consumer complaints patterns, including investigating whether complaints indicate an isolated or a more widespread issue. This analysis of consumer complaints must be communicated to the regulated entity's compliance/risk function and senior management.

4. The parties to an insurance claim are the:

   - First party: the person insured under the policy
   - Second party: the insurer that issued the policy
   - Third party: anyone else involved in a loss event.

5. First-party claims typically involve damage to the insured's own property. They include claims under (state any three):

   - Commercial fire and business interruption policies
   - Household policies
   - Motor (own damage)
   - Personal accident policies
   - Travel policies.

6. To handle third-party claims, the claims handler may deal directly with the third party, with the Personal Injuries Assessment Board (PIAB) and/or with the third party's legal representatives. They may also deal with the insured, particularly at the notification and investigation stages.

7. If a motor accident involves an uninsured or unidentified vehicle, or a foreign-registered vehicle, the insurer must advise the potential claimant to contact the Motor Insurers' Bureau of Ireland (MIBI).

8. At the claimant's request and with the claimant's written consent, an insurer must engage with a third party which a claimant has appointed to act on his or her behalf in relation to a claim.

9. The CPC requires that a vulnerable consumer is provided with such reasonable arrangements and/or assistance that may be necessary to facilitate them in their dealings with the regulated entity.

10. Many insurance companies have dedicated teams set up whose primary focus is on investigating potentially fraudulent claims. These are called Special Investigation Units (SIUs) or anti-fraud teams. If a claims handler suspects a claim may be fraudulent, they will pass this claim to this team. The SIU team examines and investigates the claim thoroughly using social media, skilled interviewing techniques and sometimes private investigators.

Answers to quick questions

1. Motor windscreen or small household claims are often treated as 'fast track' claims.

2. Where an accident has occurred and a personal injury has been suffered, a copy of the PIAB claimant information leaflet is issued to the claimant as soon as notification occurs.

3. Common indicators include (state any four):
   - Overstatement of claims
   - Late notification of a claim
   - Lack of original documents
   - Altered documents
   - Lack of evidence of ownership
   - Multiple insurance policies covering the same risk
   - Unusual changes to cover shortly before the alleged event (e.g. changes in sums insured or addition of specified items)
   - Inconsistent, vague or changing, accounts of the circumstances giving rise to the claim
   - Multiple claims
   - A claim occurring shortly after inception of the policy
   - Changing attitude from friendly and helpful to aggressive and evasive.

Sample exam questions

Question 1

Jeremy accidentally crashes into a stone wall during icy road conditions, causing damage to his car. Fortunately, Jeremy had taken out comprehensive motor insurance.

Outline the lifecycle of Jeremy's first-party motor damage claim noting the steps that his claim will go through from first notification to settlement.

Total: 10 Marks

Question 2

a) The Consumer Protection Code (CPC) specifies that all insurers must have minimum requirements in place for handling claims.

State **seven** of these requirements.

(7 Marks)

b) Outline the information an insurer must notify to a claimant when it has engaged the services of an expert appraiser.

(3 Marks)

Total: 10 Marks

Your answers

Sample answers

The answers set out below show the main points you must consider in answering the question. In some cases, a well-reasoned alternative view could earn good marks.

Question 1

Notification

Jeremy's insurer requests some basic information, so that preliminary action can begin. This includes giving the claim to a handler with the appropriate experience and expertise, who will ensure that first steps are taken.

First checks on the claim information

Following notification, Jeremy may be required by the insurer to complete a claim form, or send other supporting documents. These documents (and other information) are then checked to ensure that all is correct and to see if further enquiries are needed.

Checking that the policy covers the claim

When initial checks are complete, the claims handler examines Jeremy's claim in detail. This involves checking all aspects of cover and ensuring, for example, that Jeremy has complied with any relevant policy conditions and that no exclusions apply to the loss.

Investigation process

The initial gathering and checking of claim information and policy cover will direct further necessary investigations. This may involve a telephone follow-up desktop handling, the use of in-house investigators, independent loss adjusters, or other experts. The investigation outcome determines if the insurer will pay the claim (and if it proceeds to the remaining stages of the claims process).

Quantifying the claim

When cover has been confirmed and investigations completed, the claims handler determines the value of the claim, which is based on the principle of indemnity, which ensures that the Jeremy would be compensated for his loss to the extent of the available cover (comprehensive).

Settling the claim

Jeremy's insurer has several options when settling claims. They may, for example, make a monetary payment or arrange for a damaged item to be repaired or replaced. For motor damage claims, they may instruct one of their approved repairers to rectify the damage.

Reference Chapter 1A2 **Total: 10 Marks**

Question 2

a) The written procedure for handling claims must at least provide the following:

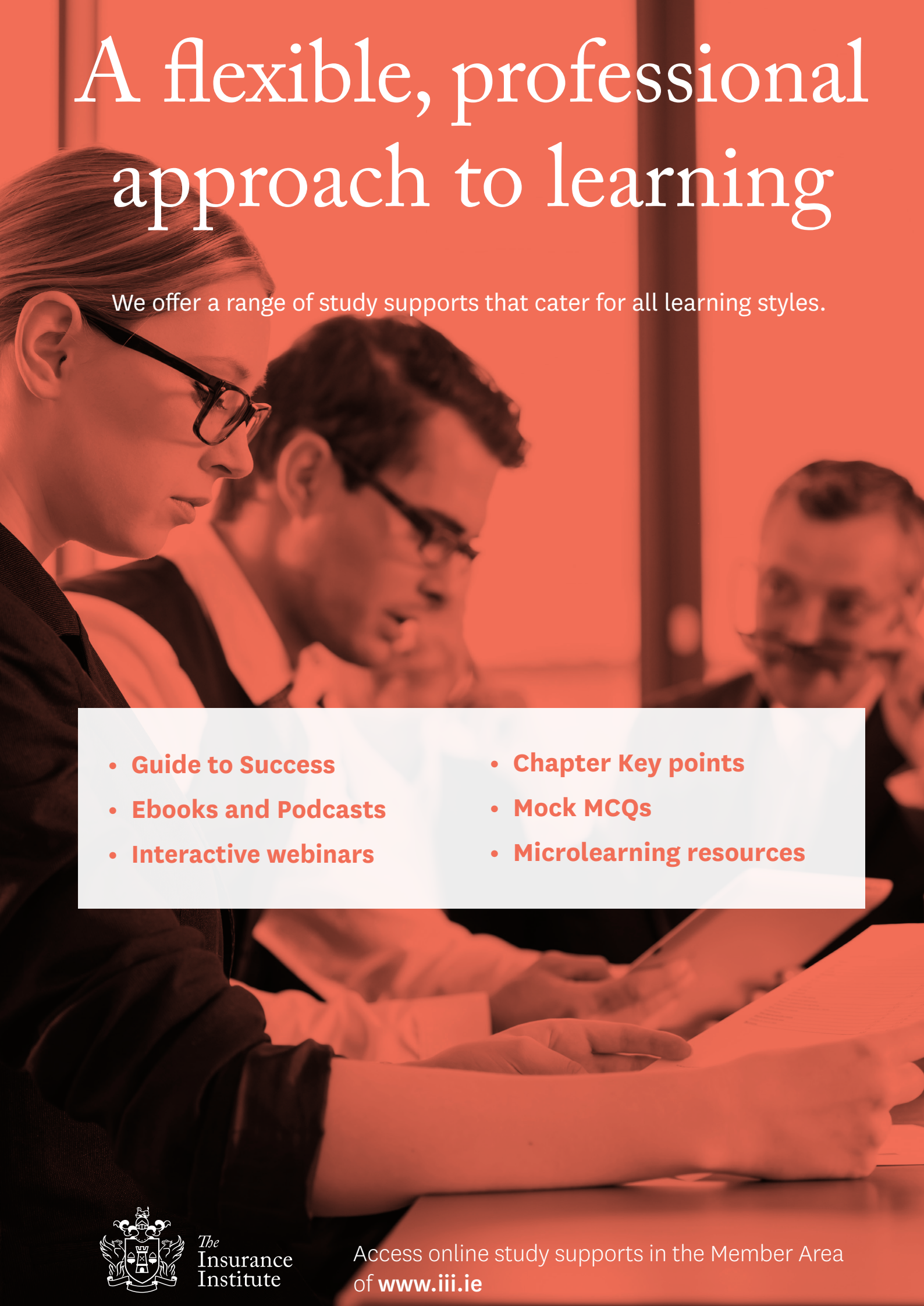
- Where an accident occurs and personal injury is suffered, a copy of the PIAB claimant information leaflet is issued to the claimant as soon as it is notified.
- If a motor accident involves an uninsured or unidentified vehicle, or a foreign-registered vehicle, the insurer must advise the potential claimant to contact the Motor Insurers' Bureau of Ireland (MIBI).
- A claim form (where required) must be issued within five business days of notification.
- The insurer must offer to assist the claimant in making a claim, highlighting any beneficial policy terms and conditions.
- A record of all conversations with a claimant must be kept.
- While a claim is progressing, an insurer must provide updates of developments affecting the claim within ten business days of each development.
- Any additional documentation or clarification must be requested from the claimant as soon as required and, if necessary, a reminder issued in writing.
- A claim must be paid within 10 business days of the claimant accepting an offer.

(7 Marks)

b) If an insurer engages the services of an expert appraiser, it must notify the claimant of their contact details and the fact that the loss adjuster/appraiser acts in the interest of the insurer, maintaining a record of this notification.

(3 Marks)

Reference Chapter 1C1 & C2 **Total: 10 Marks**



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Chapter

2

Claims notification

What to expect in this chapter

In this chapter we look at the very first stage in the claims process, i.e. the point when an insurer is made aware of an event that could lead to a claim. It outlines the important duties of the insured and the information and documentation the insurer needs to begin handling the claim and the roles that intermediaries play at the notification stage. We will also see the importance of mitigating a loss as early as possible, and of accurate claims reserving.

Contents

A Claims notification

The first stage in the claims process is notification to the insurer of an incident which the policyholder, or third-party claimant, believes will give rise to a valid claim. This normally involves a telephone call or email from the insured, although some insurers provide online notification. Sometimes a claim is notified by somebody acting on behalf of the insured, such as an intermediary/broker, a **loss assessor**, a builder or a motor garage. For motor or liability claims, the first notification of an accident may come from a third party. Insurers normally accept the initial claim information from another party, but they will require the policyholder's consent before discussing details of the policy cover or information about the insured.

To ensure effective customer service, many companies have a separate **first notification of loss** (FNOL) team. This may be a unit within the claims department or outsourced to an external provider. Along with a readily available 24-hour service, these providers also have access to emergency response services, such as vehicle recovery or building firms.

When a new claim is reported, the FNOL team first needs to verify the caller's identity, using approved questions. They ask a series of questions designed to elicit all the important information about the incident (see Section A1). This allows the claims department to take the important first steps in dealing with the claim, without any unnecessary delays. For example:

- For motor vehicle damage claims, an **approved repairer** can be instructed to recover the vehicle without delay and to carry out guaranteed repairs to a vehicle in accordance with an agreed schedule of costs. If needed, a motor engineer can also inspect the damage. This not only reduces delay in handling the insured's claim, but can also assist in preserving necessary evidence about the condition of the vehicle immediately after the accident.
- For household or other property damage claims, the FNOL team may appoint a loss adjuster (see Chapter 4C1) to inspect the property and arrange for necessary emergency works to prevent further damage.

A copy of the answers recorded in this initial phone conversation may be sent to the insured soon afterwards so that they can verify or correct them, add any other relevant information and sign and return the document. At this point, any documentary evidence required (see Section D) from the insured should be requested. These phone calls are normally recorded for training, quality and fraud prevention purposes.

loss assessor

expert in dealing with insurance claims, appointed by the insured to prepare and negotiate a claim on their behalf

first notification of loss (FNOL)

the centre or team that sets in motion the claims process once a claim has been notified

approved repairer

motor repairer that an insurer includes within a scheme to guarantee workmanship, labour rates and discounts on parts, and to reserve the right to reduce a policyholder's claim payment if they do not use the approved repairer

Quick question 1

Why do many insurers use approved repairers?

The answer is at the end of this chapter

From the claimant's perspective, an efficient notification process can help reduce the stress and trauma of a major event such as a serious motor accident or a burglary. Experienced FNOL handlers can give valuable advice on issues such as loss mitigation (see Section C), policy cover, dealing with third party correspondence and about what will happen next with their claim. This is very important from a customer service point of view and could be critical in preventing further property damage.

For the insurer, the key priority is to gather enough information to make initial decisions about how to proceed. We will consider this in more detail in Section A1.

A1 Information required at the notification stage

The insurer registers the claim at the notification stage, being the first step to determine if the loss is covered by the policy. Many of the questions asked at notification are common to most classes of insurance (see Table 2.1), while other questions will be more relevant to specific classes and to types of losses within those classes (Table 2.2).

Table 2.1 Initial questions to determine cover

Information required	Reason needed
Date of incident/loss?	• This is critical in establishing to which period of cover or insurer the loss applies. • It indicates whether or not the notification was timely, in accordance with the claims condition of the policy (see Section B1).
When did the insured first know about the claim/loss?	• This may help to explain any apparent delay in notification.
Insured's name?	• The exact name should be compared with the schedule.
What, if any, correspondence is to hand?	• Any repair estimates or legal correspondence should be sent to the insurer as soon as possible.
Does the insured know the likely cost of the claim?	• This will help determine the initial claim case reserve (see Section E). • This will also help the claims handler to decide on the next step in the process, e.g. whether to appoint a loss adjuster or other expert.
The loss address?	• The loss address should be compared to the risk address in the schedule.
Further questioning, where the answer does not make sense.	• To ensure clarity about the circumstances and to flag up any issues needing further investigation.

In Table 2.2 we look at some particular questions and considerations for specific types of policies at the notification stage. For many claims, further information will be required at later stages of the claims process.

Table 2.2 Considerations for specific classes of business

Policy type	Information sought at the notification stage
Property (household and commercial)	• What caused the loss? This is important as property policies are peril based and it will help ascertain which parts of the policy will apply and if any limits or restrictions apply. • When was the loss or damage first noticed? • Where did the damage occur? • What was the nature and extent of the damage? • Are repair estimates available yet? • Are any photographs or videos available? • What further actions have been taken? For example: - Did the insured notify the Gardaí (theft)? - Did the insured notify the fire brigade (fire)? - Has a plumber stopped the water leak (water damage)? • Does the claim fall under a liability section? • In the case of a commercial property policy, is there a business interruption element to the claim?
Motor property damage	• Driver's identity (including name, address, date of birth, licence details, previous convictions). • Vehicle registration and other details. • Date of the accident or damage. • Use of the vehicle at the time of the damage. • Location and circumstances of the accident or damage. • Details of the vehicle damage. • Details of any third party involved. • Details of any witnesses. • Garda details.

Table 2.2 (contd)

Policy type	Information sought at the notification stage
Motor injury claims	The claims handler will ask the same questions as in motor damage claims and will seek the following additional information. • What is the nature and severity of any injuries? • Was an ambulance or the fire brigade required? • How many passengers were in each vehicle? Details of each passenger (if known). • Were seatbelts worn?
Employers liability claims	• Date, location and circumstances of the accident/ incident. • The nature and extent of the injury or illness. • The nature of the work the injured person was doing. • Details of any witnesses. • Details of other parties involved who may have a liability.
Public liability claims	• Date, location and circumstances of the accident/ incident. • The nature and extent of the injury, loss or damage. • Details of the injured party, including age, occupation etc. • Details of the relationship with the injured person/ claimant, e.g. were they a visitor, a customer etc.? • Details of any witnesses. • Details of other parties involved who may have a liability.

Table 2.2 (contd)	
Policy type	**Information sought at the notification stage**
Travel claims	• What caused the loss? This is important as it will help ascertain which parts of the policy will apply. • What are the details of travel, e.g. flight number? These are needed for flight delay claims. • What are the details of any other insurance that may provide cover? For example, details of household 'all-risks' cover are needed for a theft claim or health insurance cover for an illness claim. • What was the length of the trip? There may be travel restrictions on cover. • Was the incident reported at the time, e.g. to the local police or the tour operator? • Did the insured call the emergency assistance line? This may be a specific condition of the policy in cases where the insured was hospitalised.

The questions asked at the notification stage help to identify any potential issues about cover and decide on the next steps in the handling and investigation of the claim.

B Duties of the insured after a loss

Policies contain conditions specifying the duties and obligations of the policyholder when making a claim. Often these conditions are set out in simple language under headings such as: 'What to do in the event of a claim'.

B1 Notification

Insurers require prompt notification to ensure:

- Early investigation to minimise costs
- Early appointment of loss adjusters or solicitors where needed
- Detailed evidence is not lost through delay
- Potential recoveries from third parties can be initiated
- Early notification of large losses to reinsurers if needed
- Insurers' financial information is accurate and up to date

The notification condition in a policy specifies procedures and timeframes to be followed. Sometimes policies specify a set time limit for notifications, e.g. 'within 48 hours'. In some cases, the requirement will simply be for notification to be 'prompt' or 'immediate' or 'forthwith', without further definition. Sometimes, this initial notification may need to be followed up by written particulars of the claim within (e.g.) 7, 15 or 30 days.

Example 2.1

Part of Michelle's house caught fire, resulting in considerable damage. As she has a policy insuring the house against fire, she expects to make a formal fire claim once she knows the extent of the damage. The incident should be notified immediately.

You will recall from The Nature of Insurance module or equivalent modules that an insurer may have a right to reject (repudiate) a claim because of a breach of a claims condition. A 'common sense' approach is usually taken when a late notification is made. Often the insurer may overlook a delay if there are genuine reasons or extenuating circumstances, and if the insurer's position has not been prejudiced. The **Consumer Insurance Contracts Act 2019** prevents an insurer from declining a claim made under a consumer insurance policy for late notification, unless it can be shown that the insurer's position was prejudiced. If insurers rely on this, they must demonstrate the extent of the prejudice before being entitled to refuse cover In practice, such prejudice is often difficult to prove. It is likely to happen only in cases where, for example, the delay in notifying the claim means a third party obtained a court **judgment** in default, or the property involved has been destroyed or repaired, preventing proper investigation and the ability to establish whether an insured event has occurred.

judgment

written or spoken decision of the court

B2 Other important duties

For loss, damage or breakage claims, the policy will specify that the policyholder must:

- Keep any damaged items as insurers may need to inspect them. If it is not possible to keep damaged items for inspection, the insurer may accept photographs of the items.
- Notify the Gardaí (or other relevant police force or authority) immediately about loss or damage by theft, malicious act or riot, strikes, civil commotion or labour disturbances.
- Notify the fire brigade immediately of any fire or explosion.
- Not abandon any property to insurers, e.g. salvage of a motor vehicle.
- Take reasonable steps to mitigate (minimise) their loss (see Section C).

If an incident occurs (usually under a liability or motor policy) that could result in a third party making a claim against the policyholder, they must:

- Inform insurers as soon as possible
- Send insurers any letter, claim, writ, summons or other legal document unanswered as soon as received
- Co-operate with insurers in the investigation of the incident and the defence of any resulting claim
- Not admit liability, offer or negotiate any payment of claim unless the insurers confirm their approval.

B3 Onus of proof

You will recall from The Nature of Insurance module that when a potential claim arises, the initial responsibility (onus of proof) rests with the insured. They must prove:

- **that an insured peril arose**. The insured must explain the circumstances and cause of the loss or damage and show that its **proximate cause** was a peril covered by the policy.
- **the amount of the loss**. This means showing their exact financial loss, by purchase receipts or repair estimates.

proximate cause

main or dominant cause of the loss or the cause that is most powerful in its effect

If the insurer wishes to decline to accept liability for a claim because of (e.g.) a policy exclusion, the onus of proof moves to the insurer and they must prove that the exclusion applies.

To prove that a loss was caused by an insured peril, and to show the extent of that loss, the insured will normally need to submit appropriate documentary evidence. Section D outlines the typical documentary evidence that is required.

mitigation

reducing a loss by taking action to stop it or minimise its effect

C Loss mitigation

We saw in Section B2 that the insured has a duty to **mitigate** their loss. This means that they must do everything to prevent the loss from worsening and to limit the extent of the damage already caused. For example, if property is damaged by water leaking from a burst pipe, the insured should immediately turn off the water to prevent further damage. They should also take reasonable steps to protect their property from further damage (e.g. by moving items to a dry place and making efforts to dry out the affected areas).

Insurers will also look for ways of mitigating a loss at the notification stage. They will assess, on the basis of information provided, if steps need to be taken to reduce the extent of the loss, and how quickly these actions can be taken. The emphasis is then on taking sensible steps to reduce the overall loss.

C1 Mitigating the loss in property/motor claims

When a new claim is notified, the insurer may ensure mitigation of the loss. For example:

- If a loss is still occurring, insurers will immediately enquire if further damage can be prevented. For example, in a flood situation, salvage or restoration experts might be instructed to move items in danger of damage.
- If the loss is no longer occurring, damage might be still continuing. A roof taken off in a storm might leave goods in a warehouse exposed. Moving these goods will prevent further damage.
- If damage to the goods has commenced, e.g. water damage or smoke damage, the goods may be saved by drying out or cleaning. If this is impossible, the goods may have a **salvage** value (see Chapter 7).
- Where motor policies cover the use of alternative vehicles during repairs, prompt inspection of the damaged vehicle and authorisation of repairs will minimise the hire period. Third-party claimants must also be reminded of their duty to mitigate losses. They should not hire cars for excessive periods.

salvage

what remains of the subject matter of insurance after an insured event where the insurer treats the claim as a total loss

C2 Mitigating the loss in personal injury claims

The following are some possible ways to mitigate personal injury claims:

- For employers liability claims, what approach is an employer taking? Is it appropriate to continue to pay wages to avoid the injured party suffering hardship, thus leading to a claim?
- Will the payment of medical costs possibly prevent the injured party from making a further claim?
- Can rehabilitation services intervene at an early stage? This can reduce the claimant's recovery time and help them return to work sooner.

D Claims documentation

Following initial notification, the insurer may request further documentation. This is essential at the later stages of a claim, where further checks are made to establish whether or not the loss is covered.

D1 Claim forms

As noted in Section C1, if a claim form is required, the insurer must send this to the claimant within 5 business days. However, in many situations insurers gather the claims information from the policyholder through telephone enquiries or, where a loss adjuster is appointed, face-to-face.

The purpose of a claim form is to:

- Establish whether the policyholder is entitled to indemnity under the policy – the insurer must be satisfied that the loss, actual or potential, is covered under the policy, and that the information given on the form agrees with that on the proposal form.
- Provide sufficient information to permit the insurer to begin processing any claim, if appropriate.
- Help the insurer decide the severity (potential cost) of the claim – this allows the insurer to place an accurate case reserve (see Section E) on the loss, damage or liability and to review this case reserve as the claim progresses.
- Enable the insurer to take an early view on whether there may be a claim from a third party (for motor and liability insurance).
- Enable the insurer to take an early view on possible recovery rights, either by subrogation or contribution.

In motor and liability insurance, the form is known as an accident report form. It is a policy condition in motor insurance that all accidents are reported to the insurer, regardless of whether or not the insured intends to make a claim or expects a claim from another party – hence the term 'accident report form', rather than 'claim form'.

These forms will ask certain typical questions about:

- The insured's name
- The policy number or reference
- The date, time and place of the incident causing the claim
- A description of what happened
- A description of the damage.

Where a form is used, the signature of the insured and the date the claim was notified to the insurer is recorded.

These basic questions are often summarised as 'who, when, where, why, what', and the responses allow a preliminary assessment of the claim. In Chapter 3, we will see how claims handlers check claim form information to make these preliminary assessments.

Just think

Obtain a selection of claim forms or phone checklists for claims notifications from within your own organisation and compare them with the descriptions in this section. In particular, look at the specific questions asked for different classes of business, e.g. motor, travel or household, and consider the purpose of each question.

D2 Other supporting documentation

Other requested information will vary with the class of insurance or claim type; for example:

- **First-party property claims** – Receipts are required for lost or damaged property or other evidence of its value.
- **Theft and burglary claims** – Generally evidence is sought that the incident has been reported to the Gardaí – usually Garda confirmation or the Garda date record ('Pulse' system) – as a precaution against fraud or in the event of recovery.
- **Motor claims** – Estimate of the cost of repairs, documents to verify the ownership, age, condition and value of the vehicle, third-party details/ correspondence (if relevant).
- **Liability claims** – copy of accident book entry, maintenance records for machinery, photographs, diagrams, witness statements, third-party correspondence.
- **Personal accident or travel policy claims arising from illness or injury** - medical verification of the cause and duration of the illness or injury is requested. It must be established that the claim has not arisen out of any (excluded) pre-existing condition, and that the insurer's consent to treatment overseas or repatriation have been met if required.

Quick question 2

Where an insurer decides that a claim form is required, they must send it to an insured within how many days of being notified of the claim?

D3 The role of intermediaries in claim notification

You will recall from the Compliance and Advice module that insurance intermediaries carry out a number of different roles in Ireland. Many intermediaries (such as insurance brokers) mainly arrange insurance policies for their clients and advise them about their policies. As we also saw in the Compliance and Advice module, a broker may act as an agent of both the insured and the insurer at different stages of the insurance contract.

When the insured purchases their insurance through an intermediary, such as a broker, they will often seek the broker's help in presenting a claim. Insurers will, therefore, receive the claim information from the broker rather than directly from the insured. Here the broker is the **agent** of the insured, rather than the insurer. This means that any information the insured gives to their broker, but which the broker does not give to the insurer, is deemed not to have been provided by the insured. There is a requirement under the CPC that an intermediary must pass claims documentation to the insurer within 1 business day. Where there is any delay in the transmission of such documentation from the broker to the insurer, which results in any prejudice to the insured's claim, the insured would be entitled to take an action against the broker or make a complaint to the Financial Services and Pensions Ombudsman (FSPO). The broker's professional indemnity insurance would respond to such claims.

agent

one who is authorised by a principal to bring that principal into a contractual relationship with another, a third party

In some situations, a broker (or other intermediary) may have **delegated authority** to accept claims notification on behalf of an insurer. For a broker this may be part of wider delegated authority or a **managing general agent (MGA)** arrangement. For other intermediaries it may be part of an outsourced claims notification (FNOL) contract. In both situations, the intermediary is acting as an agent of the insurer and any claims notified to the intermediary are regarded as having been notified to the insurer.

You will see from this that the relationship between the insurer and intermediary depends both on the terms of a contract between the parties, and on the precise facts of a situation. The legal concept applying here is the law of **agency**, which can be complex. If there is any doubt about the circumstances in which an agent (intermediary) has received claims information, and whether or not they have properly notified the insurer, legal advice may be needed before the insurer can decide if there has been a breach of the notification, or other policy requirements.

D4 Data protection and claims

You will recall from your Compliance and Advice module that, under EU and Irish data protection legislation (**General Data Protection Regulation** (GDPR) and the Irish Data Protection Acts (**Data Protection Acts 1988-2018**)), **personal data** gathered must be 'adequate, relevant and limited to what is necessary in relation to the purposes for which those data are processed'.[5] In relation to the claims process, this means that insurers must assess the relevance of all data requested and collected to ensure it is not excessive in relation to the handling of the claim. It also means that where an insurer outsources a claims handling activity to a third party, the insurer still retains the responsibility for compliance with the GDPR.

This legislation also requires that the data be 'processed in a manner that ensures appropriate security including protection against unauthorised or unlawful processing and against accidental loss, destruction or damage, using appropriate technical or organisational measures'.[6] In relation to the claims process, this means that insurers are responsible for maintaining the security and confidentiality of the data provided (see Case study 2.1).

2.1 Case study

Incorrect association of an individual's personal details with another file[7]

The Data Protection Commission (DPC) received a complaint in relation to an alleged breach of an individual's data protection rights by an insurance company.

During the investigation, the DPC was advised that the complainant had previously requested a quotation for household insurance with Insurer Y but had not proceeded to take out a policy with this insurer. Insurer Y had failed to delete the information on the complainant's quotation in line with its own data retention policy. In addition, Insurer Y had mistakenly linked the complainant's details on the quotation to an insurance claim file in respect of a claim it had received from a person with an identical name.

delegated authority
authority granted to the agent of an insurer, usually in the context of a scheme arrangement, to issue policy documentation and possibly carry out limited underwriting and claims functions

managing general agent (MGA)
intermediary who has been given delegated underwriting authority by a risk carrier or insurer to accept risks on their behalf, and who may also act as a wholesaler to other intermediaries

agency
a legal relationship where one party, the principal, grants authority for another party, the agent, to act on their behalf

personal data
any information about a living person, where that person either is identified or could be identified. It can cover various types of information, such as name, date of birth, email address, phone number, address, physical characteristics, or location data – once it is clear to whom that information relates, or it is reasonably possible to find out

5 Article 5, GDPR.

6 Article 5, GDPR.

7 This case study and others can be found on the Data Protection Commission website (www.dataprotection.ie)

2.1 Case study (contd)

When transferring Insurer Y's undertakings to a different insurer (Insurer X), the insurance claim file which mistakenly included the complainant as the claimant (rather than another individual who had the same name) was transferred to Insurer X. The claim, when assessed at a later stage, turned out to be fraudulent and Insurer X had its solicitors write to the complainant advising that their claim was found to be fraudulent and indicating the follow-up action which Insurer X intended to pursue to protect its interests.

The main concerns in this case related to careless handling of personal data by Insurer Y and even more significantly, the inability of Insurer Y to ascertain how the claimant's details ended up in the possession of Insurer X and how the issue that arose had come about.

The investigation by the DPC highlighted that several contraventions occurred in this case by Insurer Y:

- A breach of the requirement of a reasonable retention period due to holding onto the quotation data longer than necessary and longer than was set out in the company's own retention policy;
- Unlawful further processing of the personal data by associating it with a claim file;
- Failure to respond in a clear and timely manner to the complainant to explain how their data had been sourced and how it came to be processed in the way that it was.

The complainant in this case suffered particularly serious consequences as they incurred significant legal costs in defending the accusation of making a fraudulent insurance claim and the threat by Insurer X of initiating Circuit Court proceedings against them.

special category personal data

data that refers to a person's racial or ethnic origin, political opinions, religious or philosophical beliefs, physical or mental health, sexual life or sexual orientation, genetic and biometric data, and/or trade union membership.

The legislation also provides additional protection to certain sensitive personal data known as **special category personal data**. Special category personal data can only be processed by an organisation in limited circumstances e.g. where the individual has given explicit consent, where it is necessary for medical diagnosis etc. In a claims context, this would be most often processed by insurers in first party personal accident claims and third party personal injury claims and would include information in medical reports and records, information about criminal convictions and other documentation used during the legal process. Access to this data must be restricted to the relevant claims handlers and other people who need access to same as part of their job.

Insurers are increasingly using App technology in their claims processes and supplier exchanges. These technology platforms must be GDPR compliance and allow for seamless information access for regulators and customers. The data risk is significantly higher with cloud technology than with traditional server locations. Therefore, insurers must ensure that their data exchanges and technology withstand any cyber exposure. It is for this reason that insurers use multi-factor authentication via text or email and other stringent access systems. Even with such measures, insurers must continually review their technology and cyber risks to ensure adherence to GDPR obligations.

E Claims case reserving

A case **reserve** is an estimate of the probable ultimate cost of a claim. The placing of reserves on claims is an essential function of the claims department. Every company has a written reserving policy that explains their process for reserving claims. The policy is approved by the company's internal auditor, who monitors adherence by claims handlers.

The claims handler receiving a claim notification from the insured obtains as much information as possible at an early stage to assist in placing an initial case reserve on a claim. In some instances, notification of a claim is received by a separate First Notification of Loss (FNOL) team (see Chapter 1A). These teams will usually input a standard case reserve determined by the insurers reserving guide. This standard case reserve is then reviewed and, if necessary, revised by the individual claims handler, as more detailed information becomes available to them.

E1 Why reserve?

The first and most obvious use of a claims case reserve is simply to enable the insurer to set aside enough money to pay the claim when it becomes due. The total of these case reserves form part of the 'technical reserves' on the company's reports and accounts. The technical reserves are the largest part of any insurer's balance sheet, so their importance cannot be overstated. Accurate and up-to-date case reserves are essential in making sure that the insurer's liabilities can be met at any time.

The claims case reserves are also of importance for:

- Guiding the underwriting department when calculating **loss ratios** and setting premium rates
- Providing management information on the performance of accounts
- Accounting and statistical information purposes
- Actuarial analysis to calculate provision for claims **incurred but not reported (IBNR)** and **incurred but not enough reported (IBNER)** and for demonstrating adequate **technical provisions.**
- Financial planning and setting strategy.

E1a The cost of inaccurate case reserves

The different uses of claims case reserves mean that claims handlers must set case reserves as consistently as possible. If reserves are too high, the premiums charged may also be too high, making the insurer uncompetitive. If the reserves are too low, the premiums may be set too low, jeopardising the insurer's financial stability.

Independent Insurance Company, an apparently successful UK insurer, went into liquidation in June 2001. While there were several reasons for this, one of the main causes was a failure to record proper reserves for large outstanding claims. An Irish example showing the dangers of under-reserving is shown in Example 2.2.

reserve

a stated amount that an insurer must have set aside to cover claims from current insurance policies and any other outstanding liabilities

loss ratio

the ratio of total losses incurred in claims plus adjustment expenses divided by the total premium earned

incurred but not reported (IBNR)

amount owed by an insurer to all valid claimants who have had a covered loss but have not yet reported it

incurred but not enough reported (IBNER)

claims that have been reported to the insurer and, although the insurer has opened a case reserve within its books, the value of the case reserve proves to be inadequate in relation to final settlement

technical provisions (reserves)

reserves held so that assets are matched with known and estimated future claims liabilities and associated expenses

Example 2.2

After concerns over RSA Insurance Ireland's reserving position were highlighted in November 2013, RSA Insurance conducted an internal review and an independent audit of its claims. The review identified that reserving irregularities for large losses and insufficient reserving for personal injury claims had been made. Its parent company was then required to make an additional provision of £200 million (€241.9 million) to meet its Irish claims liability.

In addition, the Central Bank imposed a fine of €3.5 million on RSA Insurance Ireland DAC in December 2018 in respect of serious breaches in relation to its failure to:

- establish and maintain technical reserves in respect of all underwriting liabilities assumed by it
- have administrative and accounting procedures and internal control mechanisms which were sound and adequate
- have robust governance arrangements.

Case studies 2.2 and 2.3 look at recent notable insolvencies and their impact on the affected policyholders within Ireland.

2.2 Case study

Collapse of Setanta Insurance

Setanta Insurance was a Dublin-based insurer, licensed and regulated in Malta by the Malta Financial Services Authority. The firm traded only in Ireland but responsibility for prudential supervision rested with the Maltese authorities. The firm's liquidation in April 2014 affected 75,000 Irish policyholders (mainly car and van insurance). There were insufficient funds to meet its liabilities and lack of clarity as to whether the policyholders' claims would be paid by the Insurance Compensation Fund (ICF) or the MIBI. In May 2017, the Supreme Court ruled that the ICF would be liable for the claims of Setanta's policyholders.

2.3 Case study

Collapse of Qudos Insurance A/S

Qudos Insurance was an insurer authorised and prudentially regulated by the Danish Financial Services Authority (DFSA). Qudos was selling insurance in a number of European countries including Ireland on a freedom of services basis. In Ireland, Qudos primarily provided commercial and private motor insurance, and household insurance distributed through an MGA and insurance brokers. In December 2018, the DFSA notified the Central Bank that Qudos had been declared bankrupt. Existing policies remained valid until 3 months from the date of bankruptcy. The CBI strongly recommended that policyholders arrange alternative cover with immediate effect. Claims on these policies may be covered by the Danish Guarantee Fund for Non-life Undertakings; otherwise, these claims must be made to the bankruptcy estate of Qudos Insurance.[8]

[8] Central Bank of Ireland, 'Update – Qudos Insurance A/S', online press release, 20 Dec 2018, www.centralbank.ie.

E2 Initial case reserves

A claims handler should create a case reserve as soon as possible, once they have enough information to make an assessment. For some straightforward personal lines claims this may be done immediately following initial advice. For more complicated cases, some information gathering may be necessary before a claim can be reasonably quantified.

The initial case reserve should be a realistic assessment of the ultimate cost of the claim. It would be wrong to take a too optimistic or pessimistic assessment. It is also acknowledged that insufficient information may be available at an early stage to make an accurate assessment. Many insurers apply standard reserves, calculated by actuaries, until they have full details about the potential value of a claim, thereby allowing an accurate case reserve to be set.

The initial case reserve should also include an allowance for legal costs; value added tax (VAT), loss adjusters' fees and other expenses. For some claims, insurers may use standard case reserves at the notification stage. These case reserves are based on the average cost of particular types of claims. They are updated as soon as more information is available.

E2a Reserving property claims at notification

A claims handler needs to quickly establish:

- The extent of the damage
- Whether the item is destroyed, or if it can be repaired
- The original purchase price of the item (for household or commercial property contents)
- Whether there is an estimate for repairs
- Whether the damaged property has a residual or savage value
- Whether there is an exposure to a third-party property (e.g. escape of oil).

E2b Reserving personal injury claims at notification

For personal injury claims, a claims handler needs all available details as early as possible. Many decisions about the level of investigations are triggered by the initial estimate of loss. Legal costs are also important to consider when setting reserves for personal injury claims.

The following questions should be asked:

- How many people are injured?
- What is each injured party's age, occupation, family circumstances, nature of injuries and medical treatment?
- Is there likely to be a claim for **loss of earnings**? In employers liability claims the employer (i.e. the insured) will have sufficient information on this.
- What other losses may the person incur, e.g. hospital charges?

Insurers typically create separate case reserves for each claimant, rather than an overall reserve for all claims that result from the accident.

loss of earnings

past and future financial losses arising from the claimant's inability to work as a result of the injuries suffered

E3 Keeping case reserves up to date

It is acknowledged that the case reserve level will change (up or down) during the lifecycle of a claim; for example, this may occur when:

- New information is learned
- New evidence emerges about the insured's culpability
- Rebuilding costs are more (or less) than expected
- A personal injury claimant's medical condition deteriorates (or improves)
- Legal or actuarial opinion is received (in serious liability cases)
- Factors such as inflation affect third-party motor and liability claims, which take longer to settle
- There is a change in the law or a decision in a similar case affecting the likely outcome and cost of the claim.

Most insurers have procedures, such as automated diary systems, to ensure that individual case reserves are regularly reviewed. Case reserves for very large claims may also require peer or management review and sign-off.

E3a Subrogation and recoveries from third parties

If there is a possible subrogation or contribution from a third party towards the cost of a claim, this will reduce the final cost of the claim. Insurers differ about whether they reduce the claims case reserve to reflect this. Some firms prefer not to make any allowance for a recovery. The justification is that the recovery is uncertain and involves expense, reducing its significance. More importantly, this approach leaves the case reserve as a true estimate of the original claim.

Microlearning resources

In the Member Area of www.iii.ie, via the Connect logo and in Your Learning Centre, select the microlearning section of this chapter to access a resource specifically developed to help you better understand this topic.

E3b Case reserves, limits of indemnity, deductibles and partial payments

A case reserve should reflect any excesses or deductibles provided in the policy (see Chapter 5B2).

Many claims involve partial payments (also known as interim payments), or payments on account, before settlement. Examples include payments for building repair costs as they are incurred and approved by the loss adjuster, or periodic benefit payments under personal accident policies or for personal injuries. Each time such a payment is made the case reserves are reduced by a corresponding amount.

Quick question 3

During the lifecycle of a claim what events might prompt an update or review of the case reserve?

F Summary

In this chapter we looked at claims notification and the typical actions taken at the early stages of a claim. We saw how claims are notified, the important information and documentation that insurers require and the duties that the insured must observe. We also saw the importance of taking action to mitigate a loss as soon as possible, and the need to create and maintain accurate claims case reserves.

F1 What's next?

Chapter 3 looks at the next stage of the claims process, involving claim information checking.

F2 Online learning supports

Your Member Area includes a guide to success, an automated study planner, an exam countdown timer and study tips guide. These study supports are invaluable in reinforcing what you have learned so far. The webinars, chapter-by-chapter key points and other supports will help you to break down the chapter's content when revising.

Remember: This module is examined by mixed assessment, which includes:

- An online mid-semester MCQ assessment (20 questions)
- An end-of-semester written exam paper (9 questions)

Given that your online mid-semester assessment is a multiple-choice question test, completing the online practice paper is the ideal preparation for this. You can prepare for the end-of-semester written exam and test your knowledge by completing sample and past written exam papers.

To access these online learning supports, just log into your Member Area on **www.iii.ie** and click on the **Connect** logo.

End of chapter questions

Use these questions to test your understanding of what we've covered so far in Chapter 2. It should be noted that these end of chapter questions are revision questions to test your understanding of the material in the chapter just studied. They are not sample exam questions.

1. When a claim is first notified to an insurer, why is it important to ask for details of the loss address?

2. List the questions that are typically asked when a new motor property damage claim is notified.

3. Outline what is specified in a typical notification condition in an insurance policy.

4. State the policy conditions that must be observed if an incident occurs that could result in a third party making a claim against the policyholder.

5. What two things must a policyholder prove when making a claim under their insurance policy?

6. Explain the insured's duty to mitigate the loss.

7. What documentation is an insurer likely to request for a property damage claim?

8. State two situations where an intermediary acts on behalf of an insurer at the notification stage of the claims process.

9. What are the consequences to an insurer of (a) reserves that are set too high and (b) reserves that are set too low?

10. State five circumstances that could lead to an increase or a reduction in a claims case reserve.

Answers to end of chapter questions

Check your answers against those below and make a note of any points you left out. This will highlight some sections you may need to look at more closely during your revision.

1. The loss address will be compared to the risk address in the schedule.

2. Typical questions asked when a new motor property damage claim is notified:
   - Driver's identity
   - Vehicle registration and other details
   - Date of the accident/damage
   - Use of the vehicle at the time of the damage
   - Location and circumstances of the accident/damage
   - Details of vehicle damage
   - Details of any third party
   - Details of any witnesses
   - Garda details

3. The notification condition in a policy specifies the procedures and timeframe to be followed. Sometimes the policy will specify a set time limit for notifications, e.g. 'within 48 hours'. In some cases, the requirement will simply be for notification to be 'prompt' or 'immediate' or 'forthwith', without further definition. Sometimes this initial notification may need to be followed up by written particulars of the claim within (e.g.) 7, 15 or 30 days.

4. The policyholder must:
   - Inform insurers as soon as possible
   - Send insurers any letter, claim, writ, summons or other legal document unanswered as soon as received
   - Co-operate with insurers in the investigation of the incident and the defence of any resulting claim
   - Not admit liability, offer or negotiate any payment of claim unless approval is confirmed by insurer.

5. They must prove:
   - That an insured peril arose. The insured must explain the circumstances and cause of the loss or damage and show that its proximate cause was a peril covered by the policy.
   - The amount of the loss. This means showing their exact financial loss, e.g. by purchase receipts or repair estimates.

6. The duty to mitigate a loss means that the insured must do all they can to prevent the loss from worsening and to limit the extent of the damage already caused.

7. Receipts are required for the lost or damaged property or other evidence of its value.

8. Two situations where an intermediary acts on behalf of an insurer at the notification stage of the claims process are:

   - Where the intermediary has delegated authority to handle claims on behalf of the insurer.
   - Where the insurer has outsourced its notification (FNOL) service to the intermediary.

9. If reserves are too high, it is likely that the premiums charged will be high and the company uncompetitive. If the claims reserves are too low, the premiums will be set too low and the financial stability of the insurer is jeopardised.

10. Any five of the following could lead to an increase or a reduction in a claims case reserve:

    - New information is learned
    - New evidence emerges about the insured's culpability
    - Rebuilding costs are more (or less) than expected
    - A personal injury claimant's medical condition deteriorates (or improves)
    - Legal or actuarial opinion is received (in serious liability cases)
    - Factors such as inflation affect long-tail (liability) claims, which take several years to settle
    - A legislative change or legal precedent occurs in a similar case affecting the likely outcome and cost of the claim.

Answers to quick questions

1. Insurers use approved repairers as they have agreed costs with them in advance and can guarantee the work. It also allows for quick trouble-free repairs for the customer.

2. Under the CPC, where an insurer uses claims forms it must send one to the insured within 5 business days.

3. The case reserve may be updated or reviewed when:

   - New information is learned
   - New evidence emerges about the insured's culpability
   - Rebuilding costs are more (or less) than expected
   - A personal injury claimant's medical condition deteriorates (or improves)
   - Legal or actuarial opinion is received (in serious liability cases)
   - Factors such as inflation affect third-party motor and liability claims, which take several years to settle
   - There is a change in the law or a decision in a similar case that affects the likely outcome and cost of the claim.

Sample exam questions

Question 1

State **five** initial questions an insurer will ask at a claims notification stage in order to establish if a loss is covered and outline the reason for asking these questions.

Total: 10 Marks

Question 2

Outline **five** actions that could be taken by an insurer to mitigate a loss on:

(a) a property claim and

(b) a personal injury claim.

Total: 10 Marks

Your answers

Sample answers

The answers set out below show the main points you must consider in answering the question. In some cases, a well-reasoned alternative view could earn good marks.

Question 1

Initial questions to determine cover	
Information required	**Reason needed**
Date of incident/loss?	• This is critical in establishing to which period of cover or insurer the loss applies. • It indicates whether or not the notification was timely, in accordance with the claims condition of the policy.
When did the insured first know about the claim/loss?	• This may help to explain any apparent delay in notification.
Insured's name?	• The exact name should be compared with the schedule.
What, if any, correspondence is to hand?	• Any repair estimates or legal correspondence should be sent to the insurer as soon as possible.
Does the insured know the likely cost of the claim?	• This will help determine the initial claim case reserve. • This will also help the claims handler to decide on the next step in the process, e.g. whether to appoint a loss adjuster or other expert.
The loss address	• The loss address should be compared to the risk address in the schedule.
Further questioning, where the answer does not make sense.	• To ensure clarity about the circumstances and to flag up any issues needing further investigation.

Reference Chapter 2A1 **Total: 10 Marks**

Question 2

(i) When a new claim is notified, the insurer may ensure mitigation of the loss. For example:

- If a loss is still occurring, insurers will immediately enquire if further damage can be prevented. For example, in a flood situation, salvage or restoration experts might be instructed to move items in danger of damage.
- If the loss is no longer occurring, damage might be still continuing. A roof taken off in a storm might leave goods in a warehouse exposed. Moving these goods will prevent further damage.
- If damage to the goods has commenced, e.g. water damage or smoke damage, the goods may be saved by drying out or cleaning. If this is impossible, the goods may have a salvage value.

(ii) The following are some possible ways to mitigate personal injury claims:

- For employers liability claims, what approach is an employer taking? Is it worth continuing to pay wages to avoid the injured party suffering hardship, thus leading to a claim?
- Will the payment of medical costs prevent the injured party from making a further claim?
- Can rehabilitation services intervene at an early stage? This can reduce the claimant's recovery time and help them return to work sooner.

Reference Chapter 2C1 & C2 **Total: 10 Marks**

Chapter

3

Claims verification

What to expect in this chapter

In Chapter 2 we saw that an insured must notify a potential claim to the insurer as soon as possible and provide key information about what happened. Following notification, they may be asked to submit a claim form and other documentation or to provide other information to the insurer.

We will now look at how the claims handler checks the initial information and begins deciding what will happen with the claim.

Contents

A Checking the claim documentation

Once the claim form (if required) and other documents have been received, the claims handler needs to establish quickly if there is any question of the claim not being valid. They will check the information on the claim form (or other documents) against the initial information given when the claim was notified. They will also compare the claims information to the underwriting information.

Important questions at this stage are:

- Is the policy in force and has the premium been paid to the insurer or the adviser?
- Is the insured entitled to indemnity under the policy? For first party claims made under non-consumer insurance contracts, this includes checking the claim documentation and policy details to ensure that there is valid **insurable interest** (see Section C) on the part of the person making the claim.
- Is the information given on the claim form consistent with that given on the proposal form? Sometimes extra information (e.g. regarding motoring convictions) is provided when notifying a claim. The claim handler then checks the underwriting information. If it appears that there has been a breach of the duty of **utmost good faith** in the case of commercial or non-consumer contracts, further investigation may be necessary. In the case of consumer contracts, further investigation may be necessary if it appears that a question was answered incorrectly by the consumer during the insurance proposal/application process (see Example 3.1 and Section D).
- What are the exact circumstances surrounding the loss, damage or liability? As we have already learned in Chapter 2B3, the onus of proof rests with the insured to prove that their loss was caused by an insured peril. This means providing evidence to show that the proximate cause (Section E) of the loss is covered. If there is any doubt about this the claims handler will arrange further investigations.
- What is the potential cost of the claim? The claim form and/or other documents will be studied and the initial case reserve (see Chapter 2E) may be updated. This will include provision for any potential third-party claims.

insurable interest

the legal right to insure arising out of a financial relationship recognised at law between the insured and the subject matter of the insurance

utmost good faith

the positive duty to voluntarily disclose, accurately and fully, all facts material to the risk being proposed, whether requested or not

subrogation

the right of an insurer, following payment of a claim, to take over the rights of the insured to recover payment from a third party responsible for the loss

contribution

the right of an insurer to share the cost of an indemnity payment among similarly (but not necessarily equally) liable parties

- Was any other party at fault for the loss or damage? This enables the insurer to take a preliminary view on the possibility of recovery and to begin pursuing their **subrogation** rights (see Chapter 7C1).
- Is the loss covered by any other policy or policies? If so, there may be a possibility of recovery through the insurer's **contribution** rights (see Chapter 7C2).
- Does the amount claimed appear to be reasonable? If not, further documentary evidence or additional enquiries may be needed. An assessment of the reasonableness (or otherwise) of the amount claimed is based on the principle of indemnity (see Chapter 5).

Example 3.1

Mary is involved in a motor accident. She completes and returns a motor accident report form to her insurer. On reviewing the form, the claims handler notes that Mary mentions she was convicted of dangerous driving 6 months before the policy was taken out. The claims handler checks Mary's proposal form to see if they were previously notified of this conviction. There is no mention of any conviction on the proposal form.

If Mary was asked a question about previous convictions in the proposal form and she did not disclose this when asked, then this is a breach of Mary's pre-contractual duties to her insurer. If the insurer can show that it would not have entered into the contract with Mary had it known of this conviction, there will be serious consequences for Mary's insurance cover. The insurer will need to investigate whether the non-disclosure was innocent, negligent or fraudulent. If the non-disclosure was fraudulent, the insurer may void the policy for non-disclosure (see Section D1) and refuse to pay the claim. However, if a third party was involved, the insurer may have to deal with this aspect and then seek recovery of their outlay from Mary (see Section D2c).

B Checking the policy

In the initial stages of a claim, the claims handler seeks to make a preliminary assessment of whether or not the loss is covered.

B1 Policy structure

Policy structure was examined in The Nature of Insurance module, the Compliance and Advice module and the Practice of Risk Control and Underwriting module. Table 3.1 provides a helpful reminder of the general structure of an insurance policy.

Table 3.1 Policy structure

Policy section	Nature of content
Heading	Name of insurer, possibly the address and insurance company logo
Recital clause/ preamble	Descriptive clause referring to the two parties to the contract, premium payment and indemnity, and the proposal (if any) as the basis of the contract
Definitions	Frequently used terms or words with a particular meaning as defined
Signature	Pre-printed signature on behalf of the insurer
Operative clause	States the insurer's promise to pay and the extent of that promise (i.e. the scope of cover under the policy)
Policy schedule	Document tailored to provide the policy number and all the variable information about the policyholder, policy period, premium and subject matter, and highlight any special terms, conditions or exclusions that apply
Information and facilities	Information, not usually part of the contract itself, that may be provided on customer helplines, service standards, complaints procedures and claims procedures
General conditions	Standard conditions applied by all insurers to policies of a given type
General exclusions/ exceptions	Standard exclusions applied by all insurers to policies of a given type

operative clause

clause(s) that describes the standard scope of cover of each section of an insurance policy

The claims handler needs to know the terms of the policy in detail so they can establish whether the loss is covered and what restrictions or limitations apply.

schedule

tailored section (of a policy) that provides the policy number and all variable information about the policyholder, period, premium and subject matter, and highlights any special terms, conditions or exclusions that apply

claims investigator (inspector)

an individual who is skilled, experienced and qualified to investigate the circumstances of individual claims

Others may also review the policy document and **schedule** when a claim is reported. For example:

- A broker or other intermediary may need to confirm which insurer the claim should be made against and may wish to advise the client about conditions that must be complied with.
- A loss assessor may wish to check the basis on which claims are to be settled, e.g. on an indemnity or reinstatement basis.
- A loss adjuster or **claims investigator** acting for the insurer will need to check the scope of cover and the insured's compliance with particular terms and conditions.

We will now briefly examine some of the key points that the claims handler considers as part of the initial checks on policy cover:

B1a Policy schedule

The policy schedule provides specific information relevant to the policy. This is often a separately printed document to the policy booklet, but they should be read together as one insurance contract.

Just think

Review insurance policies that you might have in the office, or indeed any policies that you have taken out yourself.

Investigate how much information contained in the schedule is specific to you and what is general information that would be included in all insurance policies.

The claims handler compares the information on the schedule to that provided in support of the claim. They will check, for example, that:

- There are no inconsistencies in the insured's, name, address and business description
- The claim arose from a business activity specified in the insured's **business description** on the schedule
- The loss occurred within the **territorial limits** of the policy
- The loss occurred during the period of cover (see Section B2)
- Any special **endorsements** are taken into account, as they may change the usual level of cover under a particular type of policy or apply a warranty (see Section B1f) to a policy.

business description

an overview of key points of your business

territorial (geographical) limits

those countries or territories where the policy cover will operate

endorsement

a written document, usually incorporated within a policy wording, and referenced on the schedule, which modifies the policy in terms of the cover being afforded by the insurer

B1b Extensions

The claims handler should be familiar with the standard cover provided by the insurer's policies. Extensions can widen the cover to include areas of risk or perils not falling within the standard cover. Some typical examples of these are:

- **Motor** – additional named drivers or cover for a temporary replacement vehicle following an accident.
- **Buildings and contents** – accidental damage for personal possessions and cover for alternative accommodation following a loss.
- **Employment practices liability** – an increasingly common extension to directors and officers insurance policies (both commercial combined and stand-alone), including special limits or excesses applying only to extended sections.

B1c Exclusions

The operative clause defines the cover provided and the definition can be quite broad. The policy uses exclusions (circumstances or types of losses that are not covered) to limit the cover and the way cover operates. Proof that an exclusion applies rests with insurers. Where an exclusion operates, enquiries are usually conducted into the circumstances of a loss on a 'without prejudice'/'reservation of rights' basis before a decision is made to repudiate cover. This means that, where a potential breach of condition or exclusion might apply but cannot be determined definitively without further investigation, the insurer's 'without prejudice' investigation in these circumstances will not be deemed to be an admission by the insurer that the policy applies to provide indemnity. Also, this will not negatively impact on its (the insurer's) right to subsequently rely on the condition or exclusion to repudiate cover after the investigation is carried out. In such circumstances however, the insurer should be clear with a policyholder that the claim is being investigated without prejudice to liability, as it could be the case that an insured incurs costs in the absence of any clarity from the insurer.

Just think

In your previous studies you have looked at many different kinds of policies and how they operate. Think back about the exclusions that applied to each.

There is some commonality among exclusions in different kinds of policies. The exclusions often fall into the following general areas:

- **More specific cover** – For example, employers liability and public liability policies exclude any liability arising from motor vehicles, which would fall more properly within the insured's motor cover. Most personal policies exclude any property used for the insured's business.
- **Losses that are not fortuitous** – This means that a property policy, for example, would exclude any loss arising from want of maintenance or wear and tear. This depends on the circumstances, as resulting damage may be covered. For example, damage to a flat roof is not covered if the damage is due to normal wear and tear.
- **Policyholder's deliberate acts** – These are always excluded.
- **Dishonesty and fraud** – These are a common exclusion.
- **Criminal fines and penalties** – Generally, these cannot be insured against, as a matter of public policy.
- **Certain perils** – These include radioactive contamination, nuclear activity, war, sonic booms, terrorism and pollution.

The definitions section of the policy wording (see Section B1e) will provide further clarity on terms, setting out what it does or does not include. For example, the definition of contents in a household policy may say that it does not include golf buggies. In this case it is unnecessary to have a separate exclusion to point out that golf buggies are excluded from cover.

B1d Conditions

As discussed in Chapter 2B, any specific conditions to the policy must be properly investigated, as a claims handler needs to ensure a policyholder has complied with these.

B1e Definitions

To avoid the repeated use of lengthy lists and sentences, insurers define words and phrases that appear throughout the policy, e.g. buildings, contents, employee, and damage. These definitions are important when determining whether or not cover exists.

A key question for a claims handler to consider is whether the policy covers the person or entity seeking indemnity under that policy. In a personal lines policy, the insured may be addressed as 'you' throughout. There will then be a definition of 'you' within the definitions section. For example, 'you' may be defined as 'the person named as the insured in the schedule and all permanent members of that person's household, including domestic employees who live in the home'.

For commercial covers, 'the insured' usually includes any associated and/or subsidiary companies (usually the insurer requires specific identification of these at the proposal stage). Sometimes the main company is listed as the sole insured in the schedule and then an extension is added to list any other companies being covered. If a limited company is the insured entity, the cover extends without further elaboration to all those for whose acts the insured entity would have **vicarious liability**, unless specifically restricted elsewhere.

In each situation the policy is examined carefully to see who is defined as the insured, whether there are any elaborations of this in the 'definitions' section and to check if there are any relevant extensions or exclusions.

While definitions are helpful and provide clarity for all involved, insurers need to be clear and precise when defining terms. If the definition of a term is ambiguous, it will be interpreted in favour of the policyholder.

vicarious liability

when one person is held liable for a wrong committed by another

warranty

term (in an insurance contract) that, if broken, automatically voids the contract as a whole from the date of breach

B1f Warranties

A **warranty** in an insurance policy is an undertaking by the insured that something will or will not be done, or that a certain state of affairs does or does not exist. Warranties are intended to improve and manage risks throughout the policy period. Examples include confirming that a burglar alarm is operative or that a sprinkler or full-time security system is installed.

You will recall from The Nature of Insurance module that warranties must be strictly and literally adhered to by the insured, as failure to do so carries serious consequences. The common law position in relation to non-consumer insurance contracts is that a breach of a warranty by an insured will confer a right on the insurer to avoid the contract from the date of the breach. This right, or position, can be modified by a term in the policy where the insurer states that it will not avoid a claim where there has been a breach of warranty, provided that there has not been any increase in risk as the result of such a breach.

Under the **Consumer Insurance Contracts Act 2019**, warranties are no longer permitted in consumer insurance contracts.[9] Neither is any term which converts a statement or representation made by a consumer prior to entering into the insurance contract into a warranty ('basis of contract clause'). Under this Act, any contract term that imposes a continuing restrictive condition on a consumer is treated as a **suspensive condition**. If a suspensive condition is breached, the insurer's liability is suspended for the duration of the breach, but only if the breach has not increased the risk of loss occurring. Otherwise, if the breach has been remedied by the time the loss occurs, the insurer shall not be entitled to deny the claim on this ground alone. However, if the breach has increased the risk of the loss occurring, then the insurer's liability in terms of the breach is suspended indefinitely.[10]

suspensive condition

condition that, if breached, suspends the insurer's liability for the period of the breach.

B2 Checking the basis of cover

Before a claims handler can begin to determine the extent of cover under a policy, they must establish whether the policy was in force at the relevant time. Generally, this is a fairly straightforward process. However, for liability insurance, the handler must first check the basis of cover under the policy and must also take into account the trigger(s) that gave rise to the claim.

You will recall from the Commercial General Insurance module and the Practice of Risk Control and Underwriting module that policies may be written on an occurrence (sometimes called a 'losses occurring') or a 'claims made' basis and that different stages of a liability event may trigger a claim under a policy. We will now consider the relevance of these issues to the claims process.

Quick question 1

What is the purpose of a policy schedule?

The answer is at the end of this chapter.

B2a Liability policy triggers

A claim under a liability policy is triggered by one of the following stages in a liability event:

1. The initial act, usually negligence, but it could be another legal wrong
2. The actual injury, loss or damage resulting from the act
3. The manifestation of the injury, loss or damage
4. The aggrieved or injured party's awareness of the injury, loss or damage
5. Notification of the claim to the insured
6. Notification of the claim to the insurer.

Often the first three or four stages will occur almost simultaneously. In some types of insurance, claims develop in a more complicated way. This is particularly true with professional indemnity claims, or those involving industrial diseases. Claims handlers must therefore pay close attention to policy wordings when determining the existence of cover.

There are further variations with professional indemnity policies, or other covers that are written on a 'claims made' basis (see Section B2c). Claims under these policies are typically triggered at Point 5, i.e. the notification of a claim (or a potential claim) to the insured.

We mentioned in Section B2 that when checking the existence of cover, the claims handler must also consider the basis of cover under a liability policy. This is typically on either an occurrence basis or a claims made basis. We will now briefly examine these types of policy wordings.

[9] Section 19, **Consumer Insurance Contracts Act 2019**.

[10] Section 19.(6)(b) of the Consumer Insurance Contracts Act 2019, available on www.irishstatutebook.ie"

occurrence wordings

liability policy covers that are triggered when the incident occurs (which could be over a period of time)

B2b Occurrence wordings

Occurrence wordings are used when the policy is intended to respond to physical damage or personal injury that occurs within a specified time frame. The date of loss usually coincides with the date of the event that caused the loss, as illustrated in Example 3.2.

Almost all policies involving damage to insured property are arranged like this, as are many liability policies (including employers, public and most products liability policies).

Example 3.2

A plumber carries out works in 2017. Water damage occurs in 2023. Investigation reveals that the cause was a loose joint that did not leak until long after the works were completed. In this case it is the 2023 insurer that will be called on to deal with the claim, as this is when the loss occurred. The 2017 insurer will not have to deal with the liability.

'claims made' wording

liability policy cover that is triggered when the third party (claimant) makes a claim against the policyholder

B2c 'Claims made' wordings

The other type of cover is a '**claims made**' policy. These are policies where there is indemnity to the insured against claims first made against them during the period of cover. The date on which the claim is made is the trigger for the policy, as illustrated in Example 3.3.

Example 3.3

ABC Architects are responsible for the design of a new stadium. They complete their design and two years later, the stadium is built. During the testing stages immediately prior to the building's completion, the roof leaks, damaging the seating in the stadium. An investigation into the reason for the leak establishes that it is due to an error in the design drawings. The stadium owners have to delay opening while they replace the seating. ABC received a formal claim from the owners a year later. ABC clearly made the error when the design was completed, and while the fault was discovered in the late stages of the build; they did not receive the claim until a year after that. As a policy written on a claims made basis, it is ABC's current insurer that deals with the claim.

Claims made policies usually require the insured to disclose at inception and at each renewal 'any circumstances that may give rise to a loss'. If an insured is aware of a potential claim, then it would be usual for this to be excluded under the current policy. Clearly, this could cause difficulties, and in relation to Example 3.3, one would wonder if the architects should have notified the roof leak to their insurer at the time of occurrence as opposed to notifying the insurer on cover when the claim was made. The claims handler will need to fully clarify what information was made known to the insured, and when that happened, before deciding if there had been a breach of the notification condition. In any event, if the insured is a consumer, then under the **Consumer Insurance Contracts Act 2019** the insurer is only entitled to decline the claim for late notification if it can prove its position has been prejudiced by the late notification (see Chapter 1D1b).

In the case of *J Rothschild Assurance plc v Collyear & Others* (1998), it was stated that a claims made policy could only work on this basis. As long as the notification had been made, the policy would continue to extend cover to claims that were made after the expiry.

A typical claims made wording for this clause would be:

Insurance policy extract 3.1

Any claim arising from such circumstances shall be deemed to have been made during the **policy period** applying in which such notice was given to insurers.

Just think

Take a look at an insurance policy document from your workplace.

Can you identify the different sections listed in Table 3.1 in Section B1?

policy period

dates between which the policy is operative

C Insurable interest

As we have already learned in The Nature of Insurance module, insurable interest refers to the connection between the policyholder and the items at risk. This is an important issue for claims handlers when checking claim information, as it goes to the heart of the insured's entitlement to protection of the policy.

There are four key features for valid insurable interest to exist:

1. There must be some property, right, interest, life, limb or potential liability capable of being insured.
2. Such property, right, interest, life, limb or potential liability must be the subject matter of insurance.
3. The insured must stand in a relationship with the subject matter of insurance whereby they benefit from its safety, wellbeing or freedom from liability, and would be prejudiced by its damage or the existence of liability.
4. The relationship between the insured and the subject matter of insurance must be recognised at law.

Microlearning resources

In the Member Area of www.iii.ie, via the Connect logo and in Your Learning Centre, select the microlearning section of this chapter to access a resource specifically developed to help you better understand this topic.

subject matter of insurance

item or event insured (e.g. car, house, valuables, factory stock, or liability for acts of negligence)

legal interest

one that the law recognises and will support

It is a legal obligation for non-consumer insurance contracts to have an insurable interest in the **subject matter of insurance**. The claims handler must therefore establish that the policyholder has a **legal interest** in the subject matter of the claim. Without this financial interest, no loss has been suffered by the person named in the policy and, consequently there is no loss to be measured. A lack of financial interest may be a fraud indicator or highlight that a misrepresentation (see Section D1) may have occurred. Further detailed inquiries would be necessary to evaluate the position.

The law in respect of insurable interest has evolved significantly with the introduction of the **Consumer Insurance Contracts Act 2019**.

A consumer is defined in the **Financial Services and Pensions Ombudsman Act 2017** (and the same definition applies in the **Consumer Insurance Contracts Act 2019**) 'as a natural person, a sole trader, partnership, trust club or charity, or an incorporated body that had an annual turnover in its previous financial year of €3 million or less'.

In respect of consumer insurance contracts, it is not necessary for the consumer to show that they had an insurable interest in the subject matter of the insurance at the time that the contract was entered into; only that they have an insurable interest at the time that the claim is made. Insurers are responsible for assessing a risk before it is underwritten and if, at that stage, the insurer determines that a proposer does not have sufficient or any insurable interest in the item being insured, then the insurer does not have to sell them the insurance. However, if they do sell the insurance, the insurer cannot later seek to avoid a claim because the claimant does not have an insurable interest.[11]

However, insurable interest remains an important concept when dealing with non-consumer insurance contracts and therefore, its scope and impact is examined next.

C1 The subject matter of insurance

It is important to understand that when a person arranges car insurance, they are insuring not the car as such but their interest in the car and the liabilities that may arise from driving or owning the vehicle. Although the car and the potential liability are the subject matter of insurance, it is this interest alone that is the subject matter of the contract. This concept was expressed by Brett LJ in the case of *Castellain v Preston* (1883): '… what is it that is insured in a fire policy? Not the bricks and materials used in building the house but the interest of the insured in the subject matter of insurance'.

C1a Economic or financial interest in the subject matter

The principle of insurable interest demands a relationship between the insured and the subject matter of insurance, whereby the insured will suffer a financial loss if the insured event occurs. The words of Lawrence J in *Lucena v Craufurd* (1806) express this point well:

> 'A man is interested in a thing to whom advantage may arise or prejudice happen from the circumstances which may attend it … To be interested in the preservation of a thing is to be so circumstanced with respect to it as to have benefit from its existence, prejudice from its destruction.'

A mere hope or expectation of acquiring an interest in the future is not enough. This interest must be recognised and supported at law. The case of *Macaura v Northern Assurance Co. Ltd* (1925) emphasises this point.

Case law

Macaura had insured a quantity of timber under a fire policy in his own name. He had already sold the timber to a limited company, of which he was the only shareholder. When the timber was destroyed by fire, the insurer refused to pay the claim because Macaura (as a private individual) had no insurable interest in the property of the limited company. As a shareholder, his interest was limited to the value of his shares and did not extend to property owned by the company. The House of Lords supported the insurer's position.

[11] William Fry (Solicitors), Consumer- Insurance –Contracts- Act, pdf, © William Fry 2020,www.williamfry.ie

C2 Source and timing of insurable interest

common law

system of laws that has been built up over centuries by judges deciding individual cases

Insurable interest is usually created as a result of some legal right or obligation. This normally arises in one of two ways:

- **Common law** - sometimes insurable interest is automatically presumed to exist. For example, everybody is presumed to have an unlimited interest in their own life and in property that they own. Where an interest is automatically assumed, we can describe it as having arisen at **common law**. Equally, the common law duty of care, which persons owe to each other, may create a liability, which again entitles a person to insure (against this liability).
- **Contract** - sometimes a person will agree to accept responsibility for something for which they would not ordinarily be liable. For example, a landlord, rather than a tenant, is normally liable for the maintenance of their property. The lease will often contain a condition that makes the tenant responsible for the maintenance, or repair of the building. This gives the tenant a financial (insurable) interest in the property. Similarly, businesses hiring machinery or equipment usually sign contracts making them responsible for loss or damage to the property. Although they do not own the machinery or equipment, this obligation creates a valid insurable interest.

It is also very important to consider when the interest must exist. Traditionally, in general insurance insurable interest had to exist both at policy inception and at the time of a loss. However, as was noted earlier, this requirement changed in relation to consumer insurance contracts following the introduction of the **Consumer Insurance Contracts Act 2019**. Under consumer insurance contracts, it is not necessary for insurable interest to exist at policy inception, but it is necessary for it to exist at the time of a loss.

C3 Application of insurable interest for non-consumer insurance

We have seen that insurable interest is based on a financial interest in an item or event covered by insurance. This financial interest creates a right to insure, since if there was no policy in place, the insured would have to pay for the consequences from their own funds.

We will now consider the application of insurable interest in different types of insurance.

C3a Property insurance

The most common insurable interest is the interest a person has in property they own, such as a house or car. However, there may also be other situations where a valid insurable interest exists.

Often a person will have only a limited interest in the property to be insured. For example, the interest of a part-owner will be limited to the value of their share in the property. However, a person with a limited interest may still insure the property for its full value. This does not mean that they can keep all the insurance money in such a case. If they are paid any claim monies in excess of their interest, they are deemed to hold the balance as agent of the others.

Where a property has been purchased with a mortgage, both the lender and the purchaser have an insurable interest. The purchaser's interest arises from ownership of the property and the financial institution acquires an interest because the property is held as security for the loan. This is a very common situation and in practice the interest of the lender (usually a financial institution) is noted on the policy **schedule** as an interested party. If a total loss occurs, payment will be made jointly to the insured and the interested party.

C3b Liability insurance

Everyone faces the risk of being sued for damages if they harm another person through their negligence or other unlawful act. They also face the risk of having to pay associated costs (including expensive legal costs) of defending themselves in a negligence action. Liability can arise in connection with a business enterprise, or through private activities, such as owning a home, or driving a car. So, everybody has an interest in protecting his or her exposure to a liability and this interest is insurable.

Just think

At the start of Section C, you read about the 4 key features which must be present for a valid insurable interest to exist. Can you remember what they were?

Example 3.4 explores some of these 'financial relationship recognised at law between the insured and the subject matter of insurance', which (if all other features were present) would create a valid insurable interest.

Quick question 2

ABC Ltd. purchases a house for €200,000. It pays 20% itself and uses a mortgage to pay the balance. It takes out a mortgage protection policy with the bank, which is named as mortgagor.

What is the monetary value of the bank's insurable interest in the property?

Example 3.3

Relationship that may create a valid insurable interest

Insurance type	Relationship
Life insurance	Spouse Civil partner Employer Business partner
Private motor insurance	Car owner and driver(s)
Home insurance	Owner (for buildings) Owner or tenant (for contents) Mortgagee
Travel insurance	Person travelling
Health insurance	Anyone
Pet insurance	Pet owner
Commercial property insurance	Owner (for buildings) Owner or tenant (for contents) Mortgagee
Business interruption insurance	Business owner
Commercial motor insurance	Business owner Fleet owner Garage owner
Fidelity guarantee insurance	Business owner
Liability insurance	Business owner Property owner Employer Producer Supplier Service provider
Goods in transit	Transporter Owner of goods
Farm insurance	Farmer Farming contractor
Legal expenses	Homeowner Car owner Business owner

D Disclosure

The duty of disclosure is central to the practice of insurance. However, its application and legislative basis differ between consumer and non-consumer insurance contracts. These sections examine the scope of this duty and the requirement it places on the parties to an insurance contract.

D1 Utmost good faith

As noted in Section A, the duty of utmost good faith still applies in respect of non-consumer insurance contracts.

The duty of utmost good faith is a positive duty of disclosure to provide all important information (material facts) about a risk. It is a continuing duty in non-consumer insurance contracts that applies throughout the contract and not just at the commencement of the policy.

Case law

The origin of this duty of utmost good faith is found in the classic judgment of Mansfield LJ in *Carter v Boehm* (1766):

> Insurance is a contract upon speculation. The special facts, upon which the contingent chance is to be computed, lie most commonly in the knowledge of the insured only: the underwriter trusts to his representation, and proceeds upon the confidence that he does not keep back any circumstance in his knowledge, to mislead the underwriter into a belief that the circumstance does not exist, and to induce him to estimate the risk as if it did not exist.

The proposer knows more than the insurer and must tell the insurer the relevant facts. This is based on the assumption that an insurer will not be able to easily discover the full facts about a risk unless the proposer volunteers that information.

When dealing with non-consumer insurance contracts, the claims handler must check that the claims information matches the underwriting information. The claims information should be compared with proposal declarations to ensure they are mutually consistent. The claims notification may reveal a **material fact** that the insured knew but did not disclose at the time of the proposal (such as previous claims or a motoring conviction). Similarly, it may indicate a change since inception that underwriters need to know about, possibly because it affects renewal terms or triggers the need for an additional premium or premium adjustment. Some changes can make a risk unacceptable or subject to special terms.

material fact

any fact that would influence an underwriter/insurer in either accepting or rejecting a risk and in deciding what terms to impose

When checking this information, the claims handler's priority is to identify any potential breach of the duty of utmost good faith. This principle requires the parties to the insurance contract to:

- Tell the truth
- Volunteer all relevant information and not to conceal anything.

D2 Pre-contractual duty of disclosure

Under the **Consumer Insurance Contracts Act 2019**, an insurance consumer's duty of utmost good faith has been replaced with certain pre-contractual duties. A consumer's pre-contractual duty (i.e. for consumer insurance contracts) is confined to providing responses to questions asked by the insurer. The insurer is not entitled to ask questions of a general nature to circumvent this requirement. All questions must be in plain and intelligible language. If there is any doubt about the meaning of a question, it will be interpreted in a way that is most favourable to the consumer. The consumer is not under any obligation to volunteer any information over and above the questions that have been specifically asked by the insurer in the proposal form (or Statement of Fact). The consumer is obliged to answer all questions honestly and with reasonable care. The test for reasonable care is the care that an 'average consumer' would ordinarily give to the question being asked.

If the insurer fails to investigate an absent or obviously incomplete answer to a question, it is deemed to have waived any further duty of disclosure of the consumer. However, this does not apply where the non-disclosure arises from fraudulent, intentional or reckless concealment. The **Consumer Insurance Contracts Act 2019** also abolishes the principle of utmost good faith for post-contractual duties.[12]

Insurers therefore must ensure that they use the correct and most efficient questions on their policy proposals to ensure that they are receiving the risk information they need to review for pricing or acceptance of a risk.

Students should be aware of the difference in disclosure obligations for consumer and non-consumer insurance contracts.

Just think

When thinking about disclosure on a private motor policy proposal form, identify the impact of these similar but different questions. Remember that if the insurer does not pose the questions correctly, then it cannot rely on non-disclosure.

- Have you had any motoring conviction in the last 3 years?
- Have you ever had any motoring conviction?
- Have you had a claim in the past 3 years?
- Have you ever been party to a motor insurance claim or had anyone claim under your motor policy?

In both cases, when questions contain a specific time-limit (i.e. 3 years), the insurer can only expect the proposer to answer the question as it relates to that period. The other questions are more open-ended and ask the proposer to consider longer time periods and other, broader circumstances.

[12] William Fry (Solicitors), Consumer- Insurance –Contracts- Act, pdf, © William Fry 2020

D3 What is a material fact?

The definition of material fact is contained in the **Marine Insurance Act 1906**, Section 18(2): 'Every circumstance is material which would influence the judgement of a prudent insurer in fixing the premium or determining whether he will take the risk.'

According to the Act, the test is that of the prudent underwriter. The question is whether a prudent underwriter would consider the fact to be material in deciding the premium to be charged or in deciding whether they wish to underwrite the risk. An easy example of this, is the case of an 18-year-old who lies when taking out insurance by saying they are 23. As a result of this lie the individual would receive a cheaper premium.

The legal interpretation of what is or is not a material fact has evolved over time.

Case law

In the Irish case of *Chariot Inns v Assurazioni Generali* (1981), the court held that 'a fact is material if it would have reasonably affected the mind of a prudent insurer in determining whether he will accept the insurance and if so at what premium and on what conditions'. The court introduced a test of 'reasonableness'.

Case law

The definition of 'material fact' was again discussed in *Aro Road and Land Vehicles Ltd v Insurance Corporation of Ireland Ltd* (1986). McCarthy J stated:

> In my view, if the judgement of an insurer is such as to require disclosure of what he thinks is relevant but which a reasonable insured, if he thought of it at all, would not think relevant, then, in the absence of a question directed towards the disclosure of such a fact, the insurer, albeit prudent, cannot properly be held to be acting reasonably. A contract of insurance is a contract of the utmost good faith on both sides; the insured is bound to disclose every matter which might reasonably be thought to be material to the risk against which he is seeking indemnity; that test of reasonableness is an objective one not to be determined by the opinion of underwriter, broker or insurance agent, but by and only by the tribunal determining the issue.

This created an obligation on both the insurer and insured.

In the Supreme Court appeal of the case of *Kelleher v Irish Life Assurance Co. Ltd* (1993), the judge seemed to accept that the test was that of the reasonable insured and not the reasonable insurer: '…the true and acid test must be as to whether a reasonable man reading the proposal form would conclude that the information over and above it which is in issue was not required'. The proposal form and the manner in which the questions were asked and presented were carefully considered in this case before finding for the insured. The fact that a special short proposal form had been used was highly relevant.

It can therefore be argued that the test for materiality in Ireland has moved from the traditional requirements of a 'prudent insurer' to an objective test of reasonableness, having regard to the assumptions and knowledge of a 'reasonable proposer'.

In consumer contracts, it is recognised that it would be unfair to expect a proposer to know what is or isn't a material fact. The insurer must ask questions about issues known to be material and provide detailed warnings about the consequences of the failure to disclose material facts.

The CPC states:

> 'A regulated entity must explain to a consumer, at the proposal stage, the consequences for the consumer of failure to make full disclosure of relevant facts, including:
>
> a. the consumer's medical details or history; and
>
> b. previous insurance claims made by the consumer for the type of insurance sought.'

The explanation must include, where relevant:

- That a policy may be cancelled
- That claims may not be paid
- The difficulty the consumer may encounter in trying to purchase insurance elsewhere
- That in the case of property insurance, failure to have property insurance in place could lead to a breach of the terms and conditions attaching to any loan secured on a property.

As noted earlier, the **Consumer Insurance Contracts Act 2019** has replaced the duty of utmost good faith in respect of consumer insurance policies with other pre-contractual duties. In terms of the insurer's pre-contractual duties, the insurer is required to ask specific questions about facts that it wishes to know about and the consumer must answer these questions honestly and with reasonable care.

D3a Need there be connection between the 'missing facts' and the loss?

The issue of non-disclosure usually arises when there is a dispute about a claim. Sometimes the non-disclosure may be about something unrelated to a claim. For example, when investigating a fire claim, the insurer may discover that a policyholder failed to disclose several previous burglaries. Here the insurer will still have a legal right to avoid the policy if the policyholder when asked a specific question about such previous incidents answered the question falsely and deliberately, since burglary claims are clearly material facts in property insurance.

Other less clear situations are considered on their own merits, as seen in the case of *FBD Insurance plc v Financial Services Ombudsman* (2011).

Case law

In the High Court decision of *FBD Insurance plc v Financial Services Ombudsman* (2011), the insurer had asked in the proposal form about motoring convictions and repudiated a motor claim when they found the claimant had undeclared criminal convictions. The convictions related to crimes such as theft and intoxication in a public place, and there were no convictions for road traffic offences. The Financial Services Ombudsman (FSO) decided that this was not correct, as the conviction did not materially affect the proposal for motor insurance. The High Court made it clear that it had to decide if a serious error was made by the FSO, and finally concluded that there was none. The High Court upheld the FSO decision.[13]

This case highlights the importance of asking clear and unambiguous questions on a proposal form. When asking about criminal convictions, insurers should also be mindful that some convictions do not have to be disclosed by a proposer. Under the **Criminal Justice (Spent Convictions and Certain Disclosures) Act 2016**, which came into effect on 29 April 2016, a range of minor offences will become spent after 7 years. An adult convicted of an offence covered by the Act does not have to disclose the conviction after 7 years, except in certain circumstances.

The convictions which may be regarded as spent after 7 years are:

1. All convictions in the District Court for motoring offences except for convictions for dangerous driving which are limited to a single conviction
2. All convictions in the District Court for minor public order offences
3. A single conviction (other than a motoring or public order offence) in the District or Circuit Court which resulted in a term of imprisonment of 12 months or less (or a fine).

The Act does not apply to any conviction for a sexual offence or an offence which was tried in the Central Criminal Court. The 7 years is from the date the custodial or non-custodial sentence became operative and the individual must have complied with the sentence or order imposed.[14]

D4 Misrepresentation

A misrepresentation is a false statement of fact that induces the other party to enter into the contract.

It may be:

- **Fraudulent misrepresentation**
- **Negligent misrepresentation**
- **Innocent misrepresentation**.

Fraudulent misrepresentation occurs when a person makes a statement with an intention to deceive, knowing that the statement is false. For example, John advises on his motor proposal form that he has no previous road traffic convictions when in fact he has been convicted of dangerous driving.

[13] Citizens Information website (www.citzensinformation.ie), 'Spent convictions'.

[14] Citizens Information website (www.citzensinformation.ie), 'Spent convictions'.

Negligent misrepresentation occurs if a statement made is an honest expression of opinion while having no reason to believe it is true. It arises in contract law. For example, Peter, a car dealer is talking to a prospective buyer of a second-hand car. He claims that the previous owner had recently changed the oil in the car without even knowing if this is true or not.

Innocent misrepresentation occurs when a person has reasonable grounds for believing that their false statement is true. For example, Susan is making a claim for damage to her tables and chairs from accidental damage. She advises that they are 3 years old but it turns out they are 5 years old. When Susan advised they were 3 years old she believed this was true.

When investigating a claim, the claims handler might discover that the insured misrepresented facts when proposing the risk and needs to decide what action can be fairly taken by the insurer. An example of this might be if an insured reports that the roof of their premises was rapidly destroyed by fire. An inquiry about why the spread of flame was so rapid might lead to the insured advising that a significant part of the roof was thatched and not roofed with slate as had been declared previously. A claims handler would know that the insurer was unlikely to have offered insurance for properties with thatched roofs. Other common examples are an incorrect date of birth on a motor proposal, failing to disclose previous convictions, or a business storing undisclosed hazardous materials.

ab initio

latin term meaning 'from the beginning'. Used to describe where a policy is null and void, as though it never existed – 'void *ab initio*'

An insurer may legally avoid non-consumer insurance contracts ***ab initio*** on the grounds of misrepresentation, regardless of the type of misrepresentation involved.

Under the **Consumer Insurance Contracts Act 2019**, there are remedies available to the insurer for misrepresentation in the case of consumer insurance contracts. The remedy depends on the type of misrepresentation involved. In the case of:

- fraudulent misrepresentation, the insurer is entitled to avoid the policy
- negligent misrepresentation, the remedy should reflect what the insurer would have done had it been aware of the true facts
- innocent misrepresentation, the insurer is required to pay the claim and may not avoid the policy.

D5 Breach of utmost good faith in non-consumer contracts

You should note that under non-consumer insurance contracts, a breach of utmost good faith may be committed by the insured or the insurer.

As we have already learned in Section D3, a breach of utmost good faith on the part of the insured may take the form of:

- Misrepresentation, either innocent or fraudulent
- Non-disclosure, either innocent or fraudulent (concealment).

Table 3.2 outlines the remedies for breach of good faith by the insured. It shows that the consequences for a claim can be serious. If the policy is avoided completely, no claims will be paid and sometimes the premium can even be retained.

Table 3.2 Remedies for breach of utmost good faith by the insured in non-consumer contracts

	Innocent breach	Fraudulent breach
Right to avoid the policy as a whole?	Yes	Yes
Right to keep the premium as well?	No	Yes
Right to ignore the breach and allow the policy to stand?	Yes	Yes
Right to refuse a particular claim, but allow the policy to stand?	No	No

Note that the duty of utmost good faith also applies to the insurer. If the insurer is in breach of its duty of utmost good faith, the insured will be entitled to avoid the contract.

D5a Compulsory insurances

The duty of utmost good faith applies in principle to compulsory consumer insurances in the same way as it does to other classes. For motor insurance claims, the **Road Traffic Act 1961** prohibits the insurer from avoiding liability on the grounds of certain breaches of utmost good faith and the insurer must deal with claims to the extent of the compulsory insurance required by law.

Just think

Why do you think third-party motor insurance was made compulsory?

Compulsory insurance was introduced to ensure that the innocent victims of motor accidents would receive due compensation. If an insurer were to decline for a non-disclosure, then the achievement of this objective would be endangered.

Insurers have a contractual right under the policy to recover the claim payments from the policyholder where such a breach of utmost good faith has occurred.

E Is the loss covered?

We have already seen that when a policyholder makes a claim, they must show that their loss was caused by an **insured peril**. If the insurer disputes this, they must show that the loss was caused by something not covered by the policy. The principle of **proximate cause** is key to determining if a loss is covered.

insured peril
a cause that is listed in the policy as being covered

proximate cause
main or dominant cause of the loss or the cause that is most powerful in its effect

efficient cause
the particular act that set about a specific effect

The leading court case, *Pawsey v Scottish Union and National* (1907), defines proximate cause as: 'the active, **efficient cause** that sets in motion a train of events which brings about a result, without the intervention of any force started and working actively from a new and independent source.' Proximate cause is considered to be the real or dominant cause of loss.[15]

Most causes are easy to assess, as there may be only a single cause clearly covered under the policy and little time passes between the event causing the loss and the damage that results. For example, there can be little dispute about the proximate cause of the loss when thieves break into a shop and steal electrical goods or when a house is damaged by a fire.

Difficulty arises when the loss results from a series of events that are spread over time, and where other perils, uninsured or excluded, are involved, possibly causing a 'chain (or train) of events'. Each link in the chain should be traced to seek a break in the chain. If there is, it implies that something else caused the loss.

A further possibility occurs with a **concurrent cause**. Sometimes it may be difficult to separate the effects of a peril that is insured, e.g. fire, from the operation of another peril that is excluded, e.g. earthquake, because the two are linked. In other cases, the operation of a peril that is insured, e.g. fire, may result in damage of a different sort, e.g. damage by smoke, or water used to put out the fire, or looters who take advantage of the chaos in order to steal. We are then faced with a network of causes rather than a neat 'straight' line.

According to the principle of proximate cause, the loss in question must result directly from the operation of an insured peril if insurance is to apply.

Quick question 3
George has a fire policy. Some coals fall from the fire and set the house ablaze. Identify the proximate cause and if it is likely to be covered by George's household insurance policy.

concurrent causes
two or more perils operating at the same time (to bring about a loss)

excluded perils
cause specifically listed in the policy as not being covered

E1 Identifying the cause

We need to identify the cause to match it against the policy cover. The proximate cause of the loss must be a 'peril insured against'. How these insured perils are defined depends on how the policy is written.

In some cases, there are specified or named perils, while in other cases cover is written on an 'all-risks' basis. In the latter case, exclusions limit the scope of the insured perils, and losses from any of the **excluded perils** are uninsured. However, a fire and perils wording lists the perils or contingencies insured under the policy. There will, also be 'standard' policy exclusions applying to this style of policy.

[15] Birds, J. (2007) *Birds' Modern Insurance Law*, London, Sweet & Maxwell.

A basic Irish fire policy covers the risks of fire, lightning and explosion (to a limited degree) but excludes, for example, fire caused by earthquake, riot, war and a number of other risks. In the context of a fire policy, loss of the insured property by theft can be described as an 'uninsured' peril, i.e. a peril that is obviously not covered by the policy and is therefore unnecessary to specifically exclude.

'All-risks' policies are structured differently to specified risk perils, specified risks or named perils policies. Any peril that is not specifically excluded is automatically an insured peril, and there is no third category of 'uninsured' peril. The comparison is outlined in Table 3.3.

Table 3.3 Perils in insurance policies

Named perils policy (fire insurance)	'All risks' policy (e.g. personal 'all-risks')
1. Insured perils, e.g. fire	1. Excluded perils, e.g. wear and tear, gradual deterioration
2. Excluded perils, e.g. fire caused by earthquake or war risk or nuclear risk	2. Insured perils – any form of loss other than the excluded perils (1)

E2 'Chain of events'

Prior to the decision of the House of Lords in *Leyland Shipping v Norwich Union Fire Insurance Society Ltd* (1918), the courts were more inclined to hold that the last event in the chain was the proximate cause. The Leyland Shipping decision held that the dominant cause was the proximate one, even though another cause was introduced, the **chain of events** had not been broken. This became the leading authority on the issue.

chain of events

sequence of events that follow one from the other without anything new starting and influencing the outcome

E2a *Leyland Shipping v Norwich Union Fire Insurance Society Ltd* (1918)

Case law

The ship in question, the Ikara, was insured under a policy that covered perils of the seas, but excluded war risks. The ship was hit by an enemy torpedo and, despite being badly holed and in danger of sinking, reached the port of Le Havre, where repair work was started. When a storm blew up, the harbour master ordered the ship to an outer berth to save the harbour from being blocked if the ship sank, which it did after it left port. The ship owners argued that the 'last cause' (the storm damage) should be regarded as the proximate cause. The insurer argued that the effective cause of the ship being lost was the damage caused by the enemy torpedo. This was an excluded war risk. The House of Lords held that the proximate (real/dominant) cause of the loss was the torpedo (a war risk that was excluded) because the damage it caused had been effective throughout. The 'chain of events' had not been broken.

A similar decision had been made in the case of *Etherington v Lancashire and Yorkshire Accident Insurance Company* (1909).

E2b *Etherington v Lancashire and Yorkshire Accident Insurance Company* (1909)

Case law

The insured fell from his horse and suffered some injuries that forced him to lie in cold and damp conditions so that he contracted pneumonia, of which he eventually died. It was held that the proximate cause of his death was the original 'accident' of the fall from the horse and not the disease that ultimately killed him (which was excluded). The claim was covered.

Equally, there is no liability if the loss flows directly from an excluded peril, as in the fire insurance case of *Tootal Broadhurst Lee Company v London and Lancashire Fire Insurance Company* (1908).

E2c *Tootal Broadhurst Lee Company v London and Lancashire Fire Insurance Company* (1908)

'new intervening act'

(*novus actus interveniens*) refers to a situation where the sequence of causation is broken and something entirely new happens to bring about the loss

Case law

An earthquake caused an oil stove to overturn. Spilt oil was ignited by the wick and the building caught fire. The fire spread from one building to another by radiating heat and sparks and embers carried on the breeze until the insured premises, some 500 yards away, caught fire. The loss was not insured because the policy excluded fire caused by earthquake, and the chain of causation between this excluded peril and the loss was unbroken.

The chain is unbroken only where each event is the natural and probable result of what happened before. If the chain is broken by some '**new intervening act**' (*novus actus interveniens*) the position is different, as was affirmed in the case of *Marsden v City and County Insurance* (1865).

E2d *Marsden v City and County Insurance* (1865)

Case law

A fire caused a mob to gather and glass was broken when a riot developed and the mob took to plundering. The policy in question covered breakage of glass but excluded breakage by fire. In this case, the riotous conduct of the mob was not an inevitable or probable result of the fire, and so the chain of events was broken. The riot, and not the fire, was held to be the proximate cause, so the exception did not apply and the loss was covered.

E3 Efforts to avoid or reduce loss

Policies usually require the insured to take reasonable precautions to avoid loss or damage and to take reasonable steps to mitigate, i.e. minimise, any loss (see Chapter 2C).

Provided steps taken are reasonable efforts to prevent or limit damage caused by the operation of an insured peril, the insurer is liable for any resulting damage to the subject matter – this action being regarded as part of the insured peril itself. For example, a fire insurer is liable to pay for damage caused by water used to extinguish a fire. It is also liable to pay for damage to the premises (such as the breaking down of doors) caused by the fire services in gaining access to a burning building. The same principle applies to buildings deliberately pulled down or destroyed to make a fire break and, perhaps, damage to furniture thrown out of a window to save it from the flames.

Case law

As Kelly CB stated in *Stanley v Western Assurance Co.* (1868):

Any loss resulting from an apparently necessary and bona fide effort to put out a fire, whether it be by spoiling the goods by water, or throwing articles of furniture out of a window, or even the destroying of a neighbouring house by an explosion for the purpose of checking the progress of the flames, in a word, every loss that clearly and proximately results … from the fire, is within the policy.

Case law

In the case of *Canada Rice Mills v Union Marine and General Ins. Co.* (1941), the master of a ship that was carrying rice in stormy seas ordered the ventilators of the holds to be closed to stop sea water getting in, and the lack of ventilation to the holds caused damage to the rice. The Privy Council held that this loss was covered because the proximate cause was the heavy weather, a peril of the sea that was insured by the policy.

Wright LJ said:

> … the closing of the ventilators is not to be regarded as a separate or independent cause, interposed between the peril of the sea and the damage, but as being such a matter of routine seamanship necessitated by the peril that the damage can be regarded as a direct result of the peril.

It should be emphasised, however, that the insured peril must exist, and must either be actually operating or imminent (about to operate).

defendant

person or entity against whom a claim is made

E4 Prevention costs

Although damage to the insured subject matter is covered as the result of reasonable efforts to avoid or reduce the impact of an insured peril, the English courts have refused to allow recovery for mere prevention costs i.e. expense incurred to prevent damage being caused to the subject matter by an insured peril, e.g. in *Yorkshire Water Services Ltd v Sun Alliance and London Insurance plc* (1997).

In this case, the plaintiffs incurred expense repairing an embankment to prevent sewage sludge from escaping into the adjacent river. They argued that the **defendant** liability insurer should bear this cost because, if the remedial work had not been done, the plaintiffs would have been legally liable for damage caused by the sludge, and the insurer would then have had to indemnify them. The court rejected the claim on a number of grounds. In particular, the subject matter of the contract was not property but 'legal liability to pay damages', and this was neither operating nor 'imminent'. The court was also influenced by the usual policy clause requiring the insured to take reasonable precautions to avoid loss, and this indicated that prevention costs were to be paid by the insured.

E5 Modification of the principle by policy wordings

The principle of proximate cause can be excluded or modified by the policy wording. For example, insurers may exclude some risks (such as war risks) entirely, and then refuse payment even where a peril operates as a remote cause (i.e. a cause that makes only a minor contribution to the loss). Equally, however, commercial 'all-risks' policies may include an 'overrider' which provides cover for a policyholder where the strict operation of the principle of proximate cause would otherwise exclude the loss.

F Summary

In this chapter, we saw some of the initial checks that a claim handler makes to see if a claim is valid. Often these checks verify that there are no serious potential problems with the insured's entitlement to make a claim, and the handler will then consider the extent of cover (see Chapter 5).

Further investigation is needed when problems emerge regarding, e.g. breaches of conditions or warranties, exclusions, insurable interest, utmost good faith or proximate cause. Chapter 4 examines how insurers investigate claims.

F1 What's next?

In the next chapter we will look at how insurers determine the extent of policy cover for a claim.

F2 Online learning supports

Your Member Area includes a guide to success, an automated study planner, an exam countdown timer and study tips guide. These study supports are invaluable in reinforcing what you have learned so far. The webinars, chapter-by-chapter key points and other supports will help you to break down the chapter's content when revising.

Remember: This module is examined by mixed assessment, which includes:

- An online mid-semester MCQ assessment (20 questions)
- An end-of-semester written exam paper (9 questions)

Given that your online mid-semester assessment is a multiple-choice question test, completing the online practice paper is the ideal preparation for this. You can prepare for the end-of-semester written exam and test your knowledge by completing sample and past written exam papers.

To access these online learning supports, just log into your Member Area on **www.iii.ie** and click on the **Connect** logo.

End of chapter questions

Use these questions to test your understanding of what we've covered so far in Chapter 3. It should be noted that these end of chapter questions are revision questions to test your understanding of the material in the chapter just studied. They are not sample exam questions.

1. State the purpose of the operative clause in an insurance policy.

2. A claims handler will closely check an insurance policy when verifying a new claim. Outline the other people who may also need to check a policy document.

3. State the checks that a claims handler will make when comparing the claims information to the information on the policy schedule.

4. State the function of a warranty in an insurance policy.

5. List the possible triggers for a claim under a liability policy.

6. Outline the necessary features for insurable interest to exist.

7. Briefly outline the significance of the case of *Macaura v Northern Assurance Company* (1925) in non-consumer insurance contracts.

8. State the definition of 'material fact' in non-consumer insurance contracts.

9. The CPC requires a regulated entity to explain to a consumer, at the proposal stage, the consequences of failing to fully disclose all relevant facts. State the points that must be included in this explanation.

10. In relation to the principle of proximate cause, outline the extent to which an insurance policy will cover damage caused by efforts to avoid or reduce a loss.

Answers to end of chapter questions

Check your answers against those below and make a note of any points you left out. This will highlight some sections you may need to look at more closely during your revision.

1. The operative clause states the insurer's promise to pay and the extent of that promise (i.e. the scope of cover under the policy).

2. Examples of other people who may also need to check a policy document are:
   - A broker or other intermediary may need to confirm which insurer the claim should be made against and may wish to advise the client about conditions that must be met.
   - A loss assessor may wish to check the basis on which claims are to be settled, e.g. on an indemnity or reinstatement basis.
   - A loss adjuster or claims investigator acting for the insurance company needs to check the scope of cover and the insured's compliance with particular terms and conditions.

3. The claims handler will check that:
   - There are no inconsistencies in the insured's, name, address and business description
   - The claim arose from a business activity specified in the insured's business description on the schedule
   - The loss occurred within the territorial limits of the policy
   - The loss occurred during the period of cover
   - Any special endorsements are taken into account, as they may change the usual level of cover under a particular type of policy or apply a warranty.

4. A warranty in an insurance policy is an undertaking by the insured that something will or will not be done, or that a certain state of affairs does or does not exist. Warranties are intended to improve and manage risks throughout the currency of the policy. Examples include: confirming that a burglar alarm is operative or that a sprinkler or full-time security system is in place. Under the **Consumer Insurance Contracts Act 2019**, warranties are no longer permitted in consumer insurance contracts. Neither is any term which converts a statement or representation made by a consumer prior to entering into the insurance contract into a warranty ('basis of contract clause').

5. A claim under a liability policy is triggered by one of the following stages in a liability event:
   - The initial act, usually negligence, but it could be another legal wrong
   - The actual injury, loss or damage resulting from the act
   - The manifestation of the injury, loss or damage
   - The aggrieved or injured party's awareness of the injury, loss or damage
   - Notification of the claim to the policyholder
   - Notification of the claim to the insurer.

6. Four features necessary for insurable interest to exist:

   - There must be some property, right, interest, life, limb or potential liability capable of being insured.
   - Such property, right, interest, life, limb or potential liability must be the subject matter of insurance.
   - The insured must stand in a relationship with the subject matter of insurance whereby they benefit from its safety, wellbeing or freedom from liability, and would be prejudiced by its damage or the existence of liability.
   - The relationship between the insured and the subject matter of insurance must be recognised at law.
   - Under the **Consumer Insurance Contracts Act 2019**, insurable interest need not exist at the time that the policy is taken out, but must be present at the time of loss if an insured is to recover under the same.

7. The case of *Macaura v Northern Assurance Company* (1925) underlined that a valid insurable interest must be legally recognised. Macaura had insured a quantity of timber under a fire policy in his own name. He had already sold the timber to a limited company, of which he was the only shareholder. When the timber was destroyed in a fire, the insurer refused to pay the claim on the basis that Macaura (as a private individual) had no insurable interest in the property of the limited company. As a shareholder, his interest was limited to the value of his shares and did not extend to property owned by the company.

8. The definition of material fact is contained in the **Marine Insurance Act 1906**, Section 18(2): 'Every circumstance is material which would influence the judgement of a prudent insurer in fixing the premium or determining whether he will take the risk.' Under the **Consumer Insurance Contracts Act 2019**, the duty to volunteer material facts has been replaced in consumer insurance contracts whereby the insured is obliged to answer all questions put to them by the insurer honestly and with reasonable care.

9. The explanation must include, where relevant:

   - That a policy may be cancelled
   - That claims may not be paid
   - The difficulty the consumer may encounter in trying to purchase insurance elsewhere
   - That the failure to have property insurance in place could lead to a breach of the terms and conditions attaching to any loan secured on that property.

10. Provided the steps taken are reasonable efforts to prevent or limit the damage caused by the operation of an insured peril, the insurer is liable for any resulting damage to the subject matter – this action being regarded as part of the insured peril itself. For example, a fire insurer is liable to pay for damage caused by water used to extinguish a fire and for damage to the premises (such as the breaking down of doors) caused by the fire services in gaining access to a burning building. The same principle applies to buildings deliberately pulled down or destroyed to make a fire break and, perhaps, damage to furniture thrown out of a window to save it from the flames.

    It should be emphasised that the insured peril must exist, and must either be actually operating or imminent (about to operate).

Answers to quick questions

1. The policy schedule provides the specific information that is relevant to the policy. This is often a separately printed document to the policy booklet, but they should be read together as one insurance contract.
2. The monetary value of the bank's insurable interest in the property is €160,000.
3. Fire is the proximate cause, which is likely to be covered by George's household policy.

Sample exam questions

Question 1

a) Insurable interest is usually created as a result of some legal right or obligation.
Briefly explain, using appropriate examples, the **two** ways that insurable interest usually arises.

(6 Marks)

b) Briefly explain, using appropriate examples, why an individual may only have a limited insurable interest in a property to be insured.

(4 Marks)

Total: 10 Marks

Question 2

a) Briefly explain why a claims handler should compare a policyholder's claims details with the declarations they made on their original proposal form. (4 Marks)

b) Differentiate between fraudulent misrepresentation; negligent misrepresentation; and innocent misrepresentation.

(6 Marks)

Total: 10 Marks

Your answers

Sample answers

The answers set out below show the main points you must consider in answering the question. In some cases, a well-reasoned alternative view could earn good marks.

Question 1

a) Insurable interest normally arises in one of two ways:

- Common law – sometimes insurable interest is automatically presumed to exist. For example, everybody is presumed to have an unlimited interest in their own life and in property that they own. Where an interest is automatically assumed, we can describe it as having arisen at common law. Equally, the common law duty of care, which persons owe to each other, may create a liability, which again entitles a person to insure (against this liability).
- Contract – sometimes a person will agree to accept responsibility for something for which they would not ordinarily be liable. For example, a landlord, rather than a tenant, is normally liable for the maintenance of their property. The lease will often contain a condition that makes the tenant responsible for the maintenance, or repair of the building. This gives the tenant a financial (insurable) interest in the property. Similarly, businesses hiring machinery or equipment usually sign contracts making them responsible for loss or damage to the property. Although they do not own the machinery or equipment, this obligation creates a valid insurable interest.

(6 Marks)

b) Often a person will have only a limited interest in the property to be insured. For example, the interest of a part-owner will be limited to the value of their share in the property.

Where a property has been purchased with a mortgage, both the lender and the purchaser have an insurable interest. The purchaser's interest arises from ownership of the property and the financial institution acquires an interest because the property is held as security for the loan. This is a very common situation and in practice the interest of the lender (usually a financial institution) is noted on the policy schedule as an interested party.

(4 Marks)

Reference Chapter 3C2 & C3a **Total: 10 Marks**

Question 2

a) The claims handler must check that the claims information matches the underwriting information. The claims information should be compared with proposal declarations to ensure they are mutually consistent. The claims notification may reveal a material fact that the insured knew but did not disclose when asked at the time of the proposal (such as previous claims or a motoring conviction).

(4 Marks)

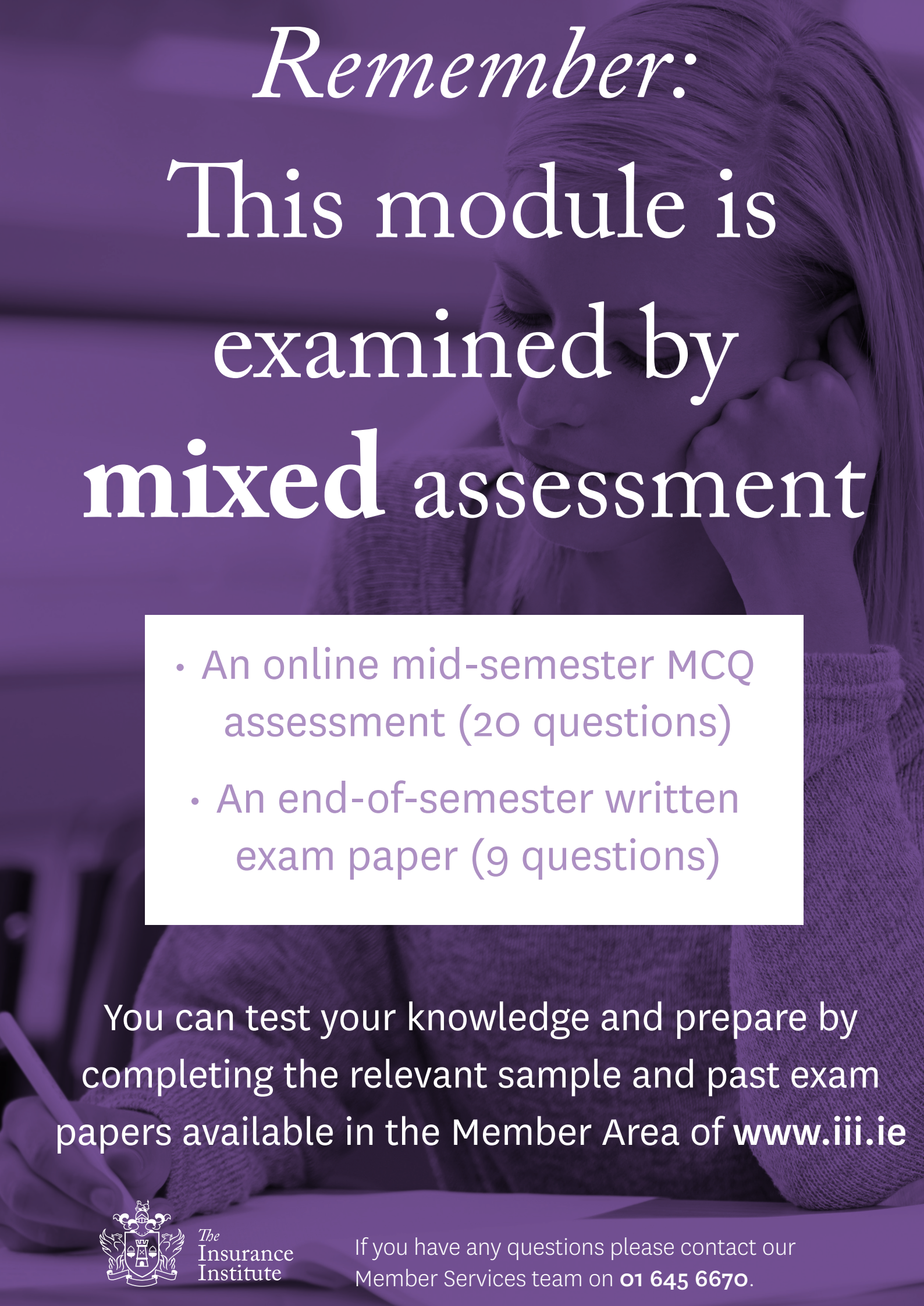
b) Fraudulent misrepresentation occurs when a person makes a statement with an intention to deceive, knowing that the statement is false. Example: John advises on his motor proposal form that he has no previous road traffic convictions when in fact he has been convicted of dangerous driving.

Negligent misrepresentation occurs if a statement made is an honest expression of opinion while having no reason to believe it is true. It arises in contract law. Example: Peter, a car dealer is talking to a prospective buyer of a second-hand car. He claims that the previous owner had recently changed the oil in the car without even knowing if this is true or not.

Innocent misrepresentation occurs when a person has reasonable grounds for believing that their false statement is true. Example: Susan is making a claim for damage to her tables and chairs from accidental damage. She advises that they are 3 years old but it turns out they are 5 years old. When Susan advised they were 3 years old she believed this was true.

(6 Marks)

Reference Chapter 3D1 & D4 **Total: 10 Marks**



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The Insurance Institute

If you have any questions please contact our Member Services team on **01 645 6670**.

Chapter

4

Claims investigation

What to expect in this chapter

In previous chapters, we saw how insurers gather information after a claim notification and carry out preliminary checks on the claim information and documentation. They can then make early decisions on whether the claim is a straightforward and valid one, or whether further investigation is needed. We will now look at the next stage of the claims process, which involves a more detailed investigation of the circumstances and extent of the loss.

Contents

A The investigation process

We have seen how insurers gather information about a claim at the notification stage (see Chapter 2) and check this information to make an initial assessment about whether the policy will cover the claim (see Chapter 3). Sometimes these initial checks confirm that everything is in order and that the claim can be settled without delay. But often the claim is more complex and further investigation is needed.

In Chapter 1C, we saw that the CPC requires an insurer to verify a claim before deciding its outcome. This means carrying out appropriate investigations and enquiries.

The nature and extent of the investigations depends on the type of claim and the circumstances of the loss. The purpose of claims investigation is generally to:

- Determine or confirm the circumstances of the loss
- Establish the full extent of the loss
- Assess the extent to which the insured (and other parties) are at fault and gather important information and evidence for claims involving a third party.
- Follow up on any concerns discovered during the initial notification or the checking of claim information. These might include issues about insurable interest (see Chapter 3C), disclosure (see Chapter 3D), the exact cause of the loss (see Chapter 3E) or a suspicion of fraud by an insured or third party (see Chapter 1D).

B The role of the claims handler

The claims handler normally oversees all aspects of the investigation, handling and settlement of a claim.

The role of the claims handler is to:

- Deal with claims quickly and fairly, delivering a high level of customer service
- Distinguish between genuine and fraudulent claims
- Assess the likely cost of a claim so that an appropriate case reserve may be allocated
- Determine whether others (e.g. loss adjusters) should be involved
- Settle claims efficiently and cost-effectively
- Review and analyse loss adjuster and specialist reports and ensure those involved have the required information and instruction to act on the insurer's behalf, particularly in the event of actions requiring urgency e.g. providing approval for interventions in the event of a cyber-attack under cyber insurance policy.

Many first-party claims are handled and settled by desktop claims handlers (see Section B1). Most have a specific claims handler authority level or claims licence, ensuring they only handle cases within their experience and knowledge, enabling them to make key decisions that deliver good customer service. For some third-party claims and for larger and more complicated first-party claims, the handler may involve other professionals (such as loss adjusters).

Cases where it would be appropriate to appoint a loss adjuster or other expert include:

- **Large property damage claims –** The cause of such losses may be difficult to ascertain, there may be multiple stakeholders, there may be questions of damage to neighbouring properties or possible subrogation recovery prospects. All of these will need to be investigated.
- **Cyber risk claim –** The nature of such a claim might involve the hacking and theft of company data or a 'ransomware' demand where a criminal organisation demands a ransom before agreeing to release the stolen data back to the company. A cyber insurance policy will cover the cost of an incident manager who will co-ordinate the resources required to investigate and manage such an occurrence. This incident manager may appoint an IT forensic investigator to identify the root cause of the breach or hack, a public relations firm to manage inquiries from the media or customers, a lawyer to assist and advise in respect of any potential regulatory breaches or notifications required and a loss adjuster to quantify the loss.

- **Claims including an element of business interruption or loss of profit –** An analysis of the accounts of the business may be needed, usually by a chartered accountant, certified accountant or forensic accountant. Advice may need to be given to the policyholder in relation to the mitigation of their loss and how the policy may respond.
- **Claims arising under natural catastrophes such as earthquake, windstorm or flood –** Many buildings in a given area will suffer damage from the same cause within a short time, so claims will need to be adjusted simultaneously; these catastrophes create their own specific problems.
- **Motor vehicle damage claims –** A **motor damage assessor** or motor engineer is usually instructed to examine the vehicle to report on the extent of the damage and estimate the cost of repair, or the pre-accident value of the vehicle. Some garages use interactive cameras which help the insurer to assess the damage remotely.
- **Third-party claims –** A claims investigator may be instructed to take statements or examine the scene of an accident.
- **Cases where the cause of loss is difficult to ascertain or where fraud is suspected –** Forensic experts are often deployed. These may include fire forensic experts, forensic locksmiths, forensic accountants, handwriting experts, civil engineers etc.

We will examine the role of experts and other claims professionals in Section C.

B1 Desktop claims handling

Desktop claims handling teams working on both first-party and third-party claims have greatly speeded up claims settlements. They are employed by insurers, loss adjusting firms and **third-party administrators** (TPAs) appointed by insurers for this purpose. They assess claims in their office, without needing an adjuster or site visit. As well as speeding up the claims settlement process, desktop claims handling can also deliver cost savings for the insurer.

Desktop handling involves some or all of the following practical steps:

- Analysing notification information and comparing claim documentation to policy information and limits. This may involve liaising with underwriters if there are concerns about e.g. insurable interest (for non-consumer insurance contracts) or non-disclosure.
- Making phone calls to the insured to clarify claim details and obtain any additional information required. Handlers then watch for possible fraud and calls are usually recorded.
- Seeking and examining estimates for damage or replacement and/or original purchase invoices where relevant. Quotations are compared to competitors, via databases, to ensure reasonable costs. Original documents may be preferred to photocopies.
- Gathering witness information and contacting potential witnesses to request completion of a witness form or to conduct a phone or personal interview.
- Phone calls may be made to the Gardaí, or a Garda report sought.
- Seeking independent verification of the cause on the date of loss, e.g. the Met Éireann website (www.met.ie) may be used to check if there was a storm.
- Contacting a third party – through a phone interview or with their legal representative. This is very effective for establishing the potential value of a claim and whether personal injury claims will be brought. After this, individuals may be asked to submit estimates or other documentation that forms the basis for settlement.
- Examining and pursuing the possibility of recoveries through subrogation, contribution or salvage.

motor damage assessor

a motor industry professional that inspects damaged vehicles to determine the extent of the damage, the repair costs and/or the vehicle pre-accident value

desktop claims handling

form of claims handling that takes place without a visit to the scene of the accident and generally without face-to-face meetings with any of the parties, including the insured

third party administrator

an independent organisation engaged by an insurer to administer all or part of the insurance process on the insurer's behalf

Quick question 1

Name a helpful website for sourcing indications of weather conditions on a given date at any location in Ireland.

The answer is at the end of this chapter.

C Other professionals involved in the investigation process

There are many situations where a claims handler needs to involve other professionals to investigate a claim. We will now consider the role of the professionals most likely to be involved.

C1 Loss adjuster

As mentioned in Section B, a claims handler may instruct a loss adjuster for large claims and for those that require special investigation. Loss adjusters are most likely to be involved in property claims, but some loss adjusting firms also assist with liability and motor accident investigations. Their role is likely to be similar to that of a claims investigator (see Section C4).

Loss adjusters play a crucial role in claims investigations. They are instructed in property and commercial claims which can range in complexity from theft through to subsidence. Loss adjusters are insurance claims specialists who are instructed by and act on behalf of the insurer. Loss adjusters are experts in many fields, including property damage, business interruption, jewellery and many other areas and can advise both the insurer and the policyholder on repairs, including emergency repairs which might be necessary to secure property or to limit further damage or loss. They help to collect relevant information about claims and then send it to the insurer with their recommendations, so that rapid settlements of claims can be made. They play an integral role in delivering the promise insurers make to their customers.

Microlearning resources

In the Member Area of www.iii.ie, via the Connect logo and in Your Learning Centre, select the microlearning section of this chapter to access a resource specifically developed to help you better understand this topic.

Typically, loss adjusters receive instructions on a new claim from an insurer when an incident or loss occurs and is notified. Claims departments have processes for immediate notification of certain types of claims to loss adjusters, which is usually via a central notification unit. Such appointments may be influenced by the location of loss, the class of insurance (whether commercial or domestic), the type of claim and the size of loss.

The loss adjuster takes some or all of the following practical steps:

- Visit the loss address.
- Interview the claimant.
- Take a statement and ask the claimant to sign (if there are inconsistencies about the events or for more serious claims).
- Seek estimates and invoices if required.

- Instruct specialist building or quantity surveyors to assist with establishing the likely cost of repair or reinstatement.
- Advise the insurer of a recommended case reserve.
- Request experts in engineering and forensics (sometimes employees of the adjusting firm, sometimes external to the firm) to examine the scene to establish cause and provide options for appropriate reinstatement.
- Provide 'case management' and 'project management services', e.g. for a rebuild.
- Visit or phone the Gardaí and fire brigade, or seek written reports if required.
- Check various fraud registers.
- Carefully consider policy information in relation to:
  - limits, including **inner limits**
  - excesses, deductibles or franchises
  - covered and excluded causes
  - operative clauses
  - compliance with pre- and post-loss conditions, e.g. auditing the presence and operation of alarm or sprinkler systems.
- Pay attention to the possibility of recoveries through subrogation, contribution or salvage.
- Instigate initial recovery actions.
- Advise the insurer on the best ways to provide indemnity (see Chapter 5).
- Issue reports, at the beginning of a claim (preliminary report) or when significant information is received or an interim payment required (interim report), or when the claim is finalised (final report). Many loss adjusters use an electronic tablet on site, which speeds up the reports sent to the insurer, thus providing better customer service and speedy updates for insurers.

inner limit

an indicator of the largest payment that will be made under a specific insurance policy heading (expressed either as a monetary amount or a percentage of another limit)

C2 Delegated authority with loss adjusters

Many uncomplicated claims are dealt with on a delegated authority basis, where the loss adjusters deal with all aspects of a claim on the insurer's behalf and agree settlement. They then submit their final report to the insurer, who issues payment in accordance with the adjuster's instructions. This typically leads to faster claims settlements, as the adjuster can agree settlement without referring back to the insurer. The arrangement also delivers savings to insurers, as VAT does not need to be charged on fees raised under this scheme. Rigorous auditing by insurers is common when such schemes are in place.

Delegated authority arrangements are not used for large or complex claims, or in cases where there are concerns about e.g. fraud, non-disclosure or other issues regarding policy cover. If, during the course of a delegated authority investigation, the loss adjuster has concerns on policy coverage or requires specific instructions from the insurer, the case must move from the delegated authority method and revert to traditional handling. In these situations, the insurer is said to 'retain' its authority (i.e. retained authority claims handling).

C3 Loss assessor

A loss assessor is a professional who prepares, negotiates and settles insurance claims on behalf of a policyholder or claimant.

Loss assessors have similar skills and perform similar analyses and functions to loss adjusters. However, there are two very important differences:

1. The insured appoints the loss assessor to act entirely on their behalf and for their benefit (unlike loss adjusters who are appointed by insurers).
2. Loss assessors, who act on behalf of consumers, must be registered as insurance intermediaries under the **EC (Insurance Mediation) Regulations 2005 (as amended).** Insurance intermediaries are subject to the CPC, MCC and Fitness and Probity Standards. Note that these specific regulatory requirements only apply to situations where the loss assessor is dealing with a **consumer** as defined by the Central Bank. Loss adjusters do not require registration under the **EC (Insurance Mediation) Regulations 2005 (as amended)**, as they are effectively regulated through their principals, the insurer.

consumer

definition of the Central Bank in its Minimum Competency and Consumer Protection Codes:

- a person or group of persons, but not an incorporated body with an annual turnover in excess of €3 million in the previous financial year (a group of persons includes partnerships and other unincorporated bodies such as clubs, charities and trusts), or
- incorporated bodies having an annual turnover of €3 million or less in the previous financial year (provided the incorporated body is not part of a group with a combined turnover of more than €3 million) and includes a potential 'consumer'

Microlearning resources

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Loss assessors may offer the following services and assistance:

- Ensure that the interests of the insured are preserved.
- Check that adequate insurance cover is in force.
- Attend the loss scene to meet with the loss adjuster appointed by the insurer.
- Assess damage and formulate a claim.
- Advise the insured on claim preparation and presentation, including required documentation.
- Advise the insured on options offered or available.
- Ensure the proposed settlement is fair and reasonable under policy terms.
- Attempt to achieve swift settlement.

C4 Claims investigators

In both first-party and third-party claims, the handler may require a better understanding of how the loss occurred, or evidence in the form of photographs and statements. For example, photographs, diagrams and statements taken shortly after an incident by someone with experience in the legal process can be extremely useful. This job is sometimes undertaken by claims investigators.

A claims investigator may work for the insurer or be self-employed. They may also work for a specialist claims investigation company or be employed by one of the traditional loss-adjusting companies.

They may attend to some or all of the following:

- Taking statements where doubts exist about evidence presented or the truthfulness of parties.
- Investigating the circumstances or background to a claim.
- Explaining the claims process to the insured. This is particularly helpful in third-party motor or liability claims, where the insured may be unfamiliar with the legal process and with the process for deciding on liability for an accident.
- Investigating the prospects of recovery from third parties by subrogation or contribution.
- Liaising with Gardaí.
- Taking photographs, measurements etc. at the scene of an accident. The **Safety, Health and Welfare at Work Act 2005**, for example, requires that a machine be properly guarded to prevent injury. The claims investigator may focus on this aspect of the claim, taking photographs to show the presence or absence of suitable guards at the accident scene.
- The accident site (known as the 'locus') will be examined. Measurements may also be taken if relevant (e.g. in road traffic accidents or trip and fall cases). Any CCTV footage will be studied and relevant sections highlighted.
- Collecting relevant paperwork – documents relating to the claim will be sought and carefully examined, including:
  - The insured's safety statement
  - Risk assessments about the area or type of work being carried out
  - Accident books
  - Records of training
  - Information obtained from Gardaí.

Inadequacies or indeed non-existence of such documents is a cause for serious concern, and will be highlighted in the investigator's report. Any such documents relating to other contractors or parties involved in the incident are also useful.

In third-party claims, the investigator offers an opinion on the insured's liability, referring also to the relevant statutory obligations and legal precedents. They also address the claimant's possible **contributory negligence** (see Chapter 6D6a), and the potential liability of other parties. Any special policy considerations, such as delayed notification, will be further explored with the insured.

C5 Accountants

For business interruption claims, both the insured and the insurer may appoint an accountant. You will recall from earlier studies that most business interruption policies cover a loss of **gross profit** following insured damage to a property. When investigating and quantifying a claim, the insurer needs to establish what the **turnover** and gross profit would have been, had the insured event not occurred. This involves professional analysis of the insured's accounts and projections. Typically, loss adjusting firms will employ a business interruption specialist who will likely be a trained accountant.

contributory negligence

a percentage reduction in damages when a plaintiff is found to be responsible in some way for the incident giving rise to the action

gross profit

the amount by which i) the sum of the amount of the turnover and the amounts of the closing stock and work in progress shall exceed ii) the sum of the amounts of the opening stock and work in progress and the amount of the uninsured working expenses (variable charges)

turnover

income generated from the business at the business premises

Quick question 2

Outline the difference between a loss adjuster and a loss assessor in terms of their regulatory status.

The insured is likely to instruct their accountant to prepare the documentation requested by the insurer. The policy is likely to cover the cost of obtaining this information. A typical policy wording is:

Insurance policy extract 4.1

We will pay your auditors and professional accountants reasonable charges for

(a) producing information we require for investigating any claim and

(b) confirming the information is in accordance with your business books

arson

the deliberate act of setting fire to property

If the insurer disputes or has concerns about the information from the insured's accountants, they may decide to instruct their own accountant or auditor. Where fraud is suspected, they may seek the services of a specialist forensic accountant. Such accountants may also be used in cases of suspected **arson.**

Accountants may also be instructed in third-party claims involving a significant loss of income or earnings.

C6 Solicitors

Solicitors are most frequently instructed for the defence of claims against the insured by a third party, and in the settlement negotiation with claimant solicitors. They may also be instructed as part of a claim investigation where coverage issues have arisen.

The claims handler may, for example, instruct a solicitor to:

- Advise on a complex matter of policy cover or indemnity
- Conduct investigations as a claims investigator would (see Section C4), as well as attending to other legal requirements.

Advice and correspondence between the insurer and a solicitor are subject to the principle of legal advice privilege. It doesn't have to be disclosed to the third party during the stage of the legal process, thus protecting confidential communications between the insurer and the solicitor.

C7 Brokers

Brokers play a vital role in the claims process, following a loss, often being the policyholder's first point of contact. Sometimes the policyholder will not know who their insurer is at the time of loss. So the insured will expect their broker to guide them through the process, while providing sound advice. A broker demonstrating a full understanding of the claims process differentiates themselves from their competitors, retaining valued customers, while attracting new ones.

Depending on the size of a brokerage there may be a specific team with expertise to deal with claims. In smaller brokerages, personnel fulfil the claims role along with other functions. Under the CPC, an insurance intermediary/broker assisting a consumer with claims must ensure that relevant claims documentation is transmitted to the regulated entity/insurer within 1 business day. Efficient structures must be in place to meet this obligation.

During the claims process a broker liaises with insurers, adjusters and other experts involved in a case to ensure that it is managed efficiently. A broker must be directly involved in resolving problems where issues arise on policy coverage.

In many straightforward property or motor claims, a broker may prefer not to be involved and may refer the policyholder directly to the insurer's notification team. It can represent an added administrative burden and for some classes of insurance, a broker and insurer may agree that the insurer's claims department will deal directly with the policyholder on all claims matters.

In third-party claims, brokers may not have as active an involvement, as this aspect does not directly involve settlement payment to their customer. They will still be keen to protect the client's interests involving such claims. An experienced broker will have a thorough understanding of third-party liability issues and of possible legal consequences, and can explain and guide the customer efficiently. They may also provide valuable information during investigations, particularly where local knowledge is important.

The role of the broker may include:

- Reporting the loss to the insurer
- Assisting the insured in completing the claim form
- Attending the scene of loss to establish the extent of the claim
- Helping with any loss mitigation actions
- Considering and advising on policy coverage
- Attending the loss adjuster's inspection to represent the insured's interests
- Providing loss details to a loss assessor, if necessary
- Guiding the insured on necessary documents to substantiate the loss
- Keeping the insured advised throughout
- Assisting settlement negotiations where needed
- Ensuring that a claim is being processed efficiently
- Conducting claims status reviews with the insurer pre-renewal, to assist premium negotiations
- Providing expertise on loss prevention into the future.

C8 Private investigators

Fraud (see Chapter 1D) is estimated to cost the industry €200 million annually. If a claims handler is concerned about possible fraudulent or exaggerated allegations in a third-party claim, they may instruct a private investigator (PI) to make enquiries or carry out surveillance. This may help to find out, for example, if a third party is as badly injured as they allege, or how their injuries interfere with their work and leisure activities.

A PI is usually an independent operator, rather than a member of the claims staff. They may undertake general investigations and interview witnesses. Frequently they check the legitimacy of documents or aspects to a claim, or undertake covert surveillance of an injured party. Any properly obtained information may form a reasonable part of the defence of a claim.

The PI must act at all times within the law and must comply with data protection legislation. Under the GDPR, there are six possible legal bases for processing personal data, namely, consent, contractual necessity, compliance with a legal obligation, protecting vital interests, performance of an official or public task, and legitimate interests (where the interest is not outweighed by the data subject's interest). Investigators must ensure that there is a legal or lawful basis for their processing of personal data.[16] For instance, it is not lawful for a private investigator to obtain information about a claimant from (for example) a bank employee concerning the claimant's personal finances where that claimant has not given prior consent to do so.

Investigators can use information that is freely available in the public domain. However, investigators must comply with the Data Protection Acts. The DPC has fined private investigators employed by insurers in the past, as illustrated in Case study 4.1.

4.1 Case study

Private investigator fined for breaches of Data Protection legislation

In June 2016, the DPC successfully prosecuted a private investigator for breaches of Irish data protection legislation. Following an investigation, the defendant was charged with sixty-one counts of breaches of Section 22 of the **Data Protection Acts 1988-2003**. The charges related to 'obtaining access to personal data without the prior authority of the data controller by whom the data was kept and disclosing that data to another person.' Insurance companies (including Zurich and Allianz) and the State Claims Agency used the defendant's services to carry out surveillance on potential fraudulent claimants in personal injuries cases. The defendant was convicted on the first four charges and was fined €1,000 per charge.[17]

C9 Expert opinion

When investigating a complex claim, an insurer may need a specialist opinion for a number of reasons. This may be to help determine liability, or assess a third-party claim.

expert witness

a witness called to give specialist evidence to help the court make a decision in a case

In the context of a third-party claim, the person providing an opinion in court is an **expert witness**. Their role is to assist in understanding technical matters. Such experts have an overriding duty to the court that outweighs any duty to their client. They must give an independent, objective opinion, without regard to whether or not it favours the position of the party instructing them. Under the **Rules of the Superior Courts (No. 6) (Disclosure of Reports and Statements) 1998**, the parties must exchange reports prepared by expert witnesses upon which they intend to rely before the Court hearing.

Microlearning resources

In the Member Area of www.iii.ie, via the Connect logo and in Your Learning Centre, select the microlearning section of this chapter to access a resource specifically developed to help you better understand this topic

We will now consider some examples of expert witnesses.

[16] Article 6, GDPR.

[17] Data Protection Commission, Case studies, www.dataprotection.ie

C9a Consulting engineers

Consulting **engineers** are retained as experts to give evidence in court, providing technical reports on issues that may affect the liability aspects of claims. They may visit the scene of a traffic accident and carefully measure and photograph the road, producing a report using photographs and maps. They may be able to draw some conclusions based on what they see about the likely speed or position of the vehicles.

An engineer might also visit a factory and examine a machine involved in an accident to give evidence to a court on whether it complies with statutory requirements.

C9b Medical experts

Medical experts can also make key contributions to the investigation process. This may be to assist the handler in validating the settlement payable under an insured's personal accident policy, or in assisting in the defence of personal injury claims against the insured – common under motor, employers liability and **public liability** policies.

When a doctor is appointed to examine the claimant on behalf of the defendant they are requested to:

- Provide an independent examination
- Possibly give evidence in court and be subject to cross-examination on behalf of the claimant
- Write a medical report outlining:
  - the background to the claimant sustaining the injury
  - the extent of medical treatment received
  - details of continuing pain and injury as outlined by the claimant
  - the capacity of the injured party to work and resume their pre-accident activity
  - their prognosis, or a recommendation for further examination.

C9c Other experts

Depending on the type of claim and the circumstances of a loss, other experts may be engaged. For example, a specialist trainer in manual handling might be asked to report and give evidence on whether specific training given to a claimant was adequate, a chemical engineer could be used to study the cause or effect of spillage from a chemical plant, an actuary might calculate the amount payable for a complex claim for future loss of earnings (see Chapter 6B2b) or (in a professional indemnity claim) an independent expert in the insured's business activities might report on whether the insured met the standard of care of a reasonably skilled practitioner in that area.

engineers

professionals of various disciplines who offer analytical services in the claims investigation

public liability cover

insurance that covers injury or death to anyone on or around the policyholder's property

Quick question 3

State two types of claim in which a claims handler might involve a consulting engineer.

D The outcome of a claims investigation

On completion of a claims investigation, the handler should be in a position to decide the outcome of a claim.

For first-party claims, this involves determining if the claim is:

- Valid – and should be paid in full.
- Partially valid – covered by the policy, but the extent of cover is reduced because of, e.g. an excess or the application of average (see Chapter 5B).
- Invalid – where the claim will be refused by the insurer, because, e.g. its proximate cause was not covered by the policy (see Chapter 3E), an exclusion applies (see Chapter 3B1c), there was a breach of a policy condition (see Chapter 2B2) or there is evidence of fraud (see Chapter 1D).

If the claim is valid or partially valid, the insurer will quantify the amount to be paid (see Chapter 6) and begin settlement of the claim (see Chapter 7). Where cover does not apply, they will refuse the claim in accordance with company procedures and regulatory requirements.

For third-party claims the insurer also needs to check that cover is in order and that the insured is entitled to indemnity. The handler should then also have sufficient information to make a decision on liability. If the insured is clearly liable, the third-party claim will be assessed subject to the principles outlined in Chapter 5D and Chapter 6B. For personal injury claims, the insurer will consent to the case being assessed by PIAB and will await their findings (see Chapter 6C). If liability is in dispute, the claims handler informs the third party and their representatives. The claim may then become the subject of legal proceedings. In this regard, the insurer will advise the PIAB that they do not consent to the assessment of the claim. An authorisation will then be issued by the PIAB allowing the third party to issue legal proceedings (see Chapter 6E).

E Summary

In this chapter we looked at the process of investigating and valuing a claim. We considered the role of the claims handler and the other professionals involved in investigating different types of claims.

E1 What's next?

The next chapter will consider how insurers apply the principle of indemnity when determining how much they should pay for a claim.

E2 Online learning supports

Your Member Area includes a guide to success, an automated study planner, an exam countdown timer and study tips guide. These study supports are invaluable in reinforcing what you have learned so far. The webinars, chapter-by-chapter key points and other supports will help you to break down the chapter's content when revising.

Remember: This module is examined by mixed assessment, which includes:

- An online mid-semester MCQ assessment (20 questions)
- An end-of-semester written exam paper (9 questions)

Given that your online mid-semester assessment is a multiple-choice question test, completing the online practice paper is the ideal preparation for this. You can prepare for the end-of-semester written exam and test your knowledge by completing sample and past written exam papers.

To access these online learning supports, just log into your Member Area on **www.iii.ie** and click on the **Connect** logo.

End of chapter questions

Use these questions to test your understanding of what we've covered so far in Chapter 4. It should be noted that these end of chapter questions are revision questions to test your understanding of the material in the chapter just studied. They are not sample exam questions.

1. State the role of the claims handler.

2. List examples of cases where a claims handler may appoint a loss adjuster or another expert (you do not need to explain each one).

3. Outline what is meant by 'desktop claims handling'.

4. State why a desktop claims handler may contact a third party.

5. Outline the reports that a loss adjuster will typically prepare for an insurer.

6. Outline the typical scope of a delegated authority agreement between an insurer and a loss adjuster.

7. List the services that loss assessors offer their clients.

8. Describe the role of an expert witness in a third-party claim.

9. Outline what a claims handler will typically ask a doctor to do when they are instructed to examine a claimant.

10. State the possible outcomes of the investigation of a first-party claim.

Answers to end of chapter questions

Check your answers against those below and make a note of any points you left out. This will highlight some sections you may need to look at more closely during your revision.

1. The claims handler will normally oversee all aspects of the investigation, handling and settlement of a claim. The role of the claims handler is to:
   - Deal with claims quickly and fairly.
   - Distinguish between genuine and fraudulent claims.
   - Assess the likely cost of a claim so that an appropriate case reserve may be allocated.
   - Determine whether others (e.g., loss adjusters) should be involved.
   - Settle claims efficiently and cost-effectively.
   - Review and analyse loss adjuster and specialist reports and ensure those involved have the required information and instruction to act on the insurer's behalf, particularly in the event of actions requiring urgency e.g. providing approval for interventions in the event of a cyber attack under cyber insurance policy.
2. Cases where it would be appropriate to appoint a loss adjuster or other expert include:
   - Large property damage claims.
   - Claims including an element of business interruption or loss of profit.
   - Claims arising under natural catastrophes such as earthquake, windstorm or flood.
   - Motor vehicle damage claims.
   - Third-party claims.
3. Desktop claims handlers may be employed by the insurer; they may be on the staff of a loss adjusting firm or work for a third-party administrator (TPA) appointed by insurers. As the title suggests, they assess claims in their office, without the need for an adjuster or site visit.
4. A phone interview may be conducted with the third party or their legal representative. This is very effective in establishing the potential value of a claim and whether personal injury claims are to be brought. When this is known, individuals may be asked to submit estimates or other documentation that forms the basis for settling a claim.
5. Loss adjusters typically issue reports at the beginning of a claim (preliminary report) or when significant information is received or an interim payment required (interim report), or when the claim is finalised (final report).
6. Many relatively straightforward claims are now dealt with on a delegated authority basis. The loss adjuster then deals with all aspects of the claim on the insurer's behalf and agrees settlement with the policyholder. They then submit their final report to the insurer, who issues payment in accordance with the adjuster's instructions. There is an additional financial benefit here as VAT does not apply to fees raised under this scheme. Rigorous auditing by insurers is common in this case.

7. Loss assessors may offer the following services and assistance:

   - Ensure that the interests of the insured are preserved
   - Check that the insurance cover was in force and adequate
   - Attend the loss scene to meet the loss adjuster appointed by the insurer
   - Assess the damage and formulate the claim
   - Advise the insured on claim preparation and presentation, including any documentation required
   - Advise the insured on options offered or available
   - Ensure that the proposed settlement is fair and reasonable under policy terms
   - Attempt to bring about a swift settlement.

8. In the context of a third-party claim, the person providing the opinion is referred to as an expert witness. Their role is to assist the court in understanding technical matters. The expert has an overriding duty to the court that outweighs any duty to their client. They are required to give an independent, objective opinion without regard to whether or not it favours the position of the party instructing them. Under the **Rules of the Superior Courts (No.6) (Disclosure of Reports and Statements) 1998**, the exchange of court reports prepared by expert witnesses upon which the parties intend to rely must be made prior to the court hearing.

9. When a doctor is appointed to examine the claimant on behalf of the defendant they are requested to:

   - Provide an independent examination
   - Possibly give evidence in court and be subject to cross-examination on behalf of the claimant
   - Write a medical report outlining:
     - The background to the claimant sustaining the injury
     - The extent of medical attention received
     - Details of continuing pain and injury as outlined by the claimant
     - The capacity of the injured party to resume work and continue their pre-accident activity
     - Their prognosis, or a recommendation for further examination.

10. The claim may be:

    - Valid – and should be paid in full.
    - Partially valid – covered by the policy, but the extent of cover is reduced because of (e.g.) an excess or the application of average.
    - Invalid – where the claim is refused by the insurer, because (e.g.) its proximate cause is not covered by the policy, an exclusion applies, there was a breach of a policy condition or there is evidence of fraud.

Answers to quick questions

1. Met Éireann (www.met.ie) is a helpful website for sourcing indications of weather conditions on a given date in Ireland.

2. Loss assessors, who act on behalf of consumers, must be registered as insurance intermediaries under **EC (Insurance Mediation) Regulations 2005 (as amended)**. Insurance intermediaries are subject to the CPC, MCC and Fitness and Probity Standards in situations where the loss assessor is dealing with a consumer as defined by the Central Bank. Loss adjusters do not require registration under the **EC (Insurance Mediation) Regulations 2005 (as amended)**, as they are regulated through their principals, the insurer.

3. Claims involving motor accidents or accidents at work (or other suitable examples).

Sample exam questions

Question 1

Outline **five** types of claim where it would be appropriate for an insurer to appoint a loss adjuster or other external expert.

Total: 10 Marks

Question 2

a) Define desktop claims handling

(2 Marks)

b) List **eight** practical steps that can be taken by a desktop handler when assessing a claim.

(8 Marks)

Total: 10 Marks

Your answers

Sample answers

The answers set out below show the main points you must consider in answering the question. In some cases, a well-reasoned alternative view could earn good marks.

Question 1

Cases where it would be appropriate to appoint a loss adjuster or other expert include:

- **Large property damage claims –** The cause of such losses may be difficult to ascertain, there may be multiple stakeholders, there may be questions of damage to neighbouring properties or possible subrogation recovery prospects. All of these will need to be investigated.
- **Cyber risk claim –** The nature of such a claim might involve the hacking and theft of company data or a 'ransomware' demand where a criminal organisation demands a ransom before agreeing to release the stolen data back to the company. A cyber insurance policy will cover the cost of an incident manager who will co-ordinate the resources required to investigate and manage such an occurrence. This incident manager may appoint an IT forensic investigator to identify the root cause of the breach or hack, a public relations firm to manage inquiries from the media or customers, a lawyer to assist and advise in respect of any potential regulatory breaches and a loss adjuster to quantify the loss.
- **Claims including an element of business interruption or loss of profit –** An analysis of the accounts of the business may be needed, usually by a chartered accountant, certified accountant or forensic accountant). Advice may need to be given to the policyholder in relation to the mitigation of their loss and how the policy may respond.
- **Claims arising under natural catastrophes such as earthquake, windstorm or flood –** Many buildings in a given area will suffer damage from the same cause within a short time, so claims will need to be adjusted simultaneously; these catastrophes create their own specific problems.
- **Motor vehicle damage claims –** A motor damage assessor or motor engineer is usually instructed to examine the vehicle to report on the extent of the damage and estimate the cost of repair, or the pre-accident value of the vehicle. Some garages use interactive cameras which help the insurer to assess the damage remotely.
- **Third-party claims –** A claims investigator may be instructed to take statements or examine the scene of an accident.
- **In cases where the cause of loss is difficult to ascertain or where fraud is suspected –** Forensic experts are often deployed. These may include fire forensic experts, forensic locksmiths, forensic accountants, handwriting experts, civil engineers etc.

Reference Chapter 4B **Total: 10 Marks**

Question 2

a) Desktop claims handling is a form of claims handling that takes place without a visit to the scene of the accident and generally without face-to-face meetings with any of the parties, including the insured.

(2 Marks)

b) Desktop handling involves some or all of the following practical steps:

- Analysing notification information and comparing claim documentation to policy information and limits. This may involve liaising with underwriters if there are concerns about e.g. insurable interest (for non-consumer insurance contracts) or non-disclosure.
- Making phone calls to the insured to clarify claim details and obtain any additional information required. Handlers then watch for possible fraud and calls are usually recorded.
- Seeking and examining estimates for damage or replacement and/or original purchase invoices where relevant. Quotations are compared to competitors, via databases, to ensure reasonable costs. Original documents may be preferred to photocopies.
- Gathering witness information and contacting potential witnesses to request completion of a witness form or to conduct a phone or personal interview.
- Phone calls may be made to the Gardaí, or a Garda report sought.
- Seeking independent verification of the cause on the date of loss, e.g. the Met Éireann website may be used to check if there was a storm.
- Contacting a third party – through a phone interview or with their legal representative. This is very effective for establishing the potential value of a claim and whether personal injury claims will be brought. After this, individuals may be asked to submit estimates or other documentation that forms the basis for settlement.
- Examining and pursuing the possibility of recoveries through subrogation, contribution or salvage.

(8 Marks)

Reference Chapter 4B1 **Total: 10 Marks**

Chapter

5

Indemnity – how much will the policy pay?

What to expect in this chapter

So far, we have seen that insurers gather information when a claim is notified (see Chapter 2), check that information against the policy document and other requirements for cover (see Chapter 3) and carry out appropriate investigations into the circumstances of a loss (see Chapter 4).

We will now examine how insurers apply the principle of indemnity to determine the extent of cover under different types of policies.

Contents

A The principle of indemnity

When all of the policy checks and investigations determine that a claim is valid, the next step for the claims handler is to establish the scope of cover. This means applying the principle of indemnity and the policy wording to the claim.

Most insurance policies are contracts of indemnity. They provide financial compensation for a loss the insured has suffered, and to put them in the same position after the loss as they enjoyed immediately before it. Most general (non-life) insurances are indemnity contracts. Many package policies, such as household, provide death or accident benefits, but they are still recognised as 'indemnity' policies with an additional benefit component. Private health insurances are also policies of indemnity, although some policies also provide cash benefits for an event.

Indemnity means that the insured should be fully compensated for their loss to the extent provided for in the policy, but not over-compensated.

Case law

As Brett LJ stated in *Castellain v Preston* (1883):

> The very foundation, in my opinion, of every rule which has been applied to insurance law is this, namely, that the contract of insurance contained in a marine or fire policy is a contract of indemnity and of indemnity only … and if ever a proposition is brought forward which is at variance with it, that is to say, which either will prevent the insured from obtaining a full indemnity or which gives the insured more than a full indemnity, that proposition must certainly be wrong.

Microlearning resources

In the Member Area of www.iii.ie, via the Connect logo and in Your Learning Centre, select the microlearning section of this chapter to access a resource specifically developed to help you better understand this topic.

Indemnity is a contractual, not statutory, principle of insurance. It can be varied if the parties involved wish to do so. So, despite the words of the judge in the quotation, the parties may agree that the policy will pay less (and sometimes more) than a full indemnity when a loss occurs. In this chapter we will see examples of how policy wordings limit or extend the operation of the principle of indemnity.

B Limits in the operation of indemnity

We will now consider policy terms that may limit the insured's entitlement to a full indemnity.

limit of indemnity

insurer's maximum liability for any one incident / claim (usually under the terms of a liability policy or section of a policy)

public place

under the Road Traffic Acts, this is 'any place where the public have access with vehicles'

B1 Sum insured or limit of liability

Under many policies, the sum insured or the **limit of indemnity** (or limit of liability) restricts the maximum amount that can be paid. When a policy has a sum insured or indemnity limit, the insured cannot recover more than this amount. This is true even where the loss, measured by the indemnity principle, is a higher figure, as Example 5.1 illustrates.

Example 5.1

A shop may have the following sums insured:

Buildings	€200,000
Stock	€2,500
Fixtures and fittings	€5,000

If all the stock was damaged by water and the total amount of stock lost was found to be €4,000, the maximum that can be paid is €2,500.

Liability insurance policies have a maximum limit of indemnity, rather than a sum insured. Policies are written on the basis that either:

- Third-party costs and legal defence costs are additional to the limit of indemnity, or
- Claimant's and defence costs are included in the limit of indemnity.

In motor insurance, the law prevents insurers imposing any limit of indemnity for third-party injury liability. The Irish **Road Traffic Act 1961** requires motor insurers to grant unlimited cover for liability in respect of death or bodily injury arising from the use of motor vehicles on a road or **public place**.

5.1

Extract Road Traffic Act 1961, Section 62(1b)

> The insurer by whom the policy is issued binds himself by it to insure the insured against all sums without limit which the insured or his personal representative shall become liable to pay to any person (exclusive of the excepted persons) whether by way of damages or costs on account of injury to person or property caused by the negligent use, during the period (in this Act referred to as the period of cover) specified in that behalf in the policy, of a mechanically propelled vehicle to which the policy relates, by the insured or by any of such other persons (if any) as are mentioned or otherwise indicated in that behalf in the policy.

While the liability section of the motor policy must be unlimited in respect of death or bodily injury, insurers may apply a limit in respect of damage to third-party property. Under the **European Union (Motor Insurance) (Limitation of Insurance in relation to Injury to Property) Regulations 2016**, this limit must be at least €1.22 million.

Motor policies also limit the amount that will be paid for damage to the insured vehicle. Most policies stipulate that the 'market value' of the vehicle will be paid in the event of a total loss, regardless of the value stated when taking out the insurance.

Within the overall sum insured or limit of indemnity in an insurance policy, there may be further separate limits for particular types of loss or particular types of property.

The following are examples of different limits for different classes of insurance:

1. A household contents policy restricting cover on individual 'valuables' (e.g. gold or silver items, jewellery, antiques, works of art) to, for example, 5% of the total sum insured. These 'single article limits' may apply to ensure that no disproportionate claims are received and to encourage policyholders to insure valuable items on an 'all-risks' basis. So if a painting valued at €7,000 is destroyed in a house fire where the contents sum insured is €60,000, the policyholder will receive no more than €3,000, which is less than a full indemnity. A limit might also apply to the total of such valuables as a percentage of the contents sum insured. Items that are specifically insured usually on an 'all-risks' basis are not subject to this limitation, but are limited to the specified sum insured.
2. Some policies include a **matching pairs and sets clause**. Example 5.2 illustrates how this clause operates.

Quick question 1

What limit, if any, does the **European Union (Motor Insurance) (Limitation of Insurance in relation to Injury to Property) Regulations 2016** allow insurers to place on third-party personal injury cover under their policies?

The answer is at the end of this chapter.

matching pairs and sets clause

refers to the exclusion of undamaged items in a pair or set such as a single earring or the couch in a three-piece suite

Example 5.2

While slipping on his bathroom floor, Tony tries to stop his fall by grabbing onto the sink. In doing so, he accidentally pulls the sink from the wall and breaks it. He submits a claim to his household insurer for a new bathroom suite, saying that he cannot find a sink that matches the rest of his suite. However, his policy has a 'matching pairs and sets' clause, so his insurer only meets the cost of buying a new sink. If Tony wants to ensure the rest of his suite matches, he will have to pay to replace his bath and toilet himself.

3. A money insurance policy normally has a limit for loss of money from a locked safe and outside of business hours.
4. A theft insurance policy has the stock sum insured divided between different categories of risk. Each category will have its own maximum sum insured. In a retail shop, stocks of cigarettes, being a higher theft risk, are usually valued separately with a higher premium. If the sum insured for cigarettes within the stock is set, for example, at €3,000, then no more than this can be recovered, regardless of the value at risk.
5. A business interruption policy normally covers loss of profits. If, following the loss, the insured needs to get the business back up and running sooner than might be the case, the policy will also pay for any increased cost of working. (Typical examples would be overtime payments to make sure building repairs are completed earlier so that the business can re-open sooner than originally anticipated, or, advertising costs to make sure that any previous customers will know that the business has re-opened). This is subject to a stipulation that these increased costs must make economic sense. The objective of these payments is to off-set any potential loss of business that the insured business might suffer. They are subject to an 'economic limit', whereby the money spent must at least match the loss of gross profit that it avoided.

B2 Excesses, deductibles and franchises

B2a Excess

An excess is the amount of a loss that the insured must bear. It is stated in the policy as a monetary amount e.g. €250. Excess clauses are common in many types of policies, including household, motor and commercial insurances, and make the insured their own insurer for the amount of the excess. Sometimes there may be an aggregate excess or deductible (see Section B2b1).

The excess reduces the size of claim payments. For small claims, the excess clause relieves insurers of the administration cost of dealing with smaller losses. Excesses can either be imposed by the insurer or requested by the insured to reduce their premium.

The excess amount is deducted from the final net value of a claim. So any negotiation of value, or application of policy terms (e.g. for underinsurance) will apply first, and the excess deducted afterwards.

Household policies often have excesses. For perils such as subsidence, a significant excess is likely to apply. A €10,000 excess is not uncommon. Again, it is important for advisers to note these issues when choosing a policy or helping a consumer.

B2b Deductible

'Deductible' is the name for a very large excess, usually applying to commercial policies, in return for a reduced premium. The terms 'excess' and 'deductible' are interchangeable in some insurance sectors. The insured voluntarily agrees to pay the first part of the amount of any claim at a figure higher than the standard excess, and a premium discount is then allowed.

Deductibles may be arranged separately for property damage insurance or combined with related business interruption insurance. The insured may choose either the same deductible level for all perils insured or different deductibles. For storm, flood and escape of water (including sprinkler leakage), the insured may arrange for the deductible to apply separately at each premises, or over the whole policy. The policy wording should always be checked when confirming how a deductible applies.

B2b1 Aggregate deductibles

An insured with a substantial deductible may suffer several losses annually but still wish to limit their financial exposure to claims. This limit is called an **aggregate deductible**. Insurers usually look for an aggregate amount of at least four times the individual deductible. The higher the deductible, the lower the exposure for the insurer and therefore the lower the premium.

When taking on a large aggregate deductible, an insured will normally arrange cover so that they absorb the losses on minor claims. This is often known as the 'worker' or 'working excess', and can vary from €500 to €50,000 or higher, depending on the size of the company and available funds. The 'worker' can act as a risk management tool and instil greater awareness and care by employees and management. This 'working' excess does not count towards the aggregate deductible.

Once the aggregate amount is reached, a standard excess may apply. Example 5.3 demonstrates this point.

aggregate deductible

a limit or maximum amount the insured can pay as deductibles on claims over a specified period

Example 5.3

Chosen Furniture Company has a policy offering the following:

Working excess	€500
Standard policy excess	€1,000
Deductible	€20,000
Aggregate limit	€100,000

During the year, Chosen Furniture Company experiences the following fire losses:

Loss €	Deductible €	Payable under policy €	Aggregate position €
500	20,000	Nil	Within 'working' excess
5,500	20,000	Nil	5,500
25,000	20,000	5,000	25,500
50,000	20,000	30,000	45,500
27,000	20,000	7,000	65,500

Example 5.3 (contd)

Loss	Deductible	Payable under policy	Aggregate position
21,000	20,000	1,000	85,500
14,500	20,000	Nil	100,000
900	N/A*	Below standard excess	100,000
1,500	N/A*	500	100,000
21,000	N/A*	20,000	100,000

* The standard policy excess applies when the aggregate deductible limit is reached.

We can now make the following explanatory comments:

- In this example, we have a working excess of €500. Therefore, no claims at or below €500 count towards the aggregate, the insured pays all such claims.
- For claims above €500, the insured is responsible for the first €20,000 of each claim. Any amount over €20,000 is payable under the policy.
- However, the insured decided that €100,000 is the maximum amount they can afford to pay; so as claims arise, the amounts payable by the insured are totalled until they reach €100,000. Once they reach the aggregate amount of €100,000 the insurer pays all the future claims and the standard excess of €1,000 is deducted for all further claims.
- The insured continues to be entirely financially responsible for all losses at or below the €500 working excess.

B2c Franchise

A **franchise** is similar to an excess, in that there is no cover for any loss less than the franchise figure. However, once a franchise has been exceeded, the loss is payable in full. The distinction between an excess and a franchise is illustrated in Table 5.1. Time franchises apply to certain insurances, e.g. business interruption following machinery breakdown. So instead of having to surpass a financial amount, a certain amount of time must pass.

Table 5.1 Comparison of the application of excess and franchise to claims

	Loss of €950	Loss of €1,045
€1,000 excess	Insurer pays nothing	Insurer pays €45
€1,000 franchise	Insurer pays nothing	Insurer pays €1,045

B3 Underinsurance or average clauses

Underinsurance is an important consideration in claims handling. For small property damage claims, a claims handler may not be in a position to notice or evaluate the adequacy of a sum insured. For larger claims, a loss adjuster's report will include a specific comment on this.

If underinsurance arises, an '**average**' **clause** may apply. The loss adjuster or claims handler will have to be aware of which product they are reviewing each loss under and, if an average clause exists on that product.

Quick question 2

Identify the difference between an ordinary excess and an aggregate excess / deductible.

Quick question 3

The insured has a loss of €2,000 with a €500 excess on the policy.

a. Calculate how much the insurer will pay in settlement.

b. If this had been a franchise would your answer have been different?

franchise

a minimum amount of loss that must be incurred before insurance coverage applies (similar to an excess except that once the amount of the franchise is exceeded, the whole of the claim is paid)

underinsurance

policy that has been effected, requiring full value as the basis for cover but where a lower figure has been declared

'average' clause

a clause in an insurance policy stating that, where a sum insured is inadequate, a claim settlement is reduced in proportion to the percentage of underinsurance

The basic calculation for the application of average is as follows:

$$\frac{\text{Sum insured at time of loss}}{\text{Value at risk at time of loss}} \times \text{Amount of loss} = \text{Value of loss}$$

For example, if a property is insured for €250,000 but valued at €500,000, then the insured has only arranged half the amount of insurance required, paying half the appropriate premium, and therefore should only be paid half the loss.

B3a 'Average' as an implied term

Insurers vary about including an 'average' clause in household policies. Some do not include the clause but import a type of 'average' by relying on the 'full value' declaration if serious underinsurance occurs. This allows them to repudiate a claim on the basis of **misrepresentation** of the **value at risk**, or to offer a partial claims settlement which effectively becomes an 'average' situation.

Very few insurers use this method in household insurance, as policies clearly stipulate the method of settlement for underinsurance. If an average clause exists, the insurer must specify this at the quotation stage.

Furthermore, in consumer insurance contracts, even in the event of gross underinsurance, it is likely that such a scenario would be considered innocent misrepresentation (see Chapter 3D1) as the consumer is unlikely to be an expert in establishing the rebuilding cost of their property.

The market now provides '**new for old**' **cover** on household policies, which is discussed in Section C2. Here if the sum insured is inadequate, the 'new for old' benefit is lost as a penalty for underinsurance. Settlement will be on an indemnity basis, with deductions to reflect the age and condition of the lost or damaged property.

In marine insurance 'average' can be an implied term, as it applies automatically by virtue of Section 81 of the **Marine Insurance Act 1906**.

misrepresentation
untrue statement of fact, either innocent or fraudulent, made during negotiations

value at risk
the total financial value of potential losses arising if the insured event occurs

'new for old' cover
cover providing replacement of lost or damaged items with new equivalent versions

5.2

Extract Marine Insurance Act 1906, Section 81

Where the assured is insured for an amount less than the insurable value, or in the case of a valued policy, for any amount…less than the policy valuation, he is deemed to be his own insurer in respect of the uninsured balance.

However, as might expected with an implied term, this would be very difficult to stand over in practice. If an insurer had intended to penalise an insured for underinsurance, it would be expected that a clause would have been inserted into the policy to this effect. Moreover, it is very unlikely that this type of implied term would be enforced by a court in a non-consumer insurance contract.

'Average' clauses appear in many types of commercial lines insurance and increasingly in household insurance. The position with other insurance types is less clear; as seen in *Carreras v Cunard Steamship Co.* (1918).

Case law

In *Carreras Ltd v Cunard Steamship Co.* (1918), it was suggested that 'average' could be implied into commercial policies. This is only theoretical, as insurers incorporate a specific condition to make the position clear and avoid any misunderstanding or dispute arising from a claim.

C Extensions in the operation of indemnity

There are instances where the insured may, depending on circumstances, recover more than a strict indemnity.

C1 Cover on a reinstatement basis

Cover on an indemnity basis may not provide the insured with enough money to restore damaged property. An indemnity settlement under a property damage claim could, for example, involve deductions against the cost of repairs or reinstatement for 'wear and tear' or deterioration. This can apply to buildings, plant and machinery. The decision in *Reynolds and Anderson v Phoenix Insurance Co. Ltd* (1978) has established that this is how an indemnity-based settlement is to be calculated (see Section D1a).

When a building in less than perfect condition is destroyed or seriously damaged, it generally cannot be rebuilt without making good existing 'wear and tear'. While the insured will be left with a better building than before, this will be of little comfort if the claim payment is not enough to cover the costs after reinstatement.

The provision of **reinstatement cover** solves this problem. Here no deduction is made for 'wear and tear' and the insurance pays for the full cost of rebuilding 'as new' (including any increased costs resulting from inflation between the date of the damage and completion). Many policies provide cover in respect of extra costs that might be incurred in the course of rebuilding, if policyholders have to comply with new building regulations or other legal requirements. This is often referred to as the **public authorities clause**.

With reinstatement cover, the policyholder will need to fix the sum insured to reflect the rebuilding costs over the period of cover, i.e. including potential increases in material and labour costs. The sum insured must be enough to cover the costs at the time of reinstatement. This can involve a certain amount of speculation, but less so in the current low-inflation environment. Recognising this difficulty in commercial property policies, the average clause is normally only applied if the sum insured is less than 85% of the reinstatement value at reinstatement. This takes account of a margin of error in calculating the value at risk. In household buildings insurance, insurers normally allow for a small level of underinsurance, recognising that the policyholder is not an expert in such matters.

Reinstatement cover is beneficial to the insured as the building will be replaced after a serious loss. It will inevitably involve a more expensive premium than an indemnity cover because the sum insured (on which the premium is based) will need to be higher to cover rebuilding costs 'as new'. Importantly, reinstatement cover policies do not permit the insured to obtain the benefit of reinstatement cover unless they rebuild the damaged property. The reinstatement memorandum (under commercial property policies) restricts cover to an indemnity value, i.e. deduction for 'wear and tear', unless the rebuilding work is commenced without delay and subsequently completed.

reinstatement cover

provides cover for the cost of rebuilding or replacing the property to a condition similar to when it was new and to be no more extensive than prior to the loss

public authorities clause

refers to cover provided for improvements that are forced on the insured by the requirements of the law

Reinstatement cover can be applied to buildings, plant, machinery and other contents, but not to stock in trade or goods in trust or held on commission.

The reinstatement memorandum (under commercial property policies) has limitations in times of high inflation as the insured may have to predict building costs 1, 2 or even 3 years ahead. Consequently, insurers offer a '**day one**' **reinstatement** cover. An automatic uplift in the sum insured applies to cater for future inflation, usually some 33% of the sum insured. The revised sum insured, as illustrated in Example 5.4, is still the limit of settlements.

'day one' reinstatement

a means of countering the effects of inflation by providing an automatic increase in sum insured based on an accurate reinstatement sum insured on the first day of the cover

Example 5.4

Rebuilding costs on day one	€200,000
Debris removal	€10,000
Professional fees	€10,000
Public charges	€5,000
Declared value	**€225,000**
Inflation during the 12-month cover	€20,000
Inflation during design and planning	€2,500
Inflation during construction	€2,500
Total sum insured	**€250,000**

The policy schedule may show the sum insured (€250,000) and the declared value (€225,000) in brackets.

Therefore, if the insured sustains a loss totalling €240,000, it is paid in full.

C2 'New for old' cover

While reinstatement cover is usually used for commercial buildings and machinery, 'new for old' is the conventional term that is used for household goods and personal possessions. This cover states that insurers agree to pay the full replacement cost 'as new' of any insured item that is lost or destroyed, without deduction for wear or tear. The cover usually excludes items such as clothing, household linen and floor coverings.

Microlearning resources

In the Member Area of www.iii.ie, via the Connect logo and in Your Learning Centre, select the microlearning section of this chapter to access a resource specifically developed to help you better understand this topic.

At first sight 'new for old' cover may seem to contradict the principle of indemnity and allow the insured to make a 'profit' out of their loss, as they receive a new item for an old one. But this cover simply reflects what policyholders do when an item is destroyed – they replace it. The cover was made available to overcome difficulties in claims settlement where shortfalls arose after deductions for 'wear and tear'. This is generally viewed as fair, provided the sum insured reflects the total replacement cost of all items 'as new'. This results in a much higher sum insured, higher premiums and an equitable contribution to the 'common pool'. Crucially the sum insured represents the total replacement cost of all items.

Insurers have been happy to provide this cover as a selling point for their product. There is no ready market to replace second-hand items, and it avoids insurers arguing over the value of the damaged item.

The own damage section of a motor policy also provides property damage cover by replacing the insured vehicle. Some policies cover replacement with a new vehicle following a 'write off', if the insured vehicle is less than 12 months old at the time of loss and has not exceeded a specified mileage.

C3 Agreed additional costs

agreed additional costs

additional items or fees that may be covered under the policy

These do not extend the principle of indemnity as in reinstatement cover. They add further legitimate categories of recoverable costs that the insured may incur. In property insurance, there is often a situation where **agreed additional costs** are incurred following a fire or other damage, e.g. debris removal from a site, adhering to public or local authority requirements, architects' or surveyors' fees. All such costs may be included within the insured's policy cover and any payments relating to them (though they may be an addition to the basic sum insured) will be payable assuming they were provided for in advance.

C4 Agreed value cover

agreed value policy

insurance arrangement in which the value of an item insured is agreed in advance and (usually) a formula agreed for partial losses

The measurement of indemnity operates differently in the case of insurances written on an agreed value basis (sometimes known as 'valued' policies). For an **agreed value policy**, a particular sum is paid regardless of the value of the property at the time. This contrasts with conventional indemnity cover, where insurers are liable to pay only for the value of the property at the time and place of the loss.

The object of an agreed value policy is to avoid disputes about the value of property at the time of loss. This cover is often used where a property is unique or has a limited market. Here the value is subjective and more likely to cause a dispute. Art, antiques and vintage cars are frequently insured on an agreed value basis.

Another use for this cover is inherited jewellery. For example, an insured could inherit their grandfather's vintage car. If its monetary value has not been assessed, it could be difficult to value if it were lost or stolen. In this case, a valuation is obtained in advance and used as an agreed value. This also makes a fraudulent claim more difficult, as the description and nature of the item is already known.

It is important to note that a policy written on an agreed value basis is not the same as a 'specified item' under the household policy (e.g. an item of jewellery). The sum insured under 'specified item' cover determines the insurer's limit of liability in the event of a loss, not the amount of payment in the event of a total loss if the cost of replacement is less than the specified sum insured.

C4a Partial losses under agreed value policies

Under an agreed value policy, in the case of a **partial loss**, the rule established in *Elcock v Thomson* (1949) is applied, unless the policy wording has a specific provision for the treatment of partial losses.

partial loss
any loss other than a complete loss of the insured item

Case law

In *Elcock v Thomson* (1949), a large house was insured under a fire policy for an agreed value of £106,850, although its actual value was only £18,000 at the time that it was damaged by fire. The effect of the fire was to reduce the value of the building to £12,600: a reduction of 30%. The court held that the insured was therefore entitled to 30% of the agreed value, namely £32,055. Under the rule, the insured is thus entitled to a proportion of the agreed value equivalent to the degree of depreciation in actual value caused by the loss.

Elcock v Thomson claim settlement

Agreed value sum insured	£106,850
Actual value at time of loss	£18,000
Value of building after fire	£12,600
Difference between actual value at time of loss and value of the building after the fire (£18,000-£12,600)	£5,400
Difference as a percentage of the value at the time of loss (£18,000 * 30%)	30%
Settlement on the 30% basis	**£32,055**

However, insurers will usually adopt wording defining what will happen in the event of a partial loss and applying a formula or restriction as a basis for settlement. For example, a policy for a vintage car may state a sum insured as an agreed value that would apply to any total loss. However, the insurer's liability for partial losses is restricted to the last manufacturer's published price for spare parts used and the reasonable cost of labour for fitting them.

D Applying and measuring indemnity

unliquidated damages

amounts of money that cannot be accurately determined until after an event has occurred

A claim under a policy of indemnity has been described as a claim for **unliquidated damages**.[18] This means that the exact amount of the compensation is not known in advance but is to be fixed afterwards on the basis of the loss suffered. Motor policies are a good example of unliquidated damages. Under the comprehensive section of the policy, a value is put on the car at inception. If the car is written off in an accident, its (market) value will be assessed at the date of the loss and this is the amount that will be paid under the policy.

Disputes sometimes arise about the correct method of valuing a loss and the exact sum necessary to provide the insured with a true indemnity. In practice, indemnity measurement depends on the type of insurance involved and the nature of its subject matter.

We will now consider how insurers apply the principle of indemnity when dealing with claims under different types of policies.

D1 Property insurance

measure of indemnity

assessment of financial compensation that is appropriate to place the insured in the required financial position

Generally, the **measure of indemnity** for the loss of any property is determined not by its original cost, but by its value at the time and place of loss. If the value increases during the life of the policy, the insured is entitled to an indemnity on the basis of the increased value, subject to the adequacy of the sum insured.[19] Similarly, if the value has decreased during the policy period, the insured will recover only the reduced value at the time of loss.

Note that the measure of indemnity is not necessarily the sum insured in the policy. The sum insured will be the maximum amount paid in the event of a claim. In the Irish case of *Vance v Foster* (1841), the judge stated: 'You must not run away with the notion that a policy of insurance entitles a man to recover according to the amount represented as insured by the premium paid.'

Under a property insurance policy, the policyholder can recover only the amount of the value of the property itself. They cannot claim for loss of prospective profits or other consequential losses unless these are specifically insured.

business interruption insurance

insurance that protects a commercial policyholder against loss of profits and other expenses following insured damage to their property

In *Re Wright and Pole* (1834), an inn had been destroyed by fire and the court held that the insured could not recover under his fire policy for loss of trade and the cost of hiring other premises. This could have been insured separately under a **business interruption** policy.

[18] See *Jabbour v Custodian of Israeli Absentee Property* (1954).

[19] See *Wilson and Scottish Insurance Corporation* (1920).

The only exception to the general rule of not being able to insure consequential loss under a property policy is that loss of rent (either receivable or payable) may be insured as a specific item. A property policy will usually cover lost rent until the premises are rebuilt and ready for occupation. This is a very useful cover, but it may take some time before a new tenant is found, meaning that the insured could suffer a continuing loss not covered by a property policy. A business interruption policy is designed to cover trading losses, which may include loss of rent receivable. If a new tenant is not found immediately, the lost rent beyond the date a building becomes fit for occupation would form part of a business interruption claim.

D1a Buildings

Where a building is damaged, the indemnity basis of settlement will be the cost of repair or reconstruction at the time of loss with, in many cases, a deduction for '**betterment**' or 'wear and tear'. Note that this kind of deduction will usually only apply on a **pure indemnity** settlement.

betterment

any improvement in the value of a damaged building or other goods as a result of reinstatement or repair

pure indemnity

a strict application of the principle of indemnity

A deduction for betterment may be applied where the repair is completed to a better quality than the original. This could be due to improved technology or where it is impossible to repair using the old method. For example, following a fire, it is unlikely for a roof to be replaced in the same condition as the old one prior to the damage. If no allowance is made for this renovation, the insured will be in a better financial position after the loss than before because the value of the building will have increased.

We can conclude that in the event of a claim and where the reinstatement of the item substantially improves the insured's position, the principle of betterment applies. Here a financial payment is required of the insured and their claim is therefore reduced.

The betterment principle can of course be varied if the policy is on an agreed value, reinstatement or 'new for old' basis. Here the insurer will not apply a deduction for betterment.

Where legislation or local laws require a building to be reconstructed meeting certain requirements, the public authorities' clause (see Section C1) in a property insurance policy covers those additional costs.

Another form of betterment arises after a total loss or substantial partial loss, where the cost of rebuilding a structure in its previous form exceeds its market value or the cost of replacing the old structure with a modern building of similar size and usefulness, as shown in Example 5.5.

Example 5.5

Textile mills, factories and old farm buildings are usually of massive construction and therefore costly to repair, but are often worth relatively little on the open market. This is usually because they have outlived their original purpose. They may also have been constructed using original materials that are no longer available or appropriate and the original structure may no longer be suitable to today's needs.

obsolete buildings

old buildings, e.g. churches and mills, often of massive construction and no longer used for their original purpose

The insurance market terms these as '**obsolete buildings**' even though they may be perfectly adequate for their current purpose or function. They may be uneconomical to restore or rebuild either with the original materials or in the original form. If such buildings are badly damaged or destroyed, the basis of assessing indemnity may be problematic. The appropriate basis depends on certain factors, including the intentions of the insured to rebuild, and whether rebuilding is reasonable. All of this needs to be considered when arriving at a sum insured.

The case of *Reynolds and Anderson v Phoenix Insurance Co. Ltd* (1978) illustrates these points.

Case law

In 1969, the plaintiffs bought old maltings (buildings used for brewing beer) and insured them for £18,000, which was a little more than the original purchase price. Subsequently, the sum insured was increased to £628,000 to cover the probable cost of rebuilding in the event of the building being totally destroyed. A fire then occurred that destroyed a substantial part of the building and a dispute arose as to the appropriate basis of indemnity. The judge outlined three potential bases:

- The market value of the building
- The cost of erecting a modern replacement building (around £50,000)
- The cost of reinstatement, i.e. rebuilding the damaged part in its original form (more than £250,000).

The market value of the building would have been difficult to assess, but would probably have been far less than the cost of rebuilding. The cost of a modern replacement would also have been much lower than the rebuilding cost. The court held that the appropriate basis of indemnity was the third option: the cost of rebuilding in the original form. This was because the insured had a genuine and reasonable intention of rebuilding, which was evident from the arranging of an increased sum insured. The insurer will usually insist that reinstatement takes place in such circumstances before settling the full claim.

The decision in *Reynolds and Anderson* is different from the decision in *Leppard v Excess Insurance Co. Ltd* (1979). The key issue in the *Leppard* case was that the building was for sale at the time of loss.

Case law

The insured had acquired a cottage from his relatives and insured it for a sum of £12,000. The cottage was destroyed by fire and the insured claimed the cost of rebuilding (around £8,600). It was evident that the insured never intended to live in the cottage and was advertising the cottage at a sale price of £4,500 at the time of loss. The price was low because a dispute over rights of way made the sale difficult. Because of the insured's intention to sell, the court held that market value (the first alternative outlined by the judge in the *Reynolds and Anderson* case) was the correct basis of indemnity. The sum of £3,000 was awarded, which represented the advertised price of £4,500 less the site value of £1,500.

D1b Machinery and equipment

Indemnity is generally based on:

- The cost of repair less an allowance for 'wear and tear', if applicable, or
- The cost of replacement, less 'wear and tear', if repair is not possible.

If there is no ready second-hand market for damaged property, the insured may be obliged to purchase new equipment, which is likely to be superior. A deduction for betterment will normally be appropriate in the circumstances. Examples of commodities where the retail price of second-hand goods is used are motor cars and certain office equipment.

D1c Motor vehicles

Indemnity for the 'write off' of a car will normally be the market value of a vehicle of the same make, model, age, mileage and condition, and not the 'trade-in' price. When a vehicle is written off, indemnity is the market value of the car provided that this value does not exceed the sum insured. For example, if the sum insured and the market value is €15,000, no problem arises. If the market value of the car is €15,000, but the sum insured is €12,000, the amount payable will be €12,000. The sum insured will limit the amount payable.

In many private type insurances, the policy proposal is based on the vehicle details (make, model, engine size and age). There is no actual sum insured so the conflict about insured value versus market value does not arise. It can in commercial vehicle insurances which do stipulate an insured value.

D1d Manufacturers' stock

Manufacturers' stock generally consists of raw materials, work in progress and finished stock. The measure of indemnity will not necessarily be the cost to the manufacturer of producing the stock. It will be what it will cost them at the time and place of loss to replace the goods or return them to the condition they were in before they were destroyed.

For raw materials, this will be the replacement cost, including delivery to site. For other stock, it will be the same raw material costs plus labour and other identifiable costs incurred in reproducing the half-made or fully completed goods that were lost.

manufacturers' stock

relates to goods held by a manufacturer at various stages in the process

D1e Wholesalers' and retailers' stock

Indemnity is based on the cost at the time of loss in replacing the stock, i.e. the current manufacturer's or wholesale price, including transport and handling costs to the insured's premises. A complication may arise if stock held is obsolete. Then the replacement cost may be higher than the market price. As with manufacturers' stock, the market price is the appropriate basis of indemnity.

D1f Farming stock

For both livestock and produce, the local market price is the normal basis of an indemnity. With other commodities, the insured is not entitled to any potential profit on sale under a property policy. Farming stock is slightly different. The indemnity is based on the prevailing price for that produce on the day, less any processing, handling or transport costs that were saved because of the destruction.

Farm produce provides a good example of the addition of inputs and how they should rightly be considered when calculating the indemnity. A field of wheat has a particular value. Once it is harvested it has a different value. The value changes again when it is transported to the local mill and perhaps again when it has been milled into flour.

D1g Household goods

The same applies to household goods as to other items. Frequently the insured wishes to attach sentimental value to an article that has been damaged or lost. This is not a matter for insurance. It is not capable of any objective measurement and certainly is not capable of financial measurement. Indemnity is based only on the cost of replacement at the time of loss, subject to 'wear and tear' deductions, except where 'new for old' coverage applies.

'Wear and tear' is the normal expected deterioration during the lifetime of a product's use. As an added benefit, many household policies will cover 'new for old' for most contents, and will only apply the 'wear and tear' provision for household linen and clothing losses.

D2 Pecuniary (money-related) insurances

Pecuniary insurances include business interruption insurances, **credit insurances**, **fidelity guarantee insurance**, and **legal expenses insurance.**

D2a Business interruption insurances

For business interruption insurance, the definition of indemnity differs from the standard definition, which relates to returning an insured to an historical financial position, i.e. to the moment before a loss occurred. Business interruption cover is forward looking and involves assessing the financial position the insured would have enjoyed, had the event giving rise to the loss not occurred.

Microlearning resources

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The loss is paid in accordance with a standard formula set out in the policy wording. The policy limitation is not simply a sum insured but also the insured's estimate of the longest period it will take to recover their trading position following a material damage loss, known as the **maximum indemnity period**. Losses continuing beyond this will not be paid.

Calculating the amount of a claim typically involves the following steps:

1. **Calculate the reduction** in the insured's turnover, by comparing it to the equivalent trading period during the previous year corresponding with the actual interruption period.
2. **Work out the loss of gross profit**, using the previous year's **rate of gross profit**. The rate of gross profit is calculated using the following formula:

$$\frac{\text{Gross profit}}{\text{Turnover}} \times 100 = \%$$

This rate is then applied to the reduction in turnover during the interruption period.

3. **Adjust for trends.** Any influences, either within the business or outside, that are expected to affect the actual results are considered, e.g. if there is a 5% downturn in sales in the policyholder's sector during the period of interruption, this is taken into account when calculating a claim settlement.

pecuniary insurances
those insurances that cover financial loss

credit insurance
a type of commercial insurance that covers losses caused by unpaid debts

fidelity guarantee insurance
a type of commercial insurance that covers the loss of money or property through fraud, theft or dishonesty by employees or other specified persons

legal expenses insurance
insurance to cover the cost of defending or pursuing certain civil actions

maximum indemnity period
a period of time chosen by a policyholder under a business interruption policy as the maximum time necessary for the business to recover to its future expected trading position

rate of gross profit
the percentage ratio of the insurance gross profit to the turnover

4. **Add the increased cost of working.** Policies cover extra costs and expenses incurred with the intention of helping the business to quickly return to normal. These expenses are normally tested against the 'economic limit', where the insurer asks: 'Is €1 in gross profit saved for each €1 of expenditure?'
5. **Deduct any savings achieved** from charges or expenses that cease to be payable because of the interruption are deducted, e.g. reduced electrical or postal costs.
6. **Apply a test for underinsurance** and adjust for 'average' (see Section B3) if appropriate.

Example 5.6

Following a fire, a small factory was closed for four weeks to allow for repairs to be carried out. When the factory reopened, production was at full capacity, but the factory's sales revenue had fallen because customers had gone elsewhere. It took the sales team another week to get sales revenue back to where it was before the fire. This means that in the case of this factory, the indemnity period was five weeks (four weeks of closure plus one week to get their old customers back).

Calculate the reduction and adjust for trends

The factory's annual turnover as recorded in the most recent accounts was €100,000. However, the sales revenue figures in the year since those accounts show that there was a positive trend towards an increase in sales revenue of 20% (this means that the factory was doing better than when those accounts were prepared). This positive trend can be included in the claims settlement because if the factory had not gone on fire and if it had not had to close, its sales revenue would have been €120,000 (€100,000 + €20,000 (20% trend in sales revenue)).

Work out the loss of gross profit

The loss in sales revenue in the five-week interruption period was €20,000 and the rate of gross profit identified in the accounts is 50%. This means that in the case of this factory, the loss of gross profit was €10,000 (€20,000 x 50%).

Add the increased cost of working

The business spent €500 in advertising costs to let previous customers know that the business had re-opened. As noted, these costs are subject to an 'economic limit', whereby the money spent must at least match the loss of gross profit that it avoided.

Deduct any savings achieved

We need to consider whether there were any savings during the period the factory's business was interrupted. In the case of this factory, there were no savings during this period.

Apply a test for underinsurance

The sum insured on gross profit is €40,000 for 12 months. In order to calculate the adequacy of the sum insured, we must calculate the gross profit that would have been earned in the 12-month period from the date of loss, assuming the loss had not occurred in the first place. We have established that a positive trend

Example 5.6 (contd)

of 20% was being achieved by the business and so when this is applied to the previous year's sales of €100,000, the projected revenue for the factory over 12 months is €120,000 (€100,000 + (€100,000 x 20%)).

Applying the Gross Profit rate of 50% to this figure results in a projected gross profit for the year of €60,000 had the loss not occurred. This means that the gross profit sum insured should have been €60,000 (€120,000 x 50%), whereas it was €40,000. It is therefore deemed inadequate.

This means that average should be applied under the policy terms.

D2b Other pecuniary insurances

policy limit

monetary amount establishing the largest financial payment that can be made under that policy

For credit insurance, indemnity is easily assessed, being the amount of the bad debt, less any recoveries. Insurers rarely grant 100% cover and normal market practice is for a 10% deductible to apply.

For a fidelity guarantee policy, the measure of indemnity is the amount of the financial loss suffered because of the dishonesty of an employee or other person, subject to **policy limits**. In legal expenses insurance, the measure of indemnity is the costs of a legal dispute, subject to the limits and conditions of the policy.

Legal expenses insurance provides cover for legal representation in the pursual or defence of legal action. It is offered as an 'add on' many general insurances. For example, it can be found on motor, home and travel insurance policies. For this type of insurance, the measure of indemnity is usually a set coverage amount, e.g. legal costs up to a maximum of €25,000 or €50,000. 'After the Event' insurance is a form of legal expenses insurance specifically designed to protect the policyholder if their legal case is unsuccessful and they have to pay legal costs.

D3 Liability insurances

Liability (including motor third party) insurances cover the insured's legal liability in specific situations. The term 'legal liability' refers to the amount that the insured is legally obliged to pay to a third party, including both damages and legal costs.

In liability insurance, the measure of indemnity is the amount of any court (or PIAB) award or negotiated settlement, plus costs and expenses. Costs and expenses include legal fees, court fees, the cost of medical and other reports, fees charged by expert witnesses, and any other expenses incurred with the insurer's consent. Without insurance, the insured would have to pay these expenses from their own funds.

The **Civil Liability (Amendment) Act 2017** allows the courts to make periodic payment orders (PPOs) in cases of catastrophic injury. Prior to this, the courts only had the power to make substantial cash sum awards, but now, where a claimant has suffered catastrophic injuries, a number of payments may be made over their lifetime in a structure that best meets their needs (see Chapter 6B4a).

D3a Third-party property damage claims

When settling a third-party property claim the aim is to compensate the claimant for damage suffered to their property, i.e. to place a financial value on the loss suffered. Generally, this will be quite straightforward, as in Example 5.7.

Example 5.7

A car hits Andrew's garden wall, damaging it. He obtains an estimate for repairs and the cost of the repairs is agreed. This cost is the financial value of the loss Andrew has suffered.

The process and principles applied are similar to those for settling first-party property damage claims.

D3a1 Wear and tear

For buildings, the measure of damages (compensation) is generally the cost of repair less a deduction for betterment due to 'wear and tear'. However, the courts are unlikely to make any deduction for minor 'wear and tear' or betterment, as they take the view that the claimant usually has no option but to repair with new materials, and they should not have to contribute to the loss caused by another. This principle is illustrated in Example 5.8.

Example 5.8

Charlotte's wooden door, which is 10 years old, is damaged beyond repair when it is hit by a car. She will be able to recover the cost of a similar new front door without deduction for 'wear and tear', unless her original door was quite obviously rotten.

If a building is destroyed, the measure of damage is reinstatement less betterment (though the same caveat applies to betterment). Occasionally market value is used, if this more accurately reflects the loss.

D3a2 Economic loss

If the property has profit-earning capacity, the claimant is entitled to claim for the loss of profit while repairs are carried out, as is illustrated by Example 5.9. Evidence would be required from the record of accounts, as would acceptance that the closure was necessary and the period of time was reasonable.

Example 5.9

A lorry hits Patrick's shop, forcing him to close while repairs are carried out. His loss of profit during the period of closure would be a valid claim.

Irish courts are unlikely to allow a claim for '**pure**' **economic loss**, i.e. a financial loss that is not a direct result of damage to property.

pure economic loss

a loss that is purely financial and not accompanied by any physical damage to the plaintiff or their property

D3b Third-party personal injury claims

Calculating the amount to be paid for a personal injury claim is a complex process, with many possible variations. We will consider this in Chapter 6.

D4 Private health insurance

Measuring indemnity in private health insurance is quite straightforward. It relates to the cost of medically necessary treatment falling within the policyholder's plan. Before providing treatment, particularly on an inpatient basis, hospitals and doctors normally try to match the service and costs to the patient's health insurance plan (e.g. by ensuring that the patient is accommodated in the type of room that is specifically covered by their policy).

E Summary

In this chapter we looked at how indemnity is provided, where it is limited or extended by the policy wording and how it applies in different classes of insurance. A full understanding is necessary to ensure the policy 'promise' is properly met at the time of a claim.

E1 What's next?

In the next chapter we will look at some of the special considerations that apply to third-party personal injury claims.

E2 Online learning supports

Your Member Area includes a guide to success, an automated study planner, an exam countdown timer and study tips guide. These study supports are invaluable in reinforcing what you have learned so far. The webinars, chapter-by-chapter key points and other supports will help you to break down the chapter's content when revising.

Remember: This module is examined by mixed assessment, which includes:

- An online mid-semester MCQ assessment (20 questions)
- An end-of-semester written exam paper (9 questions)

Given that your online mid-semester assessment is a multiple-choice question test, completing the online practice paper is the ideal preparation for this. You can prepare for the end-of-semester written exam and test your knowledge by completing sample and past written exam papers.

To access these online learning supports, just log into your Member Area on **www.iii.ie** and click on the **Connect** logo.

End of chapter questions

Use these questions to test your understanding of what we've covered so far in Chapter 5. It should be noted that these end of chapter questions are revision questions to test your understanding of the material in the chapter just studied. They are not sample exam questions.

1. It is often said that indemnity is a contractual, rather than a statutory principle. Explain the meaning of this.

2. While the liability section of a motor policy must be unlimited in respect of death or bodily injury, insurers may apply a limit for damage to third-party property. State the minimum limit that they may apply.

3. Briefly explain the operation of a deductible in an insurance policy.

4. Some policies include a matching pairs and sets clause in a property damage policy. Explain how this clause may restrict the amount paid for a claim.

5. Briefly outline the purpose and scope of 'day one' reinstatement cover under a commercial policy.

6. Explain how policies written on an agreed value basis extend the principle of indemnity.

7. Outline the measure of indemnity in claims for farming stock.

8. State the measure of indemnity for liability claims.

9. Briefly outline the provision for economic loss when valuing a third-party property damage claim.

10. State how insurers measure indemnity in private health insurance claims.

Answers to end of chapter questions

Check your answers against those below and make a note of any points you left out. This will highlight some sections you may need to look at more closely during your revision.

1. Indemnity is a contractual, not statutory, principle of insurance. It can be varied if the parties to the insurance contract wish. The parties may agree that the policy will pay less (and sometimes more) than a full indemnity in the event of a loss.

2. The minimum limit is €1.22 million for damage to third-party property under the **European Union (Motor Insurance) (Limitation of Insurance in relation to Injury to Property) Regulations 2016.**

3. A deductible is a very large excess, and usually applies to commercial policies in return for a reduced premium. The terms 'excess' and 'deductible' are interchangeable in some sectors of the market. The insured voluntarily agrees to pay the first part of the amount of any claim at a figure higher than the standard excess, and as a result a premium discount is allowed.

4. Where a policy has a matching pairs and sets clause, there is no cover in respect of undamaged items in a pair or set (e.g. a single earring or a couch in a three-piece suite). The policy will only cover the item that was lost or damaged.

5. 'Day one' reinstatement cover extends the operation of the principle of indemnity. It counters the effects of inflation under commercial property policies by providing an automatic uplift in a sum insured (usually 33%), based on an accurate declaration of the sum insured on the first day of cover.

6. The measurement of indemnity operates in a different way in an agreed value basis (sometimes known as 'valued' policies). The sum is paid regardless of the value of the property at the time. This contrasts with the situation on a conventional indemnity cover, where insurers pay only to the extent of the value of the property at the time and place of the loss.

7. In the cases of both livestock and produce, the local market price is the normal basis of an indemnity. With other commodities, the insured is not entitled to any potential profit on sale under a property policy. Farming stock is slightly different. The indemnity is based on the prevailing price for that produce on the day, less any processing, handling or transport costs that were saved because of the destruction.

8. The measure of indemnity for liability claims is the amount of any court (or PIAB) award or negotiated settlement, plus costs and expenses. Costs and expenses include legal fees, court fees, the cost of medical and other reports, fees charged by expert witnesses, and any other expenses incurred with the insurer's consent.

9. If the property has profit-earning capacity, the claimant is entitled to claim for the loss of profit while repairs are carried out. Evidence would be required from the record of accounts, as would acceptance that the closure was necessary and the period of time was reasonable.

10. The measure of indemnity in private health insurance claims is the actual cost of medically necessary treatment falling within the policyholder's plan. Before providing treatment, particularly on an inpatient basis, hospitals and doctors normally try to match the service and costs to the patient's health insurance plan (e.g. by ensuring that the patient is accommodated in the type of room that is specifically covered by their policy).

Answers to quick questions

1. None. Cover for third-party personal injury must be unlimited.

2. An ordinary excess applies to each individual loss. An aggregate excess/deductible applies to the total cumulative losses in a particular period.

3. a. After application of the excess an amount of €1,500 would be paid
   b. If this had been a franchise the answer would indeed be different, and a figure of €2,000 would be paid.

Sample exam questions

Question 1

Johnny and Rachel have a household insurance policy with XYZ Insurance. The policy has the following sums insured.

Buildings: €400,000

Contents: €80,000

Money limit: €500

The policy has an inner limit of 10% on individual valuables such as jewellery, with an overall limit for such items of 25% of the contents sum insured. The policy contains an 'average' and a 'pairs and sets' clause. There is no policy excess.

a) Johnny and Rachel's house was burgled. A number of items of jewellery were stolen, totalling €10,000. Rachel's engagement ring valued at €9,000 was also stolen, along with €1,000 in cash.
Calculate, showing your workings, the payment, if any, that XYZ will make to the couple.

(4 Marks)

b) Johnny drops an object onto the bathroom sink causing it to crack. Johnny and Rachel submit a claim of €1,500 to replace the sink, costing €500, and the matching toilet bowl costing €750. This is because they cannot find a new sink to match the existing toilet bowl.
Calculate, showing your workings, the payment, if any, that XYZ will make to the couple.

(2 Marks)

c) There is a fire at Johnny and Rachel's property causing €50,000 damage to the building. Upon investigation, XYZ Insurance establishes that the reinstatement value of the property is €500,000.
Calculate, showing your workings, the payment, if any, that XYZ will make to the couple.

(4 Marks)

Total: 10 Marks

Question 2

a) Explain how agreed value policies operate and state **two** insurable items that are typically covered by these policies.

(8 Marks)

b) Calculate, showing your workings, the payment of the following fire loss using the rule established in *Elcock v Thomson* (1949).

- agreed value sum insured is €400,000
- actual value at time of loss is €40,000
- value of building after fire is €30,000
- no excess applies.

(2 Marks)

Total: 10 Marks

Your answers

Sample answers

The answers set out below show the main points you must consider in answering the question. In some cases, a well-reasoned alternative view could earn you good marks.

Question 1

a) The stolen jewellery including the ring totals €19,000 which is less than the overall limit of 25% of the household contents sum insured (€80,000 × 25% = €20,000).

The policy contains an inner limit of 10% on individual valuables (10% of €80,000 = €8,000); so the maximum that XYZ would pay for the ring valued at €9,000 is €8,000.

The policy contains a money limit of €500, so this is the maximum that can be paid for the loss of the €1,000 in cash.

Claim settlement would be calculated as:

€10,000 (jewellery) + €8,000 (ring) + €500 (cash) = €18,500

XYZ Insurance would pay Johnny and Rachel €18,500 even though the value of their loss was €20,000.

(4 Marks)

b) Even though the couple may believe that they are entitled to claim for the entire bathroom suite as they cannot replace the toilet bowl with a matching item, XYZ Insurance can invoke the 'pairs and sets clause' to ensure that they are only liable to pay for the actual broken fixture. So XYZ Insurance would pay the couple €500.

(2 Marks)

c) XYZ Insurance will impose the average clause as the reinstatement value is €100,000 higher than the sum insured on the buildings (€400,000).

Sum insured at the time of the loss/value at risk at time of loss × amount of loss – liability of insurer.

€400,000 × €50,000 = €40,000
€500,000

Johnny and Rachel will receive €40,000. (4 Marks)

Reference Chapter 5B1 & B3 **Total: 10 Marks**

Question 2

a) The measurement of indemnity operates differently in the case of insurances written on an agreed value basis (sometimes known as 'valued' policies). For an agreed value policy, a particular sum is paid regardless of the value of the property at the time. This contrasts with conventional indemnity cover, where insurers are liable to pay only for the value of the property at the time and place of the loss.

The object of an agreed value policy is to avoid disputes about the value of property at the time of loss. This cover is often used where a property is unique or has a limited market. Here the value is subjective and more likely to cause a dispute. Art, antiques and vintage cars are frequently insured on an agreed value basis.

Another use for this cover is inherited jewellery. For example, an insured could inherit their grandmother's engagement ring. If its monetary value has not been assessed, it could be difficult to value if it were lost or stolen. In this case, a valuation is obtained in advance and used as an agreed value. This also makes a fraudulent claim more difficult, as the description and nature of the item is already known.

(8 Marks)

b) Under the *Elcock v Thomson* (1949) rule, the insured is entitled to a proportion of the agreed value equivalent to the degree of depreciation in actual value caused by the loss.

Using the figures from the scenario this would calculate as follows:

- reduction in value is 25% (i.e., €40,000 to €30,000)
- insured's entitlement is 25% of €400,000 = €100,000

(2 Marks)

Reference Chapter 5C4 & C4a **Total: 10 Marks**

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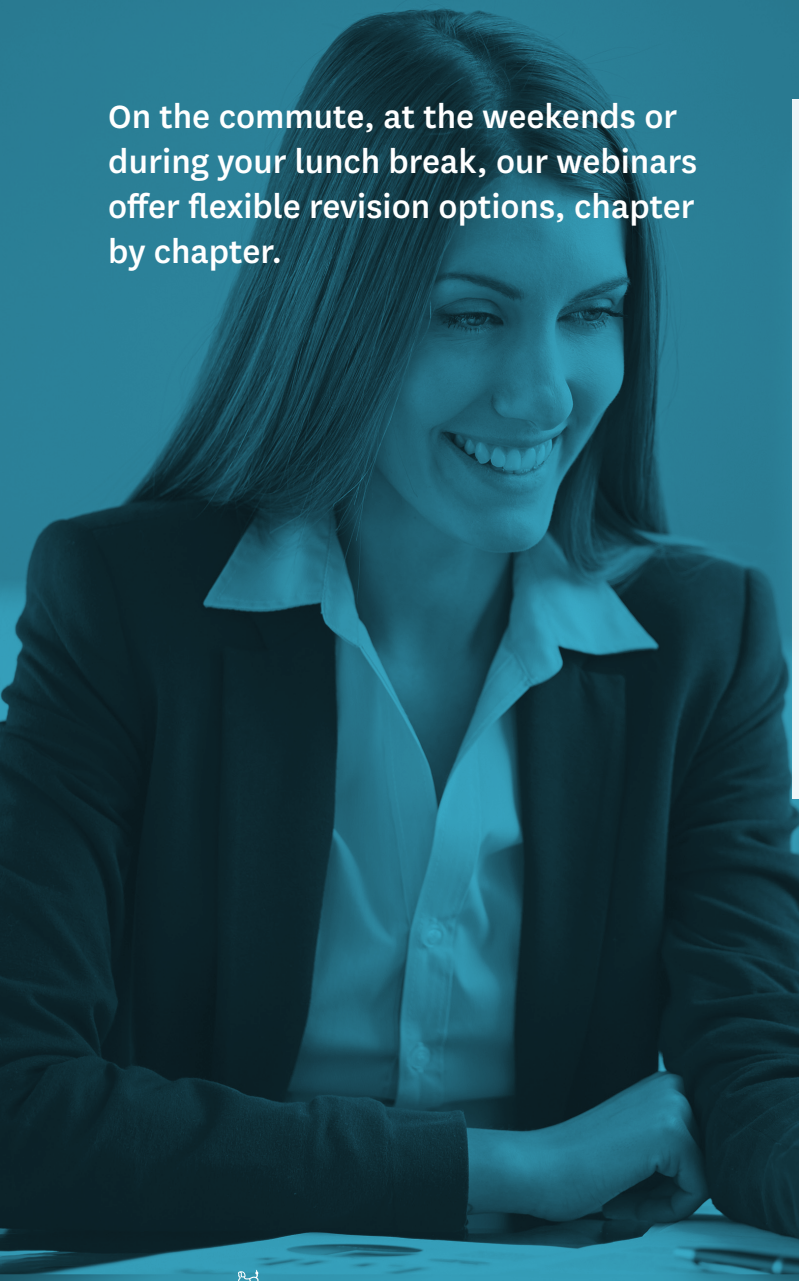

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Chapter

6

Third-party claims – legal considerations

What to expect in this chapter

Third-party claims are more complicated, largely because of the involvement of an extra party who was not part of the original contract and the need to establish whether the insured was responsible for the accident. Third-party claims also involve legal processes, with often complex rules and procedures. This is particularly so when a claim involves personal injury. In this chapter, we consider important elements of the legal process that affect how claims arise and how they are quantified and litigated.

Contents

A The legal basis for third-party claims

In Chapter 1B2, we identified that third-party claims are made against an insured by someone who is not a party to the insurance contract. Claims arise because the insured allegedly caused injury, property damage or financial loss to that person, because of a negligent act or another legal wrong. The third party must prove that the insured was in breach of a particular legal duty to succeed in a claim. The **law of torts** specifies the legal duties that we owe towards one another. As we identified in Chapter 1, negligence is the most commonly encountered tort in insurance claims.

law of torts

a body of rights, obligations and remedies that is applied by courts in civil proceedings to provide relief for persons who have suffered loss or harm from the wrongful acts of others

Third-party claims can be settled by negotiation (between the insurer and the third party or their representatives), through the PIAB process (see Section C) or by a legal action, where the judge decides the outcome. In Section E4 we will see that there are very specific civil and court procedures to be followed.

When pursuing a claim or a legal action against the insured, the third party is seeking financial compensation (damages) for an injury, loss or damage they suffered. There are also some other possible remedies in tort, with very limited relevance to insurance claims.

A1 Remedies in tort

The principal remedy in the law of torts is an award of damages i.e. monetary compensation to the plaintiff. As punishment is a function of **criminal law** rather than **civil law**, the objective of an award of damages under the law of tort is not to punish the wrongdoers but to compensate the plaintiff. An award of damages is the most usual outcome but certain equitable remedies are also available where considered more appropriate.

criminal law

term encompassing all the laws that apply to the control of behaviour for the benefit of society, the breach of which is usually punishable by fines or imprisonment

civil law

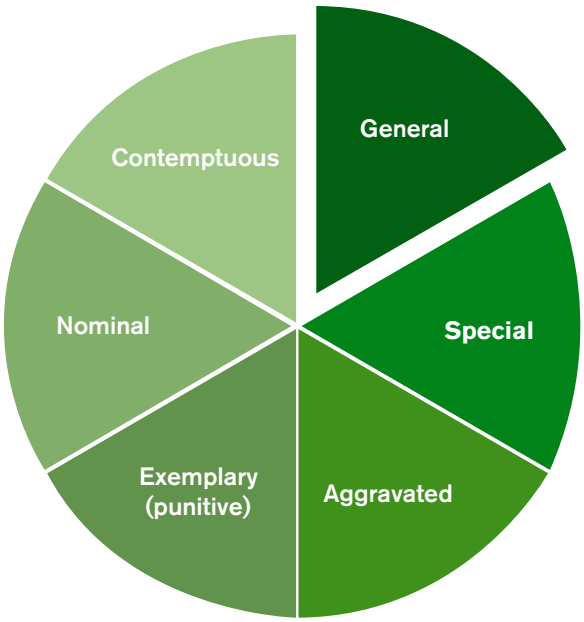
term encompassing all the laws that deal with how individuals relate legally with each other, e.g. the law of contract, the law of torts, trust and property law, family law and the law of succession

A1a Damages

The object of an award of damages is to compensate the plaintiff by paying for the loss the defendant has caused by their wrongful act. When assessing damages, the court attempts to calculate and award a sum of money that will, as far as possible, compensate the plaintiff for the harm caused.

There are specific types (sometimes called 'heads') of damages as illustrated in Figure 6.1.

Figure 6.1 Types of damages



The specific of damages include:

- **General damages –** the element of the award for the injured person's pain and suffering and loss of amenities. They are a type of unliquidated damages, since they cannot be accurately determined or proved until after an event. Figure 6.2 and Section B1 looks at how general damages are calculated.
- **Special damages –** liquidated damages (quantifiable in monetary terms) of which the plaintiff is required to give notice when they claim against the defendant, and which they must prove strictly at trial. These damages represent the 'out of pocket expenses', or the monies the claimant has lost because of the incident. Examples (arising from injuries received in a car accident) might include loss of earnings, damage to clothing and medical expenses. We will see more about special damages in Figure 6.2 and Section B2.
- **Aggravated damages** – may be awarded in certain torts (e.g. assault or trespass), to reflect that the motives and conduct of the defendant have aggravated the injury suffered by harming the plaintiff's sense of dignity or pride.

general damages

court award for pain, injury, suffering and/or inconvenience

special damages

'out of pocket' expenses or quantifiable monies the plaintiff has lost as a result of the incident

Case law

In the Supreme Court case of *Philip v Ryan and Bons Secours Hospital* (2004), McCracken J awarded €50,000 aggravated damages on top of the High Court general damages award of €45,000. The case involved a medical negligence action where the doctor had altered the medical records in his favour when a personal injury action was initiated against him by the plaintiff.

- **Exemplary (punitive) damages** – are awards that exceed the loss suffered and are intended to punish the defendant for their conduct. They are occasionally awarded in tort actions, most usually in defamation cases.

Case law

In *Shortt v An Garda Síochána* (2005), a case of the false imprisonment of Mr Shortt in Donegal, the High Court awarded exemplary damages of €50,000 on top of general damages of €505,000 due to the 'outrageous abuse of power' by some Gardaí. In 2007 Mr Shortt took an appeal to the Supreme Court, where his exemplary damages were increased from €50,000 to a €1 million combined punitive damages award, the largest ever punitive award in the history of the State.

- **Nominal** – **Nominal damages** occur where, while the plaintiff has succeeded in the case, the loss suffered was technical rather than actual.
- **Contemptuous** – **Contemptuous damages** may be awarded for any tort, whether actionable *per se* or not.

nominal damages

token sum awarded in a case where there has been no real loss caused to the claimant

contemptuous damages

damages awarded when a court wishes to show its low opinion of the claim or of the plaintiff

A1b Injunctions

In some cases, an award of damages will be inappropriate or inadequate. Often the plaintiff's main aim will be to prevent the committing of a tort or to stop the defendant from continuing to commit one. For example, the plaintiff may wish to prevent the defendant from publishing a libellous book, stop them trespassing on private land, or cease an activity that is creating a nuisance. In all these cases an injunction is appropriate.

A court can order either a **mandatory injunction** or a **prohibitory injunction**. As already emphasised, insurance contracts relate to the monetary value of losses and liabilities. They cannot, therefore, respond to an award of a different kind, such as an injunction. If the claim is of a kind that could give rise to an award of damages, insurers may meet the legal costs of defending such a claim.

mandatory injunction

court direction demanding a person do a particular thing

prohibitory injunction

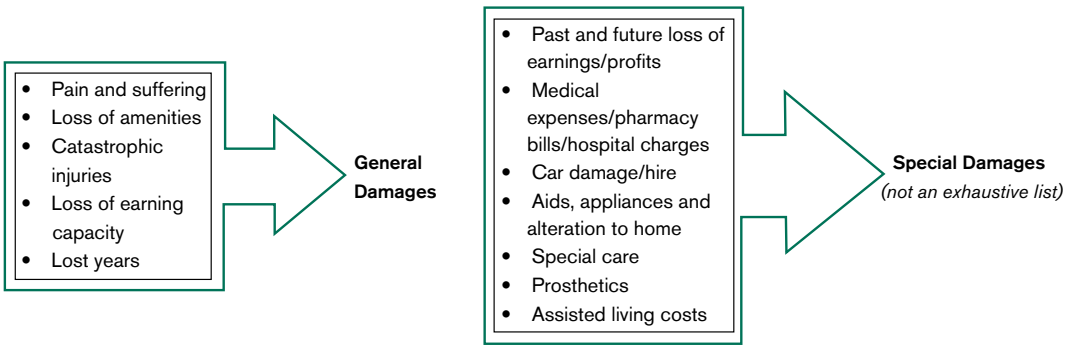
a court order to refrain from doing a particular act

B Quantifying a personal injury claim

In Chapter 5D3a, we examined how third-party property damage claims are quantified. We will now consider how the value (quantum) of a personal injury claim is assessed.

Personal injury claims are the largest single source of litigation in Ireland. Awards for personal injury claims normally have two components – general and special damages (see Figure 6.2 and Section A1a). We will now consider the main components of both types of damages and the principles used by judges, PIAB and claims handlers to calculate the amount of compensation due to a third party.

Figure 6.2 Personal injury claim components – general and special damages



B1 General damages components

Due to the nature of general damages, it is impossible to quantify it on a purely economic basis. It may comprise of one or more of the following components.

B1a Pain and suffering/loss of amenities

Pain and suffering reflects the nature and severity of pain suffered and the length of time endured both in the past and the future. Loss of amenities reflects the loss or restriction of a person's activities or leisure interests, i.e. the physical and mental limitations associated with the injury. The loss of a limb will be painful but the long-term limitations in function will be far more important, as it influences the ability to work or enjoy life.

Awards also take into account a plaintiff's special abilities. For example, the loss of amenities to a top sportsperson who suffers a debilitating injury will be worse than that of an office worker, even though the injury suffered is the same. In practice, courts break down general damages into past and future damages based on pain and suffering. As such, the general damages for the loss of an arm for a manual worker and top sportsperson would be approximately the same. However, the difference in the overall award would arise in relation to the future special damages. For example, the future loss of earnings for a top sportsperson would be significantly higher compared with those of a manual worker. While it is impossible to quantify these aspects, the damages awarded try to compensate, in monetary terms, the effect of the injury on the person.

The courts of course refer to previous case law for guidance in the valuation of damages involving similar injuries, but judges **are** obliged to reference the **Personal Injury Guidelines of the Judicial Council** and to provide a detailed rationale in their judgment should they decide to depart from same.[20] Whilst judges are under such an obligation, the recent case of *Delaney V PIAB* (2022), lawyers for the State told the Supreme Court 'Judges can depart from the guidelines, slashing damages for many minor personal injuries if they feel the award does not do an injury justice'.[21]

Medical reports are sought from general practitioners or specialist doctors to validate the alleged injuries suffered and offer an opinion on the duration of the injury.

B1b Catastrophic injuries

The Irish Supreme Court issued guidelines in several important cases on how **catastrophic injuries** affect activities of daily living and independence and give rise to a need for care, adapted housing, specialist aids and equipment. These guidelines also advise on the level of general damages that should be awarded when dealing with such life-changing injuries.

While each case is considered individually, the courts have placed a 'cap' on the maximum level of general damages awarded. This has evolved over time.

Case law

The most recent judicial limit or 'cap' on general damages was set by the Supreme Court in *Morrissey v Health Service Executive* (2020). This cap applies only to the general damages component. The special damages element (see Section B2) is calculated separately. The judicial cap on general damages was overtaken in April 2021 when the Personal Injuries Guidelines increased the cap on general damages to €550,000.

B1c Loss of earning capacity

These damages are awarded where the plaintiff's earning capacity is compromised because of being unable to work due to injury caused by the defendant's negligence. They may also be able to work in less demanding or physical jobs, but with lower pay.

Such damages can also arise where the plaintiff is still in work with no loss of earnings, but where their capacity to find work, or find it at the current level of earnings, will be prejudiced. In these cases, a lump sum is usually awarded to represent their 'loss of opportunity'. Damages are also assessed in this way where the plaintiff is young and has no employment history.

B1d Lost years

The issue of '**lost years**' arises when the plaintiff is alive at the date of hearing but will die thereafter prematurely. The precedent for this head of damages was established in Irish law in the Supreme Court case of *Doherty v Bowaters Irish Wallboard Mills Ltd* (1968).

The plaintiff, a factory worker, was seriously injured because of defective lifting equipment. The case dealt with the question of whether a plaintiff, whose life expectancy had been shortened, is entitled to lost earnings potential for those lost years. The Supreme Court held that the plaintiff was so entitled.

Personal Injury Guidelines of the Judicial Council

guideline principles governing the assessment and award of damages for personal injuries with a view to achieving greater consistency in awards

Quick question 1

Would a professional piano player who loses a hand in an accident receive more damages than an office worker?

The answer is at the end of this chapter.

catastrophic injuries

very serious, life-changing injuries, e.g. paraplegia, quadriplegia and brain damage

lost years

the time lost to a person's life if they are alive at the date of hearing but are thought likely to die prematurely as a result of the accident or illness suffered in the incident giving rise to the claim

[20] The Judicial Council, *Personal Injuries Guidelines*, www.judicialcouncil.ie.

[21] O'Riordan Ellen, 'Judge can depart from personal injury guideline valuations'. *The Irish Times*, March 2023.

B2 Special damages

Special damages may include the cost or potential cost of such items as the following:

- Past and future loss of earnings/profits
- Medical expenses/doctors' fees/pharmacy bills/hospital charges
- Car damage/hire
- Alterations to home/alternative accommodation
- Aids and appliances (wheelchairs/ adaptive cars)
- Special care (e.g. nursing care)
- Prosthetics
- Assisted living costs.

This list is not exhaustive, and there are many items that may be found in a special damages claim if vouched (proven).

B2a Long-term costs

Due to injuries sustained, a plaintiff may require future specialised equipment or medical care. Depending on the individual, long-term care may include such future expenditure such as medical expenses, nursing care, physical therapies, specialised aids, appliances or equipment, adapted transportation/ accommodation and applied technologies. These heads of damage are usually in respect of catastrophic injuries (see Section B1b).

B2b Future earning losses

Future earning loss is assessed under a separate heading to past earning loss. This is awarded where an injury causes a disability impairing a person's capacity to work and compromises earnings. Short-term future loss of earnings is relatively simple to calculate, but additional factors are considered when estimating a future loss. This may extend over a longer period, i.e. several years, or a lifetime. It is also necessary to consider aspects like job security, inflation and the rate of interest that may be earned on any payment made. Weekly loss of income is estimated and an actuary prepares a report to calculate the long-term future loss. This report includes relevant factors such as the plaintiff's gender, age, life expectancy, past earnings, future earning capacity/ prospects and the effect of inflation.

B2c Recoverable Benefits and Assistance Scheme

Introduced by the **Social Welfare and Pensions Act 2013**, the Recoverable Benefits and Assistance (RBA) scheme allows the Department of Social Protection (DSP) to recover from the compensator (e.g. an insurer) certain illness-related social welfare benefits paid to claimants. Although the insurer (as a compensator) is now liable to repay the DSP the amount it (the DSP) paid out in social welfare benefits, the insurer is still permitted to deduct this amount from the loss of earnings aspect of the plaintiff's claim. When this scheme was introduced, it applied retrospectively to existing claims. Insurers therefore had to increase many claims case reserves to allow for these additional costs. The claimant is not adversely affected by this change. It does not reduce the general damages they receive.

The illness-related social welfare payments that can be recovered under this scheme are:

- Disability allowance
- Illness benefit
- Incapacity supplement
- Injury benefit
- Invalidity pension
- Partial capacity benefit
- Supplementary welfare allowance.[22]

B3 Liability for death – general principles

Prior to the passing of the **Civil Liability Act 1961**, no action at common law could be laid against a deceased person's estate for injury caused by the deceased's negligence. Neither could the deceased's estate recover for injury caused to the deceased while alive. The death of either party effectively ended any action, i.e. *actio personolis moritur cum persona* ('a personal action dies with the person'). The main injustice dealt with by this Act was, for example, where a widow was left without financial support, as no action could be taken against the individual whose negligence led to the husband's death.

B3a The estate

The administrators or executors of a deceased's estate were also unable to bring or continue an action on behalf of the estate after death, even where the deceased's death was caused by a proposed defendant's negligence. Conversely, any action against the estate of a deceased would fail for the same reason. Since the passing of the Act, the rule of *actio moritur cum persona* no longer applies in respect of causes of action by or against a person who has died.

B3b Actions by the estate – survival actions

The **Civil Liability Act 1961** sets out the rules relating to actions taken by the deceased's personal representatives on behalf of the estate. The Act provides that on the death of a person all causes of action vested in them shall survive for the benefit of the estate.

Fatal accidents are by their nature complex, and detailed consideration of the statutory damages payable for mental distress and the rights and sources of action are beyond the scope of this module. The deceased person's claim for general damages dies with them but damages for mental distress called 'solatium' may be awarded to the dependants. The maximum damages payable for solatium is currently €35,000. This amount is apportioned by the judge among all the dependants. Additional expenses such as funeral expenses (e.g. undertakers' fees, headstone) are permitted in addition to the €35,000.

[22] Further details on the Recovery of Benefits and Assistance Scheme are available on www.gov.ie

The dependants are also entitled to pursue a claim for financial losses and dependency. This is generally a sum representing that proportion of the deceased's future earnings that would have been used by the deceased to support their dependants had the person not died. Actuarial evidence is needed to assist in the calculation of future loss. The calculation of a dependency loss is similar to the method of calculation of 'a future loss of earnings' (see Section B1c). In both cases, the court takes into account that the earnings of the plaintiff or the deceased would have been liable to income tax had they worked for the relevant period.

The dependants cannot be penalised where the deceased provided for their family by having life insurance. Section 50 of the **Civil Liability Act 1961** provides that the award cannot be reduced and they are still entitled to recover their financial loss from the loss of the provider's income.

Since the dependants have the same legal rights as the deceased person, the defendant may plead contributory negligence on the part of the deceased. This may arise in a fatal accident at work that was partly caused by the deceased person's carelessness. If a plea of contributory negligence is successful, the award to the plaintiff(s) is reduced accordingly.

B4 Alternative solutions to lump sum damages

The conventional method of settling personal injury claims by payment of a lump sum is a satisfactory method for small or medium-sized claims. It has been acknowledged that this basis may not be adequate when considering the most serious catastrophic injury cases.

B4a Periodic Payment Orders (PPOs)

Cases involving catastrophic injury require significant levels of medical treatment for the duration of life. According to the **Civil Liability (Amendment) Act 2017**, these are cases where the personal injury 'is of such severity that it results in a permanent disability to the person' which requires them to receive 'life-long care and assistance in all activities of daily living or a substantial part thereof'.[23]

periodic payments

payments made by agreement with the claimant from time to time having assessed the likely financial needs and in an effort to meet those needs in an appropriate way

It is impossible at a trial to accurately calculate the costs of future treatment with certainty. Even the most expert medical professionals have difficulty estimating life expectancy in a serious injury case. Accordingly, an injured party may not receive sufficient payment by a lump sum, or may be over-compensated in the event of early death.

The **Civil Liability (Amendment) Act 2017** empowers the courts, as an alternative to lump sum awards, to make **periodic payments** to compensate victims in cases of catastrophic injury where long-term care is required. This ensures regular payments to the injured party for the agreed medical and care aspects of the claim. The previous system of a lump sum payment meant that a claimant was either over compensated or under compensated.

[23] **Civil Liability (Amendment) Act 2017**, www.irishstatutebook.ie

This regular payment will provide the security required to the victims by meeting care costs arising out of the injury. Expected future improvements or deteriorations in the plaintiff's medical condition are accounted for in the calculation of the payment as once awarded the payment cannot be revisited or recalculated. The decision whether to make a periodic payment order award will be at the court's discretion, having considered the preferences of both the plaintiff and defendant. In deciding whether to make such a settlement the 'best interest' test of the injured party will apply.

PPO awards may have a significant impact on insurers and their claims process. The financial impact of this adds substantially to the overall cost of such claims. As well as the additional challenge of adequate and accurate reserving, because of the basis for settlement it may mean claim files remain open for longer periods.

B4b Rehabilitation

It has long been recognised that early intervention with rehabilitation can improve a claimant's long-term prognosis. Rehabilitation includes options like:

- **Medical** – dealing with the injury or disease.
- **Vocational** – finding alternative employment, if return to the pre-accident job is not possible, and providing appropriate training.
- **Qualitative** – making the most of the claimant's impaired capabilities to enable them to lead as full a life as possible.

assessment

process by which a file is considered by PIAB, and a term for the damages award figure arrived at

respondent

a term used by PIAB referring to the defendant

C The role of the Personal Injuries Assessment Board

We will now consider the role of the Personal Injuries Assessment Board (PIAB) in assessing the amount of damages to be paid to an injured party. All personal injury actions, except those involving medical negligence, must be presented to PIAB before court proceedings can be issued. The function of PIAB is to make **assessments** for compensation for personal injury caused by the negligence or breach of duty of another, where liability is not in dispute and the **respondent** consents directly, or by default, to such an assessment.

Respondents, such as insurers, may enter into an agreement to settle with the claimant or their solicitors at any time. When notified that a settlement has been reached, PIAB will take no further steps.

C1 The assessment process

All claimants must submit their claim to PIAB. PIAB then notifies the respondent of the claim, allowing 90 days to confirm if they wish PIAB to assess it. If a respondent does not reply to PIAB within the 90 days, it is deemed that they have consented to the assessment.

Under the **Personal Injuries Assessment Board (Amendment) Act 2019**, a submission is not considered to be complete and a formal claim will not be notified by PIAB to a respondent until the application, a medical report and the appropriate fee have been received by PIAB. Where an incomplete submission is made, PIAB will provide only a preliminary notice to the respondent, and the time that is afforded to the respondent to decide whether to consent to an assessment does not commence until the application has been fully completed.

The PIAB assessment procedure takes between 9 and 15 months from commencement to conclusion. The procedure is straightforward:

1. **Processing a claim** – The claimant fills out a PIAB application form, advising the details of the claim and submits this together with a medical report and an administration fee. Further details may be required, like support for special damages and a copy of the letter of demand to the respondent. The system is questionnaire-based rather than the current adversarial court system, so there is no oral evidence, and solicitors are not involved in examining or cross-examining witnesses. PIAB will avail itself of the right to obtain any information it may require. PIAB will generally obtain an independent medical report on the claimant. In making an assessment on quantum, PIAB will use written reports, including those from medical practitioners and specialists.

The **Personal Injuries Assessment Board (Amendment) Act 2019** states that if a claimant fails to co-operate with PIAB (e.g. failing to submit additional documentation or to assist experts retained by PIAB), this may have implications in terms of costs if an authorisation is issued and the matter proceeds to hearing. The judge in that hearing may take account of these failures when considering how to award costs.

2. **Consent to assessment by a respondent** – Consenting to an assessment is not necessarily a concession on legal liability on the part of the respondent. The PIAB process does not consider whether a respondent is deemed liable for an incident. A respondent may decide to make a tactical decision to consent to the PIAB process based on many factors including the risk of legal liability and the likely additional cost of a protracted claim. If the respondent clearly decides to contest liability, they may not consent to PIAB assessing the claim. The claimant is then issued with an Authorisation (release certificate) and the claimant must decide whether to pursue their claim through litigation. If the respondent consents to assessment, PIAB makes its award with reference to the Personal Injuries Guidelines (see Section C3). If either side declines the final award amount, an Authorisation is issued and the case is permitted to enter into the civil court process. This allows the claimant to issue legal proceedings so that damages can be decided by a judge.
3. **Finalising the assessment** – If claimants do not accept or reject the assessment within 28 days, it is assumed that it is rejected, and a release certificate is issued. If the respondent does not accept or reject the award within 21 days, they are deemed to have accepted the assessment. If the award is accepted by both parties any right of action is waived, and PIAB will issue an 'order to pay', which is equivalent to a court order.

The 2-year limitation period in bringing actions for personal injuries (see Section E3) does not run while the case is with PIAB. On release from PIAB (i.e. when it issues its release certificate), the time period does not start to run again until a period of 6 months has elapsed from the date of the release certificate. This provides an extra period or window for the remainder of the limitation period in which to begin proceedings.

Under the **Personal Injuries Assessment Board (Amendment) Act 2019**, where a further respondent(s) is added to an application which is already with PIAB, the statutory limitation period against the additional respondent(s) is amended to allow them an additional 6 months after the date of their addition as opposed to the date of the original application. This corrects the position which was identified in the case *Renehan v T & S Taverns* (2015).

C2 Legal costs

The **Personal Injuries Assessment Board (Amendment) Act 2007** was passed with the intention of tightening procedures for personal injury claims, particularly regarding legal costs. Where a claimant rejects a PIAB assessment and in subsequent court proceedings fails to get an award of damages in excess of the amount of damages assessed by PIAB, then the claimant may not be entitled to their legal costs. The Act also makes it clear that no costs shall be allowed for the making of an application to PIAB.

Section 51A of the Act also states that the court may, at its discretion, order the claimant to pay all or a portion of the defendant's legal costs.

Quick question 2

Paddy has a claim assessed by PIAB. He rejects this assessment. The case goes to court and he gets less. Can he recover his legal costs for going to court?

C3 Personal injuries claims costs

The **Personal Injuries Assessment Board (Amendment) Act 2019** was introduced to bring about greater compliance with the PIAB process and to ensure that more claims progress within the framework and conclude with an award being made. The Act introduced measures to deter non-compliance with the PIAB process. The courts were given discretion to order the claimant to pay all or a portion of the respondent's costs where it finds that a claimant was uncooperative with the PIAB process.

The **Judicial Council Act 2019** established the Judicial Council. The Council's purpose is to:

- promote and maintain judicial excellence
- facilitate education and training for judges
- provide a mechanism for investigating complaints against judges
- establish guidelines in relation to sentencing and the awarding of damages in personal injuries claims.

In April 2021, the Judicial Council's Personal Injuries Guidelines (the Guidelines) came into effect.

In accordance with the **Personal Injuries Assessment Board (Amendment) Act 2019**, the Guidelines have applied to the assessment of damages in all personal injuries actions since 24 April 2021. The fundamental difference between the Book of Quantum and the Guidelines is that the application of the Guidelines is mandatory. Case study 6.1 recounts a challenge that was posed to the implementation of the Guidelines versus the Book of Quantum.

6.1 Case study

High Court rejects challenge to PI guidelines[24]

In the case of *Delaney v The Personal Injuries Board & Oars* (2022), a claimant was awarded €3,000 in damages for an ankle injury sustained in 2019. However, this amount was challenged as the claimant had been advised that (based on the Book of Quantum), the range of assessment for such an injury would have been between €18,000 and €34,000. The reduction in the value of her claim was due to the fact that the Personal Injuries Guidelines, rather than the Book of Quantum, applied.

The claimant challenged the legal basis for the drawing up and passing of the Guidelines, and also maintained that PIAB erred in law in assessing the value of her injuries under the Guidelines instead of the Book of Quantum.

The challenge was brought to the High Court in 2022 and the High Court judgment rejected the legal challenge to the Personal Injuries Guidelines and affirmed that the PIAB had acted in accordance with the relevant provisions of the legislation. Under the Guidelines, the parties identify relevant damages bracket (by reference to the dominant injury) in the Guidelines and, having regard to the presence or absence of lesser injuries, make a submission as to where within the bracket the injuries are located. It is mandatory for the trial judge to make their assessment having regard to the Guidelines and if they depart from the Guidelines, they are obliged to state the reason(s) in any judgment.

[24] https://www.lawsociety.ie/gazette/top-stories/2022/june/high-court-rejects-challenge-to-pi-guidelines

Case study 6.2 reports on the impact of these Guidelines.

6.2 Case study

Impact of Personal Injures Guidelines on award levels

The Guidelines have reduced the awards for minor and moderate orthopaedic injuries. For example, a minor neck injury, which has substantially resolved within 6 months, is valued between €500 to €3,000. This compares with a value of up to €15,700 in the Book of Quantum. Similarly, a back injury where a substantial recovery has been achieved within a period of two to five years is valued between €12,000 and €20,000. Again, this represents a significant reduction on the Book of Quantum where the same type of injury is valued between €21,400 and €34,400.

The Guidelines will directly impact on the level of damages awarded and should see awards and settlements becoming more proportionate to the injury suffered. The implementation of the Guidelines should also lead to a greater number of claims being assessed by PIAB.[25]

The **Personal Injuries Resolution Board Act 2022** was signed into law in December 2022. This Act aims to have more cases resolved through PIAB with its quicker processing times and lower legal expenses than litigation, thereby ultimately reducing the costs of claims for consumers and businesses.

From 13 February 2023, under this Act:

- where a claim proceeds to litigation, a PIAB assessment that has been accepted by a respondent (insurer) will have the status of an offer of tender payment. This means that where the court award is not greater than the value of the PIAB assessment, the claimant will not recover their costs and will generally also be liable for the respondent's costs.
- PIAB will have additional time to assess claims relating to long-term injuries where a prognosis may not be available within the statutory timeframe, with an increase to two years for such cases, or longer where the parties consent.
- new anti-fraud measures require claimants to provide a PPS number to verify their identity, and make it an offence to provide false or misleading information to the Board. The Board may also report suspected offences (e.g. fraud) to the An Garda Síochána.

At the time of writing some of the Act's provisions are awaiting commencement but once fully commenced, the Act will also:

- Rename PIAB. It will become the Personal Injuries Resolution Board.
- Expand the remit of PIAB. In terms of extended scope, PIAB will have the power to consider purely psychological claims.
- Introduce options for mediation. The process will be voluntary and is modelled on the **Mediation Act 2017**. The mediation process will operate separately to, but concurrently with, the current assessment process. Parties to the mediation process will be entitled to be represented by their legal advisor or to obtain independent legal advice. A mediation report will be prepared, although the parties may withdraw from the agreement within 10 days. Where mediation does not resolve the claim, the Board will assess the claim, unless the respondent has indicated that they do not intend to accept the assessment.

[25] Further details are available at Kennedyslaw (The Personal Injuries Guidelines 2021: Ireland -) www.kennedyslaw.com)

D Defences in tort

A claims handler or investigator dealing with a claim where liability is in issue (capable of being contested) will know the possible defences available in the circumstances. Hopefully at this stage significant liability investigations will have been completed to allow the handler to assess the liability position and consider the possible defences that can be raised.

You may recall from The Nature of Insurance module that there are a number of general defences in tort. These defences are:

D1 Self-defence

The law allows people to use reasonable force to defend themselves, their property and other persons, such as members of their family or employees. Self-defence is a good (legal) defence to intentional torts against the person, such as battery or false imprisonment.

necessity

defence in tort meaning that the act which is alleged to be a tort was carried out in order to avoid a greater evil

statutory authority

a defence suggesting that the defendant was given a legal right to commit the wrong complained of

D2 Necessity

Necessity is another possible defence to intentional torts. For example, in *Cope v Sharpe* (1912), the defendant entered the plaintiff's land and cut down heather and other vegetation to prevent a fire spreading to his own land. The need to protect his own property was a legitimate defence to trespass.

D3 Statutory authority

Statutory authority is a common defence because, in the interest of society as a whole, governments often allow firms and individuals to engage in activities that have some harmful effect on others. For example, statute law may permit civil aircraft to fly over private land (which would otherwise be a trespass).

Case law

In *Allen v Gulf Oil Refining Ltd* (1981), statutory authority to construct and operate an oil refinery was held to be a defence when the plaintiffs alleged that the noise, smells and vibrations produced by the refinery amounted to a nuisance. Statutory authority will not be a defence in negligence, as it is unlikely that the Oireachtas would wish to authorise negligent behaviour.

D4 Act of God

An **Act of God** has been described as 'circumstances which no human foresight can provide against, and of which human prudence is not bound to recognise the possibility'.

To use this defence, the event causing the damage must be so extreme that a reasonable man could not have expected that it would be a factor when considering his duty to others. It might, for example, be used in a case where a healthy and well-maintained tree fell because of very extreme weather and caused damage to a neighbouring property.

Act of God

term used to describe an accident or event resulting from natural causes, without human intervention

D5 Consent and *volenti non fit injuria*

These are two separate defences but are dealt with together because of their similarity.

The defence of **consent** applies where the plaintiff agrees to a deliberate act by the defendant that would be a tort if no consent had been given. For example, the participants in a boxing match consent to being punched by each other and customers in a hairdresser's salon agree to have their hair cut or treated. If no consent was given each of these actions would amount to a battery.

consent

defence (in torts law) that applies when the plaintiff agrees to a deliberate act by the defendant that would be a tort if no consent had been given

Microlearning resources

In the Member Area of www.iii.ie, via the Connect logo and in Your Learning Centre, select the microlearning section of this chapter to access a resource specifically developed to help you better understand this topic.

Consent is primarily a defence to deliberate torts, and particularly to trespass to the person. It may also be a defence to other torts, such as libel or nuisance.

The expression, ***volenti non fit injuria***, literally means 'no legal wrong is done to a person who consents'. In this case the defence is based on the view that the plaintiff consented not to a deliberate act but to the risk of negligence by the defendant. For this reason, the defence is sometimes known as 'a voluntary assumption of risk'. *Volenti* is somewhat out of favour with the ideal of 'consent' as previously described (i.e. an agreement to a deliberate act) being preferred. It is primarily a defence to negligence. It may also operate as a defence to certain other torts. In particular, it is specifically stated to be a defence to a breach of the 'common duty of care' owed by an occupier under the **Occupiers Liability Act 1995**.

volenti non fit injuria

a defence in tort, stating that if someone knowingly places themselves in a position where harm might result, they are not able to bring a claim against the other party

It is expected that the **Courts and Civil Law (Miscellaneous Provisions) Bill 2022** will significantly amend the **Occupiers Liability Act 1995**, rebalance the duty of care and increase the cases in which an occupier can successfully plead the defence of *volenti*.

This defence is rarely accepted in relation to an employment injury.

Case law

In *Smith v Baker* (1891), the plaintiff, who worked for a firm of railway contractors, was injured when a stone fell on him. He was aware of the danger because a crane continually swung crates of stones over his head while he worked in a railway cutting. The House of Lords held that *volenti* was no defence because the plaintiff did not freely consent to run the risk. He was obliged to come to work to earn a living and had to obey the orders of his superiors.

Case law

In *Ryan v Ireland* (1989), the Supreme Court rejected *volenti* where a soldier was injured in Lebanon during UN service. There was no question of an express contract waiving his right to sue if injured by the negligence of his superior officers. While he had accepted the risks inherent in the possibility of being involved in armed conflict, this did not imply that he had accepted the risk of being unnecessarily exposed to injury by negligence.

D6 Other issues that may lead to a reduction in the cost of a third-party claim

As well as the defences outlined in Sections D1-D5, other arguments may also provide grounds for a successful denial of liability on an insured's behalf or a reduced third-party claim.

These arguments include:

- That the claimant is to some extent responsible for their own misfortune (contributory negligence).
- Other parties were to some extent responsible (apportionment of liability).

We will now consider their operation.

D6a Contributory negligence

If a plaintiff is found to be responsible in some way for the accident that has befallen them, the judge is empowered by the **Civil Liability Act 1961** to reduce the plaintiff's damages by an amount that reflects the plaintiff's own contributory negligence.

If contributory negligence is alleged by the defendant against the plaintiff (claimant), it can arise in various ways, as Example 6.1 illustrates.

Example 6.1

In a motor claim the defendant may admit that they pulled out of a side road. They may suggest, however, that the plaintiff (claimant) was speeding along the main road and was therefore partly responsible for the accident. If this is found to be true it would mean that the person on the main road (plaintiff/claimant) was guilty of some contributory negligence.

In motor cases the most common reduction for contributory negligence arises from the failure of the claimant to wear a seat belt. The defendant must prove that the plaintiff was not wearing a seat belt and that the injury was caused or contributed to by the non-use. The courts will apply a reduction depending on the individual circumstances (a deduction of between 15% and 25% is common).

Employers liability cases have the potential to identify contributory negligence. The **Safety Health and Welfare at Work Act 2005** imposes obligations on both employers and employees regarding workplace safety. Employers have a duty to provide training to their employees, e.g. the provision of manual handling training, and to document same. The employee has an obligation to recognise the training provided for their own safety. If such training has been provided and the employee fails to observe the recommended procedures and practices, there could be scope for a finding of contributory negligence.

Every case is decided based on the facts particular to an accident, so a court will listen to evidence from both parties and decide if there is merit in the allegation of contributory negligence. Where the plaintiff (claimant) is found to be completely responsible for an accident, they are said to be 'the author of their own misfortune', and the claim will fail.

D6b Apportionment of liability

Contributory negligence focuses on whether the defendant can attribute some responsibility to the plaintiff, but in some cases the defendant may be able to reduce his liability by means of **apportionment of liability**.

In a case where more than one defendant is being sued and all defendants are found to be at fault, a judge is empowered by the **Civil Liability Act 1961** to award the plaintiff a sum of money for damages, and to apportion fault between the defendants on a percentage basis. In such cases, the defendants are known as **concurrent wrongdoers**, and they can be **jointly and severally liable** to the plaintiff. Under the Act, where both defendants are held jointly and severally liable, they are each liable for the whole amount if the other cannot or does not pay their share to the plaintiff. Therefore, the successful plaintiff can choose to collect their full damages from either of the parties.

In practice, this can cause significant difficulties for insurers where their insured is minimally responsibly for the loss (e.g. 5%) as the plaintiff can choose to recover in full from them. This is particularly relevant to construction claims where there are often several defendants, many of which are no longer trading at the time the claim is resolved, leaving one or more insurers to pay the claim in full.

Just think

Refer back to the claims scenario at the start of this textbook. The outcome of that legal action is a good example of an apportionment of liability. Both Jiffy Couriers and the Pothole Contractor Co. were equally responsible for the accident and were 'concurrent wrongdoers'.

Quick question 3

John has sustained injuries following an accident at work. He pursues a claim through the courts. The judge finds that while his employers were negligent, John's own actions amounted to a contributory negligence of 20%. If the judge were to award a settlement of €180,000, calculate how much, if any, of this award John will receive.

apportionment of liability

the sharing of responsibility between parties to an incident

concurrent wrongdoers

defendants jointly liable to a claimant

jointly and severally liable

where two defendants both have a liability and the plaintiff may pursue 100% of the obligation against either of them

E Civil and court procedures

When a claim cannot be settled by negotiation between the insurer and third party, or by the acceptance of a PIAB assessment, it may become the subject of formal legal proceedings. This might be because the parties cannot agree on the value (quantum) of the claim, or there may be a dispute about who was at fault.

We will now briefly consider the process and procedures that govern personal injury legal actions.

E1 Personal Injuries Guidelines

As noted in Section C3, the Personal Injuries Guidelines came into effect in April 2021 and replaced what was known as the Book of Quantum of the Personal Injuries Assessment Board. PIAB will refer to these Personal Injuries Guidelines when making their awards. The Courts will retain their independence in making awards of damages. However, it is now mandatory for the Courts to refer to the Personal Injuries Guidelines and to detail within their judgement the rationale for departing from them.

In respect of claims involving multiple injuries, the approach set out in the Personal Injuries Guidelines is that the Court should:

1. identify the dominant injury and the area of damages that most resemble the claimant's significant injuries
2. value that injury
3. allow for additional pain and limitations arising out of the injuries that are less significant.

Where the claimant has a pre-existing condition that is aggravated by an injury, the Court should have regard only to the extent to which the condition has been made worse by the injury under consideration.

The Personal Injuries Guidelines set out 12 categories of injury including a number of those previously addressed within the Book of Quantum. These categories are:

1. Injuries resulting in foreshortened life expectancy
2. Injuries involving paralysis
3. Head injuries
4. Psychiatric damage
5. Injuries affecting the senses
6. Injuries to internal organs
7. Orthopaedic injuries
8. Chronic pain

9. Facial injuries
10. Non-facial scarring and burns
11. Damage to hair
12. Dermatitis and other skin conditions

Injuries are to be considered as:

- Minor
- Moderate
- Severe and serious
- Most severe.

6.3 Case study

Injury assessment under the Personal Injuries Guidelines

John is a front-seat passenger in a car driven by Tom. Tom fails to stop the vehicle in time and crashes into a vehicle in front of them. Liability is not an issue and John has suffered a whiplash injury, for which he makes an application to PIAB. Based on the Personal Injuries Guidelines, how much should John receive?

Whiplash symptoms may be minor, moderate or severe and permanent. Many individuals who suffer this recover within months. However, some symptoms can persist for several years, and may involve injections of local anaesthetic for pain relief, cortisone/steroid and muscle relaxants, or the use of a transcutaneous electrical nerve stimulation (TENS) machine or ultrasound. John's GP tells him that the whiplash will take about 18 months to clear up provided he attends physiotherapy classes.

As noted already, the process under the Personal Injuries Guidelines is to:

- identify the dominant injury
- identify the relevant damages bracket
- consider where within the bracket the injury lies
- have regard for the presence or absence of lesser injuries.

John's injury would be under the category of minor neck injury and the relevant damages' brackets are as follows:[26]

Where a substantial recovery takes place in 1-2 years	€6,000-€12,000
Where a substantial recovery takes place in 6 months to 1 year	€3,000-€6,000
Substantial recovery within 6 months.	€500-€3,000

As John recovered within 18 months, his award will be in the range of €6,000 to €12,000.

As noted in Section C3, the Personal Injuries Resolution Board Act 2022 includes several measures which are scheduled to be in operation by late 2023. The most important of these new measures is the introduction of mediation within the PIAB process.

[26] The Judicial Council, *Personal Injuries Guidelines*, www.judicialcouncil.ie

E2 The courts

Personal injury actions are brought in the civil, rather than the criminal courts. Table 6.1 shows the comparison between the Irish criminal and civil courts, from lowest to highest level. Both civil and criminal courts at any level can be populated by the same staff and judges. This is especially true in the lower courts. A sitting of a district court could, for example, hear both civil and criminal cases in one day.

Table 6.1 The Irish Civil and Criminal Courts system

Criminal courts	Civil courts
	Small Claims Court
District Court	District Court
Circuit Court	Circuit Court
Central and Special Criminal Courts	High Court
Court of Criminal Appeal	Court of Appeal
Supreme Court	Supreme Court

Microlearning resources

In the Member Area of www.iii.ie, via the Connect logo and in Your Learning Centre, select the microlearning section of this chapter to access a resource specifically developed to help you better understand this topic.

Each court deals with a different level of case. In the civil courts, this is determined by the size of the claim in monetary terms[27], while in the criminal courts, the level is determined by the type and severity of the crime.

The Court of Appeal is the default court for all appeals from the High Court. In most cases the decision of the Court of Appeal will be final.

The Court of Appeal has taken action in respect of the reduction of awards of lower courts where matters have been referred to it. In the case of *Emma McKeown v Alan Crosby and Mary Vocella* (2020), the Court of Appeal found that the award of the High Court was not proportionate to the injuries caused and damages should have been settled by reference to the Book of Quantum at the time. This followed the cases of *Payne v Nugent* (2015) and *Nolan v Wirenski* (2016) where, similarly, damages were reduced on referral to the Court of Appeal. The reductions of awards made by the Court of Appeal has largely been brought into wider effect with the introduction of the Personal Injuries Guidelines in April 2021.

A direct appeal to the Supreme Court is allowed in certain limited circumstances. Parties are allowed to bypass the Court of Appeal and appeal a ruling of the High Court directly to the Supreme Court if the Supreme Court is satisfied that:

(i) The High Court decision involves a matter of general public importance

(ii) The interest of justice requires that the appeal be heard by the Supreme Court

[27] The monetary value of the claim that each court can deal with can be found on www.citizensinformation.ie

E3 Time limitation of actions

The law imposes a **time limitation** of actions on victims of a civil wrong. To allow unlimited time would be unfair to the defendant since the possibility of legal action could hang over them indefinitely. A very long delay would also make a fair hearing difficult since evidence tends to become less clear and less readily available with the passage of time.

Claims based on tort are governed by the **Civil Liability and Courts Act 2004**, which stipulates the periods of limitation. If the plaintiff does not issue proceedings within the statutory period, the claim then becomes 'statute barred', and cannot be proceeded with if the defendant objects.

In actions involving personal bodily injury and death the limitation period is 2 years from the date of the alleged wrongful act, while the time limitation for defamation is 1 year from the date of the alleged wrongdoing. For claims involving damage to property, the period is 6 years from the date of the alleged wrongdoing. The legislation also requires a 'letter of claim' to be issued within 1 month of the incident or date of knowledge of the incident. This can be a brief, informal written note giving details to the alleged wrongdoer of the 'wrong'. This puts the possible defendant/respondent on notice of a possible action, and it is essential that all such letters be sent to insurers as soon as possible.

There are some exceptions to the limitation period in personal injury cases summarised as follows:

- Where the injured person is a minor (i.e. a person under the age of 18, the 2-year period does not begin to run until the minor or infant has reached their 18th birthday.
- Where the plaintiff was not aware of their injuries at the time the negligent act, the limitation period of 2 years will run from the date that the injury is discovered. This can arise in cases involving industrial disease or medical negligence.
- When a case is being considered by PIAB, the limitation period is suspended during the PIAB process and for a further 6 months after that. This is usually referred to as 'stopping the clock'.

Although the limitation periods are very clearly defined, a judge has a certain amount of discretion to extend the limitation period if it is considered fair and just in all the circumstances.

time limitation

the requirement to bring a legal action within specific time periods, e.g. the 2-year period allowed for injury claims

Quick question 4

On the day of her tenth birthday in 2012, Daisy suffered personal injuries in an accident. By what year, at the latest, would Daisy have to issue proceedings against the negligent party for the case to be heard?

E4 Civil procedure

When a personal injury claim becomes the subject of legal action, both the plaintiff and defendant must follow very strict procedures. We will now consider the main elements of these procedures.

The **Civil Liability and Courts Act 2004** sets down the process for bringing proceedings. Proceedings in the High Court, Circuit Court or District Court, in respect of a personal injuries action, are commenced by a summons known as and referred to as a 'personal injury summons'.

A personal injury summons specifies the:

a. plaintiff's name, address and occupation

b. plaintiff's personal public service number (PPSN)

c. defendant's name, address and occupation (if known to the plaintiff)

d. plaintiff's injuries (alleged to have been caused by the defendant)

e. full details of all special damage in respect of which the plaintiff is making a claim

f. full details of the defendant's actions which caused the injuries and the circumstances relating to same.

As stated in Section E3, the plaintiff must submit a 'letter of claim' (also known as a 'Section 8 letter') to the wrongdoer within 1 month of the incident or date of knowledge of the incident. This letter sets out the nature of the claim and the intention to seek redress.

Prior to issuing proceedings, the plaintiff and their solicitor have certain obligations under the **Mediation Act 2017** which are outlined in Chapter 7E3.

The plaintiff must then issue proceedings within 2 years for personal injury claims (see Section E3). This involves serving a personal injury summons on the defendant, in the manner set out in the **Civil Liabilities and Courts Act 2004**. The summons should include the names, addresses and occupations of the parties, and the PPS number of the plaintiff. Full details of the accident, the particulars of injury and the special damages being claimed should be outlined.

Service must normally occur within 12 months of issue and the defendant has 8 days to enter an appearance once service of proceedings is issued on them. A memorandum of appearance (also known as 'entering an appearance') is filed in the Central Office.

The defendant is then required to serve a defence on the plaintiff within 8 weeks of the service of the personal injury summons. This can be extended either by consent of the parties or upon application to the court. The defence must answer all allegations made by the plaintiff, within a prescribed period of time. The defendant may then also bring a **counterclaim** against the plaintiff to be heard in the same proceedings. The counterclaim must specify any injury, detailing the remedy sought. This should also include full details of allegations made against the plaintiff.

If either party fails to fulfil requirements, the aggrieved party can obtain a judgment against the other, or the failure can be taken into account in the award of costs.

counterclaim

claim made by a defendant, which alleges that they too suffered losses as a result of the incident and that they wish to claim against the original claimant for those losses

The Civil Liability and Courts Act 2004 requires a **verifying affidavit** by both the plaintiff and the defendant. The document must contain a statement that the person swearing it is aware of the consequences of making a false or exaggerated claim. If a person swearing an affidavit makes an untrue or false statement, they are guilty of an offence that can lead to a fine of up to €100,000 or 10 years' imprisonment, as well as the case being dismissed with costs being ordered against them.

As the case approaches a court hearing, the parties typically request information and documents from each other, as part of the **discovery** process. This can be done through a **notice for particulars** document and formal requests for discovery. For example, a defendant will require details of previous accidents, injuries or relevant medical history.

There is no obligation to disclose to the other side the contents of technical, medical or expert reports, or photographs relevant to a litigant's case, unless the party intends to use them at trial. A **privileged** document does not have to be disclosed to the other party for inspection or shown to the court at a hearing.

In this regard, the Insurance (Miscellaneous Provisions) Act 2022 resolved a question concerning legal privilege that arose from the Consumer Insurance Contracts Act 2019 (CICA). Section 16(10) of CICA, which introduced a mutual duty of disclosure during the claims handling process, requires that 'If, after a claim has been made under a contract of insurance, the consumer or the insurer becomes aware of information … that would either support or … would prejudice the validity of the claim made by the consumer, the consumer or … the insurer shall be under a duty to disclose such information to the other party.' This was believed to encroach upon or erode the concept of legal privilege. Section 8(3) of the **Insurance (Miscellaneous Provisions) Act 2022** clarifies this position by stating that 'This section shall not affect the operation of any enactment or rule of law by virtue of which - (a) a report prepared by a lawyer, or (b) a communication between a lawyer and another person, is privileged'. Where no legal privilege exists in respect of information established during a claim investigation, Section 16(10) of CICA applies. In effect, neither the consumer nor the insurer should withhold information from one another during the claim investigation process.

verifying affidavit
a specific legal document furnished by each side in a case promising that the things they have alleged are truthful

discovery
legal process allowing a party to a legal action to seek specific information relevant to the claim

notice for particulars
legal document issued seeking more information about the claim being made

privilege
the freedom to make statements in certain contexts, e.g. government and legal proceedings, that might otherwise be considered defamatory

E4a Striking out

The courts can strike out any action before a hearing for a number of reasons, including the following:

- The action may not disclose a cause of action in law.
- The action may be frivolous and vexatious or an abuse of the court process.
- If a party fails to comply with time limits, the other side may apply to the court to issue an appropriate order, i.e. service of further and better particulars within a certain time, or for the action to be struck out.

Where a plaintiff delays prosecution of an action, the defendant may argue that they are prejudiced by this delay in preparing a proper defence. One of the most important procedures available to the defendant where a claimant is not progressing their claim is an application to strike out for want of prosecution. To obtain such a strike out order, the defendant must prove they are prejudiced in the defence of the claim by the claimant's delay e.g. provide evidence that witnesses have died or become incompetent to testify.

E4b Third-party proceedings

Where a defendant is of the view that another party is responsible or has an involvement, they may issue a third-party notice on that party.

Leave to serve a third-party notice shall, unless otherwise ordered by the court, be made within 28 days from the time limited for delivering the defence, or, where an application is made by the defendant to a counterclaim, the reply. The question of apportionment of liability (see Section B6b) between the defendant and third parties is determined at the same time as the trial of the main action.

Proceedings may also be brought within 2 years of judgment or settlement agreed in the original action. A party who delays unreasonably even within that time may be refused leave to serve third-party proceedings, especially where the proposed third party can show prejudice.

setting down

the date sought for the case to be heard

E4c Setting down

Normally a plaintiff **sets down** their case for trial and a notice is served on the defendant. If the plaintiff fails to set the matter down for trial within 6 weeks of the close of pleadings (that is, the date on which the last pleading was delivered), the defendant is entitled to set down the matter.

barrister

a type of lawyer who specialises in court advocacy and the giving of legal opinion

alternative dispute resolution

various methods by which cases can be settled without resorting to the courts

arbitration

a less formal but still quasi-judicial process whereby cases are heard by an arbitrator rather than a judge in court

mediation

informal method of dispute resolution involving the help of a neutral mediator, who helps the parties work out their own solutions to problems with no apportioning of blame or right and wrong

E4d Lodgments/tenders

After litigation begins, the defendant can lodge or tender a sum of money into court to fully satisfy the plaintiff's claim. A tender can be made at any time before a notice of trial is served. A tender can only be made within 4 months of the date of the notice of trial being served, or within 21 days of the expiration of 18 months from the date of the notice of trial, or if the plaintiff delivers unsolicited updated particulars of injury. The plaintiff must be allowed 21 days in which to accept a tender.

The advantage to the defendant is that if the amount was not accepted and the case proceeded to trial, and if the plaintiff obtained damages equal to or less than the tender, the plaintiff is liable for the costs of the action from the date of the tender.

The judge is never informed of the amount lodged or tendered into court.

E4e Preparation for trial

Before trial, the parties make the necessary preparations, including a review of all the evidence, the checking of witnesses against their statements, a decision on which witnesses to call and any other steps required for the hearing. Prior to trial, counsel (a **barrister**) is asked for an 'advice on proofs' for the hearing. This outlines the facts to be proven in the case and the manner in which they can be proven with reference to the associated law.

The courts are encouraging, where possible, resolving disputes through **Alternative Dispute Resolution** (ADR), including **arbitration** and **mediation**. This is especially so since the passing of the **Mediation Act 2017** (see Chapter 7E3). The **Civil Liability and Courts Act 2004** also makes particular reference to mediation between the parties to the action. Another new step in proceedings is the mediation conference. The Act allows that, prior to a trial, either party may request a mediation conference. The power is also given to the court to direct the holding of a mediation conference if it will aid the proper disposal or settlement of the action. The aim of this is to try to dispose of a case amicably without proceeding to court. To date, this mechanism has not been used as frequently as was envisaged. However, voluntary mediation between the parties is becoming increasingly common in complex personal injures claims (e.g. medical negligence and workplace bullying claims).

Quick question 5

What are the time limits for a defendant to serve third-party proceedings in a personal injury action?

E5 Court procedure

The court attempts to set up a procedure and an environment where both sides to a dispute can present their case. The judge, on the basis of the evidence and arguments before the court, adjudicates on the facts, applying the relevant law. The onus of proof is on the plaintiff, and the judge decides if the case has been proven using the test for civil actions of 'the balance of probabilities'.

Cases are normally adjudicated by a judge alone. Jury trials are usually confined to defamation cases.

E5a Speeches and examination of witnesses

The plaintiff's counsel opens the case by reciting the facts as the plaintiff sees it, and the law on which they intend to rely. The plaintiff's counsel calls witnesses in turn, beginning with the plaintiff. Each witness can be cross-examined by the defendant's counsel, who will seek to obtain an admission of facts detrimental to the plaintiff's case, or by exposing inconsistencies. Counsel for the plaintiff has the right to re-examine the witness.

At the end of the plaintiff's presentation, the defence may submit to the judge that the plaintiff has not proven that the defendant has a case to answer. This is 'seeking a direction'. If the application before the court is successful then the case will be dismissed by the judge, but if unsuccessful the defendant, then begins the defence.

After the plaintiff's evidence, the defendant's counsel may rely on the evidence gleaned from cross-examination and call no witnesses. It is likely that the defendants will present their case in like manner to the plaintiff, utilising witness and expert evidence. The plaintiff's counsel will then begin a summation of the case before the judge. This will relate to the law and those facts proved in evidence in support of the plaintiff's case and on which they intend to rely in asking the judge to find for the plaintiff. **Counsel** for the defence then sums up, leaving the plaintiff's counsel with the last word. After the summations the judge provides a concise summary of the case and then gives their judgment.

Occasionally the law applicable to the dispute is unclear, and counsel for each side addresses the judge on the law, each citing precedents and sections from statutes or **statutory instruments** (SI) in support of that interpretation that supports their client's case.

counsel

a barrister or other legal adviser conducting a case

statutory instrument

a form of delegated legislation, which provides detailed rules that implement the more general provisions of a particular European Directives or Acts of the Oireachtas

E5b Judgment and the role of legal precedent

The judge will refer to the arguments of counsel and indicate the full reasons for their judgment, including a resume of the facts and commentary on both the weight of evidence and the laws applicable. A judgment is a decision on both liability (who was at fault and to what extent) and quantum (the damages to be awarded).

Most judgments are delivered immediately at the end of the trial, but if the case is particularly complicated a judge may reserve judgment or, alternatively, indicate which side has won but postpone a detailed judgment until later.

When reaching a decision, the judge is bound by a previous decision of a higher court in similar cases. They will look at the reason for the previous decision or the rationale behind it (*ratio decidendi*). In practice, both the plaintiff's and defendant's counsels will have already raised potentially binding precedents, either arguing that they should apply in the current case, or that the cases should be distinguished from each other. If a case can be successfully distinguished, then the precedent will not apply.

obiter dictum

('said by the way') something that is said usually as part of a judgment, which, though not binding, is often regarded as an important guide for future cases

The court is not bound, but can choose to be influenced, by situations such as the following:

- The principle of ***obiter dictum*** ('said by the way') may arise in very specific circumstances, where a judge makes a passing comment, usually as part of the judgment. For example, the judge might state that an issue raised during the trial is not relevant to the decision. A later case may arise in which that same issue is deemed relevant. It would then be argued that the comment made by the judge in the previous case should be acknowledged.
- A decision may be made by a court of equal or lower jurisdiction to the present court, e.g. a previous Circuit Court decision cited to the High Court in a later case.
- As the Irish system of law is quite similar to the English system, judges will often be persuaded by decisions on current matters in the English courts and sometimes those of Canada and Australia. Decisions made by courts outside of Ireland can be very influential.

A case falling into one of these categories may only be treated as persuasive authority. The Supreme and High Courts tend to follow their own decisions unless there is an exceptional reason why this should not be done. Decisions of the European Court of Justice, on questions of EU law, will be strictly binding on all national courts of EU member states.

E5c Costs

Legal costs form a significant part of the overall cost of litigation claims. For individually litigated cases, the total costs can be up to 60% of the award cost. This explains why detailed consideration is made during the lifecycle of the claim whether to contest a case or try to settle.

Legal Costs Adjudicator

an independent and impartial person appointed by the Irish Government to assess legal costs incurred by an individual or company involved in litigation

Costs normally follow the event so if the plaintiff wins, the legal costs are paid by the defendant, and vice versa. Theoretically the decision on costs is at the discretion of the judge. If these costs cannot be agreed between the parties, they are 'adjudicated'. Adjudication is a procedure whereby the **Legal Costs Adjudicator** inspects details of the costs incurred to assess whether they are reasonable in the circumstances.

In Ireland, the Legal Services Regulatory Authority (LSRA) protects and promotes the public interest and that of consumers. It does so by regulating legal practitioner's provision of legal services and ensuring the maintenance and improvement of standards in the provisions of those services. More information on the LSRA can be found on www.lsra.ie.

E Summary

In this chapter we looked at some of the important issues that arise with personal injury claims, in the context of Irish law and claims practice. We saw the legal basis for such claims, the way they are valued and the process of litigation.

F1 What's next?

Chapter 7 examines how insurers settle different types of claims and the main issues that arise at the settlement stage.

F2 Online learning supports

Your Member Area includes a guide to success, an automated study planner, an exam countdown timer and study tips guide. These study supports are invaluable in reinforcing what you have learned so far. The webinars, chapter-by-chapter key points and other supports will help you to break down the chapter's content when revising.

Remember: This module is examined by mixed assessment, which includes:

- An online mid-semester MCQ assessment (20 questions)
- An end-of-semester written exam paper (9 questions)

Given that your online mid-semester assessment is a multiple-choice question test, completing the online practice paper is the ideal preparation for this. You can prepare for the end-of-semester written exam and test your knowledge by completing sample and past written exam papers.

To access these online learning supports, just log into your Member Area on **www.iii.ie** and click on the **Connect** logo.

End of chapter questions

Use these questions to test your understanding of what we've covered so far in Chapter 6. It should be noted that these end of chapter questions are revision questions to test your understanding of the material in the chapter just studied. They are not sample exam questions.

1. Identify the two headings into which claims for general damages are usually broken down.

2. Briefly explain the defence of statutory authority.

3. State when a claim for 'lost years' arises.

4. List some of the injury types that could be described as 'catastrophic'.

5. Outline how contributory negligence can reduce the cost of a third-party claim.

6. Identify what happens if the respondent refuses to allow a case to go for assessment by PIAB.

7. State the standard statute of limitation periods for property and personal injury claims. Outline how this is varied for claims involving minors.

8. State the reasons why a court may strike out a personal injury action.

9. Explain what a verifying affidavit is and its relevance.

10. State the objective of the Legal Services Regulatory Authority.

Answers to end of chapter questions

Check your answers against those below and make a note of any points you left out. This will highlight some sections you may need to look at more closely during your revision.

1. General damages refer to the compensation for the actual injury received. It can be segmented into the headings 'pain and suffering' and 'loss of amenities'.

2. Statutory authority is a common defence because, in the interest of society as a whole, governments often allow firms and individuals to engage in activities that have some harmful effect on others. For example, statute law may permit civil aircraft to fly over private land (which would otherwise be a trespass).

   Statutory authority will not be a defence in negligence, as it is unlikely that the Oireachtas would wish to authorise negligent behaviour.

3. A claim for 'lost years' arises where at the time of trial the injured plaintiff can prove a reduced life expectancy as a result of the injury.

4. Injuries that can be described as 'catastrophic' include: paraplegia, quadriplegia, brain damage.

5. Where in a particular case a plaintiff is found to be responsible in some way for an accident that has befallen them, the judge is empowered by the **Civil Liability Act 1961** to reduce the plaintiff's damages by an amount that reflects the plaintiff's own contributory negligence.

   Examples: motor accidents (e.g. failure to wear a seat belt), accidents at work (failure to follow safe procedures) or other suitable examples.

6. If the respondent refuses to allow a case to go for assessment by PIAB, the board will issue an authorisation to allow the claimant proceed through the courts.

7. The limitation period is 6 years for property damage. The period for personal injury claims is 2 years. In cases involving minors the statute is extended to 2 years from the claimant's 18th birthday.

8. Reasons a court may strike out a personal injury action include:

   - The action may not disclose a cause of action in law.
   - The action may be frivolous and vexatious or an abuse of the court process.

   If a party fails to comply with time limits, the other side may apply to the court to issue an appropriate order, i.e. service of further and better particulars within a certain time, or for the action to be struck out.

9. A verifying affidavit is a document issued as part of the pleadings in a case, promising that the allegations made by that party are true. If a person swearing an affidavit makes an untrue or false statement, they are guilty of an offence that can lead to a fine of up to €100,000 or 10 years' imprisonment, as well as the case being dismissed with costs.

10. The objective of the Legal Services Regulatory Authority is to protect and promote the public interest and that of consumers by regulating legal practitioner's provision of legal services and ensuring the maintenance and improvement of standards in the provisions of those services.

Answers to quick questions

1. Yes, it is likely. The piano player's loss may be deemed the greater of the two.

2. No. As per the **Personal Injuries Assessment Board (Amendment) Act 2007**, where a claimant rejects a PIAB assessment and then fails in court proceedings to get an award of damages in excess of the amount of damages assessed by PIAB, the claimant may not be entitled to legal costs.

3. In this situation, John would receive €144,000 (80%) of the award.

4. Daisy would have to issue proceedings against the third party by 2022 (8 years until her 18th birthday plus 2 years of the normal statute equals 10 years from the date of the incident).

5. Leave to serve a third-party notice is usually allowed within 28 days from the time limited for delivering the defence, or, where an application is made by the defendant to a counterclaim, the reply.

   Proceedings may also be brought within 2 years of judgment or settlement agreed in the original action. A party who delays unreasonably even within that time may be refused leave to serve third-party proceedings, especially where the proposed third party can show prejudice.

Sample exam questions

Question 1

John has been injured in a motor accident and asks you, his insurance broker, to explain how his future loss of earnings will be assessed.

Explain, to John, how these earnings will be assessed and include any other factors that may need to be taken into account.

Total: 10 Marks

Question 2

When a personal injury claim becomes the subject of legal action, both the plaintiff and defendant must follow very strict procedures under the **Civil Liabilities and Courts Act 2004.**

Explain the key procedures that must be followed by a plaintiff to commence an action against a defendant.

Total: 10 Marks

Your answers

Sample answers

The answers set out below show the main points you must consider in answering the question. In some cases, a well-reasoned alternative view could earn good marks.

Question 1

Future earning loss is assessed under a separate heading to past earning loss. This is awarded where an injury causes a disability impairing a person's capacity to work and compromises earnings. Short-term future loss of earnings is relatively simple to calculate, but additional factors are considered when estimating a long-term future loss.

This may extend over a longer period, i.e. several years, or a lifetime. It is also necessary to consider aspects like job security, inflation and the rate of interest that may be earned on any payment made. Weekly loss of income is estimated and an actuary prepares a report to calculate the long-term future loss. This report includes relevant factors such as the plaintiff's gender, age, life expectancy, past earnings, future earning capacity/prospects and the effect of inflation.

Reference Chapter 6 B2b **Total: 10 Marks**

Question 2

The plaintiff must submit a 'letter of claim' (also known as a 'Section 8 letter') to the wrongdoer within 1 month of the incident or date of knowledge of the incident. This letter sets out the nature of the claim and the intention to seek redress. Prior to issuing proceedings, the plaintiff and their solicitor must adhere to certain obligations under the **Mediation Act 2017**.

The plaintiff must then issue proceedings within 2 years for personal injury claims. This involves serving a personal injury summons on the defendant, in the manner set out in the **Civil Liabilities and Courts Act 2004**. The summons should include the names, addresses and occupations of the parties, and the PPS number of the plaintiff. Full details of the accident, the particulars of injury and the special damages being claimed should be outlined.

Service must normally occur within 12 months of issue and the defendant has eight days to enter an appearance once service of proceedings is issued on them. A memorandum of appearance (also known as 'entering an appearance') is filed in the Central Office.

If either party fails to fulfil requirements, the aggrieved party can obtain a judgment against the other, or the failure can be taken into account in the award of costs.

The Civil Liability and Courts Act 2004 also requires a verifying affidavit by both the plaintiff and the defendant. The document must contain a statement that the person swearing it is aware of the consequences of making a false or exaggerated claim. If a person swearing an affidavit makes an untrue or false statement, they are guilty of an offence that can lead to a fine of up to €100,000 or 10 years' imprisonment, as well as the case being dismissed with costs.

Reference Chapter 6E4 **Total: 10 Marks**

Chapter

7

Claims settlement

What to expect in this chapter

We will now consider the final stages of the claims process and the methods of settling different types of claims. We will also examine some important considerations for claims handlers and the different issues that may need to be addressed at the point of settlement.

Contents

A Settlement methods

In Chapter 5 we examined how claims handlers use policy wordings and the principle of indemnity to determine the extent of cover for individual claims. We will now consider how insurers decide on the precise method of settling valid claims.

You may recall from The Nature of Insurance module that insurers have four options when settling claims. These options are:

- Paying money (to the insured, or another person)
- Repairing a damaged item
- Replacing an item that was lost, stolen or damaged beyond repair
- Reinstating a property.

The settlement method chosen will depend on the type of policy. For all types of insurance, the settlement options must be stated in the policy. If they are not stated, the insured has a right to a monetary settlement.

A1 Settling first-party claims

As we have already learned in earlier chapters, first-party claims (policyholder claims) are claims under an insurance contract. They typically involve damage to the insured property, or other losses that the policyholder suffers.

A1a Property damage claims settlement

For claims under a property policy, an insurer has several settlement options. Insurers generally choose the method that is most economical to them. They are also keen to give a good service and will often comply with an insured's request for a claim settlement in a specific way, provided it does not materially increase their costs.

The available methods under property policies are set out in the operative clause of the policy. The following is fairly typical:

Insurance policy extract 7.1

'The company may, at its option, indemnify the insured by payment of the amount of the loss or damage or by repair, reinstatement or replacement.'

While the payment of money remains the most common method of claims settlement, insurers frequently exercise their option to repair or replace damaged property. The repair option is most often used in motor claims, but is also used in claims involving damage to computers or electronic goods.

Replacement of household goods is increasingly seen as a valuable service. If damaged goods are promptly replaced and delivered to the insured, significant customer satisfaction can result. Claims for jewellery, carpets, electrical and electronic goods are particularly suitable for this method of settlement. This can also act as an effective fraud prevention tool (especially in theft claims).

Reinstatement is the least popular method of settlement, although it is occasionally used for buildings claims, for some types of machinery and where the insurer suspects fraud on the part of the insured.

The difficulties faced by insurers if they decide to reinstate are:

- The insurer becomes responsible for problems that arise in the reconstruction process. This principle was established in *Brown v Royal Insurance Co.* (1859).

Case law

In *Brown v Royal Insurance Co.* (1859), the insurer chose to reinstate the property but the process became frustrated. The policyholder pleaded non-performance of a duty by the insurer. It was held that where the insurer elected to reinstate the property, the contract became one for reinstatement. Therefore, irrespective of the costs involved, the insurer was obliged to reinstate the property on an equivalent or like basis.

Another good example of this in recent cases has been the operation of planning delays after a decision to reinstate. If the insurer chooses to reinstate, the original contract to pay money becomes a contract to provide a restored building (or machinery). If the restored property or machinery is defective or in any way inferior, the insurer may have to pay compensation to the policyholder for breach of contract. This point is also relevant to the repair option, where more insurers using approved repairers or nominated builders will be liable for any defect in the repaired property.

- At common law, the insurer cannot limit its expenditure to the sum insured. Instead, the insurer usually seeks to protect itself against some of these pitfalls by stating in the commercial property policy that if it does choose, or become obliged, to reinstate, it will only do so 'as circumstances permit and in a reasonably sufficient manner'. Policies usually also provide that 'in no case shall [the insurer] be obliged to expend more than the sum insured' on reinstatement. This particular wording has not been tested in a legal or an Ombudsman case and the extent to which this restriction might be effective is a matter for speculation. It appears (on the face of it; without being tested) to give the insurer the right to choose which option to use and, having done so, to only partially rebuild.
- The insurer must reinstate within a reasonable time and failure to do so might make it liable to pay damages to the insured for loss of use.
- The insurer becomes its own insurer during reconstruction, responsible for any further damage that may occur during reconstruction, e.g. a fire on the building site. This point was confirmed in *Smith v Colonial Mutual Fire Insurance Co. Ltd* (1880).

Case law

In *Smith v Colonial Mutual Fire Insurance Co. Ltd* (1880), the insurer elected to reinstate a house following a partial loss by fire. After a second fire occurred on the site, the insurer was not allowed to deduct the amount they had already spent on reconstruction before it happened.

A1b Motor claims settlement

When settling claims for vehicle damage, motor insurance policies provide three settlement options: payment, repair and replacement. The option chosen by the insurer will depend on the extent of the damage.

A typical policy wording is:

Insurance policy extract 7.2

'We may:

- repair or replace the car or any part of it
- pay a cash amount for the loss or damage'

The repair option is very commonly used in motor insurance and typically involves the use of a network of approved repairers. The operation of approved repairer schemes was considered in The Nature of Insurance module.

Where an insured vehicle is beyond repair, uneconomical to repair or stolen and not recovered, the insurer will settle the claim on a **total loss** basis. This invariably involves the payment of money to the insured, or to another party (like a finance company).

total loss (write off)
a judgement, by the insurer, that the value or repair cost of a damaged property exceeds the value of its policy

You may recall from the Personal General Insurance and the Commercial General Insurance modules that comprehensive cover under a motor policy typically includes a replacement vehicle (or 'new for old') option. This arises when a vehicle is less than 1 year old, has not exceeded a specified mileage and repair cost, or exceeded a defined percentage (usually 60%) of the current list price. The policy provides for the claim to be settled by the replacement option, by providing a new vehicle of the same make, model and specification.

The reinstatement option does not exist in motor insurance.

A1c Private health insurance claims settlement

Settlement of private health insurance claims involves payment of money for medical treatment or other specified benefits. Payment is made to either the policyholder or member or to the healthcare provider.

There are no other settlement options in private health insurance.

A1d Other first-party claims settlement

Most other first-party claims are settled by making a monetary payment. This is because the nature of the loss makes other types of settlement impossible. These policies include: business interruption, money, legal expenses and fidelity guarantee policies.

A2 Settling third-party claims

We noted in earlier chapters that third-party claims arise in policies that cover the insured's legal liability in specific situations. These include motor (third party), employers liability, public liability, products liability, professional indemnity and other liability policies.

The term 'legal liability' refers to the amount that the insured is legally obliged to pay to a third party, and includes both damages and legal costs. Consequently, third-party claims can only be settled by the payment of money.

We considered the complex process of quantifying a third-party claim in Chapter 6. When this process reaches a conclusion following negotiation, a PIAB award or a legal action, the insured will make the necessary payments.

Depending on the nature of the claim, payment is typically to one or more of the following:

- The third party suffering injury, disease, financial loss or damage to their property
- The personal representatives of a third party who died in an accident, or before their claim was settled
- The third party's legal representatives
- The legal representatives appointed by the insurer to defend a claim
- Medical examiners, engineers and other expert witnesses (see Chapter 4C9)
- Other persons involved in the investigation and handling of the claim
- The third party's insurer, exercising their subrogation rights (see Section C).

When making a payment to a third party, the insurer may request a form of discharge. This document is signed by the third party and has two main purposes. Firstly, it confirms acceptance of the amount offered in settlement. It also discharges the insurer and the policyholder from further liabilities towards the third party. However, these forms are not used for claims involving minors or vulnerable consumers.

Quick question 1

How do insurers settle claims under private health insurance policies?

The answer is at the end of this chapter.

B Salvage and abandonment

We will now consider some of the other issues that arise when a claim is settled.

'Salvage and **abandonment**' are related, but different terms. For clarity, it is useful to define them here:

- Abandonment means the action of giving up the subject matter to the insurer.
- Salvage refers to the right of the insurer to take over the subject matter of the insurance (e.g. a damaged car that has been declared a write-off).

abandonment
legal situation where the salvage can be left in the hands of the insurer

Both salvage and abandonment arise when the insured property is either damaged beyond repair, or uneconomical to repair. They most often arise in motor insurance. If the cost of repairs represents a substantial proportion of the value of a vehicle (often set by insurers at 60% of current replacement cost), insurers will treat the vehicle as a write-off. Insurers normally stipulate in the insurance policy that the vehicle must be less than 12 months old from the date of registration 'as new' and has not exceeded a certain mileage (e.g. 24,000 km).

There are four write-off categories as noted in Table 7.1.

Table 7.1

A	End of Life Vehicle (ELV), needs to be scrapped, parts are not suitable for re-sale.
B	ELV, parts are suitable for sale but the remainder of the salvage needs to be disposed of by an authorised treatment facility, and the vehicle cannot be put back on the road.
C	Beyond Economical Repair (BER), can be repaired and placed back on the road but costs exceed the vehicle's pre-accident value. However, the insurer may request a roadworthiness certificate issued by a motor engineer confirming that the vehicle has been properly repaired.
D	Constructive write-off, where the insurer decides to deal with the claim on a total loss basis due to certain factors. This may occur, for example if the full extent of damage is not ascertained, as costly dismantling of the car would be required.

Here the policyholder is compensated for the market value of their vehicle and an unrepaired vehicle becomes the insurer's property (salvage). The principle of abandonment means that the insured must not give up the damaged property to the insurer. They cannot simply 'walk away' from a crashed car and leave all responsibility for it with the insurer.

When motor insurers settle a claim in this way, they pay the insured the full market value of the damaged car. Where the salvage has value, the insurer will make arrangements to dispose of the vehicle with the agreement of the policyholder who will sign over the necessary waiver. The claims handler will also request the vehicle registration certificate and keys and will record the category of write off on the InsuranceLink Database. The **Road Traffic Act 2016** imposes a requirement on insurers to notify the Department of Transport of written off vehicles (Category A and B end of life) within 5 working days of inspection. An insurer who fails to comply, commits an offence and is liable to a Class A fine (currently classified as not exceeding €5,000).[28]

Salvage may also arise in other types of property claims. For example:

- An expensive dining room table is scratched and cannot be restored to its former condition. Under the terms of a household policy, the claim is settled on the basis of the cost of replacing the table. The damaged item then becomes the property of the insurer, who arranges for a salvage agent to sell it at auction.
- A valuable painting is stolen from the insured's home. The insurer settles the claim by paying the full value of the painting. Six months later, Gardaí recover the painting, which then becomes the property of the insurer.

When salvage and abandonment arise, the insurer becomes the legal owner of the property and has full rights as owner. This means that they are entitled to make a profit from the sale of the salvage (although this rarely happens in practice).

Where the policyholder decides to retain the damaged item, they will be paid the market value less the current salvage value, as shown in Example 7.1.

Example 7.1

Francine owns a clothing shop. A burst pipe causes water damage to her stock, which means she cannot sell the stock as new. However, she knows she could sell it at a much reduced price as damaged stock. Her insurer would settle her claim as follows:

Full value of loss	€10,000
Less salvage (damaged stock)	€1,000
Claim payment	€9,000

[28] **Road Traffic Act 2016**, Section 5, Part 2.

C Subrogation and contribution

We saw in Section B that insurers may recover part of their outlay through the sale of salvage. They may also make a recovery by virtue of the principles of **subrogation** and **contribution.** These principles (already studied in The Nature of Insurance module) are sometimes described as corollaries of the principle of indemnity. This means that they support the principle of indemnity by making sure that an insured does not profit from a claim under a contract of indemnity. They do not apply to benefit contracts, such as life or personal accident policies.

subrogation

the right of an insurer, following payment of a claim, to take over the rights of the insured to recover payment from a third party responsible for the loss

contribution

the right of an insurer to share the cost of an indemnity payment among similarly (but not necessarily equally) liable parties

Microlearning resources

In the Member Area of www.iii.ie, via the Connect logo and in Your Learning Centre, select the microlearning section of this chapter to access a resource specifically developed to help you better understand this topic.

C1 Subrogation

Subrogation refers to the right of an insurer who has indemnified an insured in respect of a particular loss, to recover all or part of the claim payment by taking over any alternative right of compensation that the insured possesses. For example, if a motor insurer pays for the cost of repairing a vehicle following an accident caused by a third party, they can recover the cost of the claim from the third party or their insurer.

It is worth noting that the **Consumer Insurance Contracts Act 2019** limits an insurer's subrogation rights in respect of family relationships, personal relationships, and employment scenarios. The Act also sets out how funds generated from the exercise of subrogation rights should be distributed between an insurer and the consumer so that the consumer is not prejudiced. The details of these changes and their impact are beyond the scope of this module.

We will now review some key points concerning the operation of subrogation.

C1a Recovering twice for the same loss

As we have already learned in Chapter 5, the rule of indemnity is that the insured is placed in the same position as they were before the loss occurred. If they succeed in recovering twice for the same loss; they are better off than they were before the loss occurred. The principle of indemnity prohibits this (see Case law).

Case law

In *Castellain v Preston* (1883), fire had damaged a house during the period between the signing of the contract for sale and its completion. The seller recovered €330 from the insurer in respect of the damage. Afterwards, the buyer completed the purchase and, despite the fire, paid the full price of €3,100. The court held that the seller had to pay €330 to his insurer out of the money he received from the buyer. If not, he would make a 'profit from his loss'.

This rule that the insured cannot recover twice in respect of the same loss is subject to some qualifications:

- **The insured must be indemnified** – For example, in *Scottish Union and National Insurance v Davies* (1970).

Case law

In this case, the insurer had paid €409 to the motor vehicle repairers who had carried out repairs on the insured's car. However, after three attempts the work was still unsatisfactory. The insured then sued the person who caused the damage and recovered €350, which he used to get the work done properly. The court held that the motor insurer could not claim this money via subrogation as the original repairs had been useless and therefore the insured had not received an indemnity.

- **Gifts** – In general, if a gift is intended to be for the sole benefit of the insured, it cannot be claimed under subrogation rights. This is a rare situation, but Example 7.2 shows a possible scenario.

Example 7.2

Kate returns to her flat to discover that there has been a break-in. Among the items stolen was a guitar, bought in Spain and of great sentimental value. Kate makes a claim under her household policy and includes the cost of replacing the guitar.

Later Kate's dad finds a similar guitar online and orders it for Kate as a surprise gift. As this new guitar was a gift (and not a compensation payment), Kate will not be regarded as recovering twice for the same loss.

uninsured losses

expenses such as a policy excess, car hire or loss of earnings that are not covered by an insurance policy

C1b Action in the name of insured

The insurer must bring an action in the name of the insured, and can only bring one action for a single loss. Therefore, when they bring the action in the name of the insured, it must be for the whole loss. The action must also include any **uninsured losses** the insured has suffered. Example 7.3 demonstrates how this works.

This principle also applies if the insured initiates the action; they must include the insurer's losses. Insurance policies require the insured to refrain from doing anything to prejudice the subrogation rights of the insurer.

Example 7.3

Garth owns an office, which he has insured against damage. There is an excess on his policy of €250.

A negligent driver drives into the office building, causing impact damage.

The following losses are incurred:

- Buildings damage = €3,500
- Fixtures and fittings damage = €500.

The insurer pays €3,750 (€4,000 less the excess of €250). The insured's loss is €250 (the excess). The total claim against the negligent driver is €4,000 of which €250 is reimbursed to the insured.

C1c When subrogation rights arise

At common law, the insurer must indemnify the insured before it can exercise subrogation rights. This delay could potentially prejudice the insurer's chance of making a successful recovery. For example, the negligent party may change address in the meantime and become impossible to trace.

Insurers therefore include an express subrogation clause in non-marine policies. This allows an insurer to begin proceedings against a third party before it has settled the insured's own claim.

C1d Sharing the recovery

Operation of the principle of subrogation, and the way in which any recovery from a third party is shared between the insured and insurer, depends on two factors:

- The amount of the recovery in relation to the loss.
- Whether the insurance covers the loss in full.

We will look at the following three scenarios, i.e. where recovery is:

- Equal to the loss
- Greater than the loss
- Less than the loss

C1d1 Recovery equal to loss

In the majority of cases, the recovery will be the same as the loss suffered by the insured. Example 7.4 takes a second look at the earlier example of Garth's office.

Example 7.4

Total loss of both insured and insurer = €4,000. Insurer recover €4,000. Insurer retains the €3,750 they had paid to Garth.

The balance of €250 is held in trust for the benefit of Garth and reimbursed to him.

If instead Garth recovered the €4,000, the same principle would apply and he is liable to reimburse his insurer €3,750.

C1d2 Recovery greater than loss

This is a rare situation, but when it occurs, the insurer cannot recover more than it has paid out. An example of this is a claim made in a different currency to that of the insurer or insured, e.g. in sterling where the insured is based in Ireland. When the monies recovered are converted to euro, rate fluctuations could render the amount greater than the original loss. If this happens, the insured is entitled to the surplus monies.

C1d3 Recovery less than loss

Sometimes the amount recovered by the insured may be less than the loss suffered. This may happen if the third party is insolvent or unable to pay, or the third party is only partially responsible for the loss. If the insurer has paid for the whole loss there is no issue, and the insurer is entitled to keep all monies recovered. However, what happens if the insurer has paid less than the full amount of the loss and the insured has losses which have not been covered by the policy? Here the parties have certain guidelines to follow:

- **Policy excess** – The UK House of Lords case of *Napier v Hunter* (1993) followed the case of *Napier v Kershaw Ltd*. (1993). In *Napier v Hunter* (1993), it was found that the insurer has a prior claim on any money recovered, with the insured receiving the balance of any money which may include the policy excess. In practice however, it is commonplace for the insurer to reimburse the insured the policy excess which was deducted from their claim.
- **Underinsurance** – There are two schools of thought about the correct way of apportioning the payment. One is that the insured is paid first because they pay a premium and therefore do not stand equally with the insurer. Alternatively, the recovered amount is shared proportionately, relative to the loss by both parties, as the insured is deemed to be their own insurer for the uninsured element. Sometimes the policy conditions state what happens in such a situation.
- **Losses not covered** – This refers to items which were not covered under the claim (e.g. the costs involved in collating the claim or the cost of any professional advice obtained in presenting the claim to the insurer). When a claim is presented against a third party in a recovery, headings of claim will be detailed and the third party or their insurer should respond separately against each heading of claim. Therefore, this should not result in any ambiguity as to where the monies are to be allocated and to whom.

Finally, the insured can deduct from any amount, to which the insurer is entitled by way of subrogation, any legal costs or other expenses reasonably incurred in attempting to recover the loss that was insured.[29]

C1e *Ex-gratia* payments

If an ***ex-gratia* payment** is made by the insurer, it is not entitled to subrogation rights. Subrogation arises only from indemnity payments made under the terms of the policy. If the insured recovers any monies, they are entitled to keep them unless the insurer acquires these rights by agreement before payment is made.

***ex-gratia* payment**

claim payment made when there is no indemnity under the policy

[29] See *England v Guardian Insurance Ltd* (2000).

C1f Contractual waiver

It is not always appropriate, from a business point of view, for a negligent third party to be pursued following a claim. For example, the third party's insurer may be a subsidiary of the policyholder's insurer and so the insured would be suing themselves. Sometimes an insurer will agree with an insured that they will not exercise subrogation rights against certain other parties or persons who are associated with the insured. The way that two parties arranged their insurance may persuade the court that there should be a **waiver of subrogation** rights.

Where the insurance benefits both parties, the insurer cannot exercise its subrogation rights against one of the parties. This follows the decision in *Mark Rowlands Ltd v Berni Inns Ltd* (1986).

waiver of subrogation
when the insurer agrees to give up its right to subrogation

Case law

In *Mark Rowlands Ltd v Berni Inns Ltd* (1986), the tenant had contributed to the buildings premium. A fire occurred, believed to be the tenant's fault. The Court of Appeal ruled that the insurer could not exercise subrogation rights against the tenant, as the tenant, having contributed to the premium, was effectively considered by the Court to be a joint insured with the landlord.

C1g Comparing subrogation, abandonment and salvage

The subjects of abandonment and salvage, as discussed earlier, allow an insurer to claim for its own benefit anything that remains of the subject matter after it has paid for a total loss. Abandonment is often linked to subrogation and has the same purpose of preventing the insured from recovering more than an indemnity.

There are important differences, as follows:

- Subrogation gives the insurer the right to pursue a claim against a third party for the loss of the subject matter, but abandonment and salvage only confer rights over the subject matter (i.e. the damaged property).
- A subrogation action cannot be brought in the insurer's own name, whereas an insurer who accepts abandonment becomes the owner of the goods and has full legal rights as the owner.
- The insurer can profit by the sale of the salvaged property, whereas subrogation allows the insurer to recover no more than its own payment.
- Subrogation operates automatically as a result of the principle of indemnity, whereas abandoned property need not be accepted by the insurer.

Quick question 2

An insured makes a claim under a policy covering water damage. Payment of €10,000 is made on an *ex-gratia* basis. It is later discovered that a plumber was responsible for the leak that caused the damage.

How much of this money can the insurer hope to recover from the plumber?

C2 Contribution

Contribution is also a corollary of the principle of indemnity. It prevents the insured from 'making a profit from their loss'. Here the possibility of making a profit arises from the existence of double insurance. Contribution is concerned with the sharing of losses between insurers when such double insurance exists as in Example 7.5. The main principles are that the insured cannot recover for the same loss twice or for more than indemnity and that the insurers should share the loss in a fair way.

Example 7.5

Dales Fabrics has an insurance policy covering its warehouse stock. The fluctuating nature of Dales' business means that it sometimes needs to store stock in other warehouses. To facilitate this, it has another policy with a different insurer, on a 'floating' basis, covering stock in a series of warehouses. Contribution arises, as both policies cover stock held in Dales' original warehouse on their industrial estate.

Microlearning resources

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Contribution arises when the following conditions are satisfied:

- Two or more policies of indemnity exist.
- Each insures the subject matter of loss.
- Each insures the peril that brings about the loss.
- Each insures the same interest in the subject matter.
- Each policy is liable for the loss.

In theory the insured could simply claim from one of the policies covering the loss and ignore the other. This does not offend the principle of indemnity, but it means that one insurer pays for the whole loss, while the other receives a premium for the loss without having to meet it.

rateable proportion clause / condition

condition stipulating that the insurer will be responsible to pay only its share of the loss

C2a Rateable proportion clauses

Insurers respond by including a **rateable proportion clause** in most indemnity insurance policies and use it in conjunction with other contribution conditions. This clause provides that where other insurances exist, the insurer shall only bear its own rateable proportion of the loss. In other words, each policy pays a percentage apportionment by reference to the policy limits of each insurance.

This prevents the insured from recovering in full under a policy that includes the condition. Generally, both policies will carry such a clause, so the insured will be obliged to separately claim an appropriate proportion from each insurer. In practice, however, one insurer may pay the claim in full and seek appropriate contribution from the other insurer(s) involved.

C2b Basis of contribution

Contribution may arise at common law (i.e. under policies with no contribution clause) or, more frequently, under a standard 'rateable proportion' clause. Either way the question arises as to exactly how the insurers should share the loss. Unfortunately, there is little legal authority on this issue. In most situations, the assessment of the insurers' liability in cases of double insurance is based on market practice rather than established legal principles.

There are two main methods of calculating the ratio of contribution:

- **maximum liability**
- **independent liability**.

maximum liability

means of apportioning losses where the contribution applies in proportion to the maximum amount of cover available under each policy

independent liability

a method of contribution whereby the liability of each insurer is assessed as though its policy were the only one in force and is then shared in proportion to the independent liabilities of the two insurers

C2b1 Maximum liability method

Under the maximum liability method (sometimes referred to as the 'sum insured' method), the insurers share the loss in proportion to the maximum amount of cover under each policy. The formula used to calculate each insurer's contribution is:

$$\frac{\text{Policy sum insured}}{\text{Total sum insured (under all policies)}} \times \text{loss}$$

In the case of property insurance, this is usually based on the sum insured, as in Example 7.6.

Example 7.6

John insures his premises as follows:

- €10,000 with Insurer A
- €20,000 with Insurer B.

Here, using the maximum liability method, insurers will pay the following proportion of loss:

- Insurer A: one-third
- Insurer B: two-thirds.

John suffers a loss of €6,000.

Insurer A pays $\frac{€10,000}{€30,000} \times €6,000 = €2,000$

Insurer B pays $\frac{€20,000}{€30,000} \times €6,000 = €4,000$

Insurers use this method for property policies not subject to average and where the policies are concurrent or identical (i.e. they provide the exact same cover and for the exact same subject matter of insurance, such as a house and its contents).

C2b2 Independent liability method

Insurers use this method where property policies are subject to average or other conditions limiting full indemnity.[30] It may also be used for liability policies.

The independent liability method assesses the liability of each insurer for the loss, as though its policy were the only one in force. The resulting figure in each case represents the insurer's independent liability for the loss. The two insurers share the loss in proportion to their independent liability. The formula for calculating each insurer's proportion of the loss is:

$$\frac{\text{Independent liability}}{\text{Total of independent liabilities}} \times \text{loss}$$

When two different excesses apply, caution must be exercised to ensure the insured is not being penalised to the benefit of the respective insurers and that the excesses are dealt with equitably. Example 7.7 looks again at John's commercial insurance (from Example 7.6), using the independent liability method.

Example 7.7

John experiences a loss of €15,000 and his insurers use the independent liability method to calculate their share.

Policy A sum insured	€10,000
Policy B sum insured	€20,000
Loss	€15,000
Independent liability A	€10,000
Independent liability B	€15,000 (the full loss, subject to **adequacy of sum insured**)

A pays

$$\frac{€10,000}{€25,000} \times €15,000 = €6,000$$

B pays

$$\frac{€15,000}{€25,000} \times €15,000 = €9,000$$

adequacy of sum insured

term used to examine whether the property is sufficiently insured in policies where the average condition applies

C3 Contribution in third-party claims

dual insurance

occurs when there is more than one active policy covering the subject matter of insurance

It is unusual for a policyholder to have more than one policy covering third-party liability. This situation can arise where a driver is operating a vehicle other than their own. The driver's own policy may cover them for driving others cars (DOC), and they may be covered as a named driver under the policy of the vehicle owner. **Dual insurance** applies here to cover the third-party liability. Some insurers operate a 'DOC agreement' (also referred to as a dual indemnity agreement), where it is agreed that a third-party claim will be met by the driver's insurer as the liability follows the driver. Where there is no agreement existing the wordings of the respective policies are examined. Without a definitive wording, it is likely that responsibility will be shared equally between insurers.

[30] Following the case of *Commercial Union v Hayden* (1977), it is also the method used for liability insurances.

Table 7.2 shows the settlement outcomes when the principles of abandonment and salvage, and contribution and subrogation are applied.

Table 7.2

Sums insured			
Sum insured - Policy A			€7,000
Sum insured - Policy B			€3,000
Sum insured			€10,000
Loss			
Loss amount			€9,000
Salvage and abandonment		**Salvage**	**Abandonment**
Salvage value	€750		
Salvage owner - insured		Y	
Salvage owner – insurer			Y
Settlement under each principle		€8,250	€9,000
Contribution			
Policy A settlement			€6,300
Policy B settlement			€2,700
Total			€9,000

Subrogation

In this situation if the insured was only 25% responsible for the accident, the insurers would pay their policyholder €9,000 and recover €6,750 from liable party insurers.

D Reinsurance recoveries

Reinsurance is 'insurance for insurance companies' and is the protection of the insurer's profitability by either sharing the risk with reinsurers or buying protection against adverse loss. It is important that claims handling does not prejudice any recoveries the insurer may seek under its reinsurance programme. Previous modules have provided a basic understanding of reinsurance, and this knowledge is essential for claims handlers so that they can handle, record, negotiate and settle claims to ensure reinsurance recoveries.

Reinsurance is legally a form of insurance and is governed by the **Marine Insurance Act 1906**. Therefore, reinsurances are based on utmost good faith, and all the same considerations apply to them as to insurance policies.

Following many cases, it is now firmly established in law that reinsurers are only obliged to respond to claims from the reinsured parties if the original claims are:

- Settlements of liability or probable liability under the original policies, and
- Properly and professionally arrived at, in a 'business-like manner'.

The terms of the treaty agreement between reinsurer and insurer will include requirements on notification of losses to the reinsurer. The treaty may stipulate a monetary limit for notification, or require notification either for specific types of injury, such as death or loss of limb, or for cases involving policy disputes or arbitration. The extent of detailed information and documentation required is agreed between the parties.

Reinsurers need sufficient information on the underlying claim to ensure its validity under the original policy. If, for any reason, the claims handler has made a payment to an insured on any basis other than demonstrable liability within the policy terms, reinsurers will not be obliged to respond to a request for recovery. The most common ways this can arise are the making of a 'without prejudice' settlement or an *ex-gratia* payment to the insured.

Some reinsurance contracts allow the reinsurer to participate in dealing with claims. This can permit the reinsurer to either:

- Be involved in or assist with the handling of the original claim (claims co-operation), or
- Take over the decision-making (claims control).

These provisions may be written into the contract as a condition precedent to the reinsurer's liability. If so, failure to comply could lead to the reinsurer denying the claim entirely.

Because the reinsurance company is the 'insurer of the insurer' they will have the same information needs as the original insurer. Reinsurers need to be satisfied that policy cover applies, and will want accurate reserving to fulfil their solvency obligations. They must be assured that the claim is managed proactively so that the best economic outcome is achieved. The terms of their treaty and protocol with the insurer will clearly stipulate the details required.

Quick question 3

An insurer deals with a large number of claims following floods in the Munster area. Later they discover that there was no cover for flood under property damage policies, and a special exclusion had been issued for those areas. They decide to let the payment stand and claim it back from reinsurers.

What can the reinsurers do here?

E Dispute resolution

The majority of claims are settled under the terms of the relevant policy, without any significant dispute or disagreement. Occasionally an insurer and an insured are unable to agree, but the parties still have a number of options.

Firstly, the insured is likely to make a formal complaint, which the insurer handles in accordance with its internal complaints procedure (see Chapter 1C4). You may recall from the Compliance and Advice module that when the insurer completes its investigation of a complaint, it will issue a final response letter stating the outcome of the investigation and any redress offered. If the complainant (the insured) is unhappy with this response, they may refer their complaint to the Financial Services and Pensions Ombudsman (FSPO). A senior management figure should be clearly identified as the person who can 'sign off' that a complaint has been fully dealt with as far as the organisation is concerned. It is only at this stage that the FSPO will become involved.

E1 Financial Services and Pensions Ombudsman

The **Financial Services and Pensions Ombudsman Act 2017** led to the merger of the offices of the Financial Services Ombudsman's Bureau and the Office of the Pensions Ombudsman to form the Financial Services and Pensions Ombudsman (FSPO) which opened for business in January 2018.

Most complaints against insurers arise from claims issues. Many relate to situations where the insurer has turned down a claim, or offered an amount of money less than the claimant's expectations.

Microlearning resources

In the Member Area of www.iii.ie, via the Connect logo and in Your Learning Centre, select the microlearning section of this chapter to access a resource specifically developed to help you better understand this topic.

The role of the FSPO was considered in detail in the Compliance and Advice module. It deals independently with unresolved complaints from consumers about their dealings with financial service providers (FSPs). The office makes decisions on individual cases and has significant powers to change decisions by FSPs that it deems to be incorrect.

In practice, the FSPO aims to deliver a fast and efficient dispute resolution service for both the complainant and the FSP with the minimum necessary formality.

Informal methods including mediation (see Section E3) are the first and preferred options for resolving complaints. Immediately on receipt of a complaint, a dispute resolution officer will contact the complainant and FSP to establish the essence of the complaint and to try and resolve it by facilitating a solution that both parties can accept. Dispute resolution officers use a range of interventions including telephone conversations, email and voluntary mediation. This gives both parties the opportunity to develop a shared understanding of the complaint and to work towards a swift and fair solution. If the parties successfully resolve their dispute through this process they will sign a settlement agreement, the file will be closed and the terms of the settlement will remain confidential.

If the complaint is not resolved by the dispute resolution process it will progress to a formal investigation. The investigation process involves a consideration of the information and material collected and a preliminary decision being issued to both parties. This preliminary decision can only be challenged if there have been possible errors of law or if there are significant additional points of fact to be considered – it is not an opportunity to revisit the complaint. If the parties make no further submissions, a legally binding decision, in the same terms is issued and the file will be closed. If either or both parties make further substantive submissions, these are reviewed before the legally binding decision is issued.

Of necessity, the investigation process is more formal than the dispute resolution process and occasionally requires an oral hearing where evidence is taken on oath.

The FSPO decision is legally binding on both parties, with a right of appeal only to the High Court. Any such appeal must be made within 35 calendar days from the date of the FSPO's decision.

There is no limit to the amount of rectification that the FSPO can order, and financial awards up to €500,000 or an annuity payment of €52,000 can be ordered in compensation as per the **Financial Services and Pensions Ombudsman (Compensation) Regulations 2018**. As well as making a financial award, the FSPO has the power to order that any process deemed unacceptable is to be changed. FSPs need to take care that a major and very expensive systems review is not necessitated in order to establish a principle in a very minor complaint case. Anyone who refuses to co-operate with the FSPO faces fines or a period of imprisonment.

Under the **Financial Services and Pensions Ombudsman Act 2017**, the time limit for a consumer to make a complaint to the FSPO is six years. However, if the complaint relates to a long-term financial service, different time limits apply.

Under Section 25 of the Financial Services and Pensions Ombudsman Act 2017, the FSPO's 'naming and shaming' powers allow it to publish the names of those regulated FSPs they have made three or more adverse findings against in the previous year; if it is believed to be in the public interest.

It is believed that such reporting would incentivise FSPs to avoid adverse publicity, settle more complaints at an earlier stage, avoid recourse to FSPO and thereby, lead to an improvement in complaint management by FSPs.

Quick question 4

Other than making a financial award, state the other powers the FSPO has in reviewing an issue.

E2 Arbitration

Arbitration is a legally binding dispute resolution process used as an alternative to litigation. It is used by parties who want their dispute heard by a tribunal knowledgeable in the subject of the dispute instead of by the court. They may also wish the case and its outcome to remain private.

Many commercial insurance policies and most reinsurance contracts contain an arbitration clause stating that disputes will be arbitrated (rather than litigated through the courts), where, under what rules and the arrangements for appointment of the arbitrator(s). In the absence of pre-agreed rules, the parties may decide what procedures and rules to adopt. If the policy does not contain an arbitration clause, the parties may decide to arbitrate if they both agree. If the policy requires a dispute to be resolved by arbitration and it cannot be settled in the normal way (or using some form of ADR), then the parties are bound to go to arbitration rather than court.

As the arbitration clause in a contract is deemed a separate 'contract', it remains valid for determining a dispute, even if the policy or treaty is allegedly void.

Most courts will enforce an arbitration clause if one is present in the policy, and insist on its use before allowing litigation to proceed between the parties.

The **Arbitration Act 2010** confers considerable powers of litigation procedure and process to the arbitrators and to the parties. In Ireland, major arbitrations are frequently conducted following similar procedures to those in the courts, with full legal representation on each side. Arbitration is often neither quicker nor cheaper than litigation.

It is completely confidential, and the result does not set a precedent for future similar disputes, which may sometimes be attractive to one or both parties. The panel or tribunal deciding the claim or dispute usually consists of people knowledgeable in its subject matter, so that their decisions align with market practice and expectations. It should not generally be necessary then to present expensive expert evidence. A key to successful arbitration, therefore, is the choice of arbitrator(s).

E2a Friendly arbitration

Friendly arbitration is another method of dispute resolution that avoids litigation and saves on legal costs. It is used where two insurers are in dispute. The parties agree to be bound by the decision of the external expert with no appeal process. It is effective where the matter relates to a policy coverage issue or a policy wording interpretation. If the arbitrator needs clarification on any issue, they can clarify with the party.

For such cases, it is common to retain an industry colleague who has expertise in the area of dispute. Similarly, a leading junior counsel or senior counsel can be used. The parties may prefer to use this method for cases without a significant financial value, which is why they may agree to a binding, no-appeal outcome. It is also useful where the parties do not wish for a precedent to be created for similar situations.

friendly arbitration

informal process, entered voluntarily, using an expert to resolve a one-off specific issue, whereby the parties agree to accept the finding

E3 Mediation

Mediation is used in third party disputes or, by agreement, in disputes between an insurer and the insured. Agreements to mediate and 'mediation clauses' are beginning to appear in a number of policies and contracts. It is not necessary to have a prior contractual agreement in place in order to mediate.

The **Mediation Act 2017** recognises mediation in the Irish High and Commercial Courts and in the rules of the Superior Courts. It places the obligation to consider mediation on a statutory footing and requires plaintiffs to confirm to the courts that they have considered it.[31] It obliges solicitors to advise their clients (prior to issuing proceedings) to consider mediation and to provide information on mediation services. Solicitors are required to make a statutory declaration evidencing that these obligations have been properly fulfilled. This statutory declaration must accompany the Civil Bill or Summons.[32]

The mediator acts as a go-between and guides the parties to a choice of settlement by using a combination of reality-testing, 'what if' questions and suggestions, and an analysis of the parties' needs. Nothing confidential revealed at the mediation can subsequently be used in court proceedings.

The advantages of mediation are as follows:

- It is relatively inexpensive. In cases to be litigated or potentially litigated, the preparation costs will be incurred anyway, and only the mediator's fee and, usually, the costs of a day's hearing will be additional.
- Normally, it is relatively speedy.
- It is flexible about outcome and attempts to avoid win/lose outcomes.
- It allows for non-financial conclusions such as an apology, public retractions of allegations or agreement to go forward on a new basis.
- It preserves relationships.
- It is confidential and can prevent reputational damage.
- Even when unsuccessful, it can narrow the issues in dispute and give an appreciation as to how the courts may adjudicate its decision.

Its disadvantages are as follows:

- It can add to total costs if attempted at the wrong time.
- The process is non-binding and does not determine legal liability.
- The other party will hear the details of your case (although the process is confidential).
- Some reinsurers may be reluctant to provide reinsurance recoveries on the basis of a mediated agreement, seeing it as a compromise settlement and not one of liability.

[31] **Mediation Act 2017**, Section 14.

[32] **Mediation Act 2017**, Section 14.

F Summary

Throughout this textbook, we have followed the claim event from notification to finalisation. In this concluding chapter, we have examined relevant issues at the point of settlement. This is the culmination of the claims process and the moment where the insurer fulfils its promise of indemnity. We also identified the options for claimants and insurers where they are unable to reach agreement about the final outcome of a claim.

F1 Study tip

It is important to remember that this textbook is the primary information source for this module. All the questions in your exam will relate directly to information featured in the textbook.

F2 Online learning supports

Your Member Area includes a guide to success an automated study planner, an exam countdown timer and study tips guide. These study supports are invaluable in reinforcing what you have learned so far. The webinars, chapter-by-chapter key points and other supports will help you to break down the chapter's content when revising.

Remember: This module is examined by mixed assessment, which includes:

- An online mid-semester MCQ assessment (20 questions)
- An end-of-semester written exam paper (9 questions)

Given that your online mid-semester assessment is a multiple-choice question test, completing the online practice paper is the ideal preparation for this. You can prepare for the end-of-semester written exam and test your knowledge by completing sample and past written exam papers.

To access these online learning supports, just log into your Member Area on **www.iii.ie** and click on the **Connect** logo.

End of chapter questions

Use these questions to test your understanding of what we've covered so far in Chapter 7. It should be noted that these end of chapter questions are revision questions to test your understanding of the material in the chapter just studied. They are not sample exam questions.

1. State the difficulties insurers may face if they opt to settle a claim by reinstatement.

2. List an insurer's options when settling a claim for vehicle damage under a motor policy.

3. List four examples of first-party claims that can only be settled by making a monetary payment.

4. Explain the terms 'abandonment' and 'salvage'.

5. Outline the significance of the case of *Mark Rowlands Ltd v Berni Inns Ltd* (1986) in relation to an insurer's subrogation rights.

6. List the conditions that must be satisfied for contribution to arise.

7. In relation to the principle of contribution, identify when insurers are likely to use the independent liability method to calculate their rateable proportions of a claim payment.

8. For an insurer to make a recovery from a reinsurer, two basic requirements must be met. State these requirements.

9. State the maximum financial award that the Financial Services and Pensions Ombudsman can order a financial services provider to pay to a complainant.

10. Explain what is meant by 'friendly arbitration'.

Answers to end of chapter questions

Check your answers against those below and make a note of any points you left out. This will highlight some sections you may need to look at more closely during your revision.

1. The difficulties faced by insurers if they decide to reinstate are as follows:
   - The insurer becomes responsible for any problems that arise in the reconstruction process.
   - At common law, the insurer cannot limit its expenditure to the sum insured.
   - The insurer must reinstate within a reasonable time and failure to do so might make it liable to pay damages to the insured for loss of use.
   - The insurer becomes its own insurer during reconstruction.
2. Motor insurance policies provide three settlement options: payment, repair and replacement. The option chosen by the insurer depend on the extent of the damage.
3. Examples of first-party claims that can only be settled by making a monetary payment include business interruption, money, legal expenses and fidelity guarantee policies.
4. Abandonment means the action of giving up the subject matter to the insurer. Salvage refers to the right of the insurer to take over the subject matter of the insurance (e.g. a damaged car that has been declared a write-off).
5. The case involved a tenant who had contributed to the insurance premium for the buildings. A fire occurred, which was believed to be the fault of the tenant. The Court of Appeal ruled that the insurer could not exercise subrogation rights against the tenant, as the tenant, having contributed to the premium, was effectively considered by the Court to be a joint insured with the landlord.
6. Contribution arises when the following conditions are satisfied:
   - Two or more policies of indemnity exist.
   - Each insures the subject matter of loss.
   - Each insures the peril that brings about the loss.
   - Each insures the same interest in the subject matter.
   - Each policy is liable for the loss.
7. Insurers use the independent liability method for liability policies and for property policies that are subject to average or other conditions limiting full indemnity.
8. Reinsurers are only obliged to respond to claims from their reinsureds if the original claims are:
   - Settlements of liability or probable liability under the original policies, and
   - Properly and professionally arrived at, in a 'business-like manner'.
9. Financial awards up to €500,000 or annuity payment of €52,000 can be ordered. In March 2018, the Minister for Finance ordered a review of this award, but this has yet to occur.
10. Friendly arbitration is a method of resolution that aims to avoid litigation and saves on legal costs. It is often used where two insurers are in dispute. The parties agree to be bound by the decision of the external expert, with no appeal process. It can be effectively used where the matter relates to a policy coverage issue or a policy wording interpretation. If the arbitrator needs clarification on any issue, they can clarify with the party.

Answers to quick questions

1. Settlement of private health insurance claims always involves payment of money for medical treatment or other benefits specified in the policy. Payment is made to either the policyholder/member or to the healthcare provider.

2. None. The insurer has no subrogation rights in relation to *ex-gratia* payments. Subrogation arises only from payments made under the terms of a policy.

3. The reinsurers could refuse to deal with the claims, especially if they agreed to carry the reinsurance on the basis that flood cover would be refused on property damage policies issued in that area.

4. As well as making a financial award, the FSPO has the power to order that any process deemed unacceptable is to be changed. Under Section 25 of the **Financial Services and Pensions Ombudsman Act 2017**, the FSPO has 'naming and shaming' powers. The FSPO may, if it is believed to be in the public interest, publish the names of those regulated FSPs they have made three or more adverse findings against in the previous year.

Sample exam questions

Question 1

a) List the **five** conditions that must arise for contribution to apply.

(5 Marks)

b) Mike is a property owner and suffers a loss of €36,000. He has two insurance policies covering his premises with the following sums insured:

- €300,000 with Insurer A
- €150,000 with Insurer B

Calculate, using the maximum liability method, the amount each insurer will pay towards the loss. Clearly show your workings and formula used in your calculations.

(5 Marks)

Total: 10 Marks

Question 2

Explain how the concept of 'friendly arbitration' may be used to resolve a dispute.

Total: 10 Marks

Your answers

Sample answers

The answers set out below show the main points you must consider in answering the question. In some cases, a well-reasoned alternative view could earn good marks.

Question 1

a) Contribution arises when the following conditions are satisfied:

- Two or more policies of indemnity exist.
- Each insures the subject matter of loss.
- Each insures the peril that brings about the loss.
- Each insures the same interest in the subject matter.
- Each policy is liable for the loss.

(5 Marks)

b) $\frac{\text{Policy sum insured}}{\text{Total sum insured (under all policies)}} \times \text{loss}$

Insurer A pays:

$$\frac{€300,000}{€450,000} \times €36,000 = €24,000$$

Insurer B pays:

$$\frac{€150,000}{€450,000} \times €36,000 = €12,000$$

(5 Marks)

Reference Chapter 7C2 & C2b1 **Total: 10 Marks**

Question 2

Friendly arbitration is an informal process, entered voluntarily, using an expert to resolve a one-off specific issue. It's another method of resolution that avoids litigation and saves on legal costs. It is used where two insurers are in dispute. The parties agree to be bound by the decision of the external expert, with no appeal process. It can be effectively used where the matter relates to a policy coverage issue or a policy wording interpretation. If the arbitrator needs clarification on any issue, they can clarify with the party.

For such cases, it is common to retain an industry colleague who has expertise in the area of dispute. Similarly, a leading junior counsel or senior counsel can be used. The parties may prefer to use this method for cases without a significant financial value, which is why they may agree to a binding, no-appeal outcome. It is also useful where the parties do not wish for a precedent to be created for similar situations.

Reference Chapter 7E2a **Total: 10 Marks**

Referenced websites, legal cases and legislation

Study Tip

Do you wish to find a specific website, legal case, key term or legislation within this textbook?

You can do a quick find in the module eBook, which is available on **Connect** via your Member Area Login at www.iii.ie.

Websites

An Garda Síochána
www.garda.ie

Central Bank of Ireland
www.centralbank.ie

Data Protection Commission
www.dataprotection.ie

Insurance Confidential
www.insuranceconfidential.ie

Insurance Ireland
www.insuranceireland.eu

The Insurance Institute
www.iii.ie

Legal Services Regulatory Authority
www.lsra.ie

Met Éireann
www.met.ie

Personal Injuries Assessment Board
www.piab.ie

Legal cases

Allen v Gulf Oil Refining Ltd (1981)

Aro Road and Land Vehicles Ltd v Insurance Corporation of Ireland Ltd (1986)

Brown v Royal Insurance Co. (1859)

Canada Rice Mills v Union Marine and General Ins. Co. (1941)

Carreras Ltd. v Cunard Steamship Co. (1918)

Carter v Boehm (1766)

Castellain v Preston (1883)

Chariot Inns v Assurazioni Generali (1981)

Commercial Union v Hayden (1977)

Cope v Sharpe (1912)

Delaney v The Personal Injuries Board (2022)

Doherty v Bowaters Irish Wallboard Mills Ltd (1968)

Dunleavy v Swan Park Ltd t/a Hair Republic (2011)

Elcock v Thomson (1949)

Emma McKeown v Alan Crosby and Mary Vocella (2020)

England v Guardian Insurance Ltd (2000)

Etherington v Lancashire and Yorkshire Accident Insurance Company (1909)

FBD Insurance plc v Financial Services Ombudsman (2011)

J Rothschild Assurance plc v Collyear and others (1998)

Jabbour v Custodian of Israeli Absentee Property (1954)

Kelleher v Irish Life Assurance Co. Ltd (1993)

Leppard v Excess Insurance Co. Ltd (1979)

Leyland Shipping v Norwich Union Fire Insurance Society Ltd (1918)

Lucena v Craufurd (1806)

Macaura v Northern Assurance Co. Ltd (1925)

Mark Rowlands Ltd v Berni Inns Ltd (1986)

Marsden v City and County Insurance (1865)

Morrissey v Health Service Executive (2020)

Napier v Hunter (1993)

Napier v Kershaw Ltd. (1993)

Nolan v Wirenski (2016)

Pawsey v Scottish Union and National (1907)

Payne v Nugent (2015)

Philip v Ryan and Bons Secours Hospital (2004)

Platt v OBH Luxury Accommodation Limited & Anor (2017)

Re Wright and Pole (1834)

Renehan v T & S Taverns (2015)

Reynolds and Anderson v Phoenix Insurance Co. Ltd (1978)

Ryan v Ireland (1989)

Scottish Union and National Insurance v Davies (1970)

Shortt v An Garda Síochána (2005)

Smith v Baker (1891)

Smith v Colonial Mutual Fire Insurance Co. Ltd (1880)

Stanley v Western Assurance Co. (1868)

Superwood Holdings v Sun Alliance & London plc and Others (1995)

Tootal Broadhurst Lee Company v London and Lancashire Fire Insurance Company (1908)

Vance v Foster (1841)

Wilson and Scottish Insurance Corporation (1920)

Yorkshire Water Services Ltd v Sun Alliance and London Insurance plc (1997)

Legislation

Accidental Fires Act 1943

Arbitration Act 2010

Central Bank (National Claims Information Database) Act 2018

Civil Liability (Amendment) Act 2017

Civil Liability and Courts Act 2004

Civil Liability Act 1961

Consumer Insurance Contracts Act 2019

Court of Appeal Act 2014

Courts and Civil Law (Miscellaneous Provisions) Bill 2022

Criminal Justice (Spent Convictions and Certain Disclosures) Act 2016

Data Protections Acts 1988-2018

EC (Insurance Mediation) Regulations 2005

EU (Motor Insurance) (Limitation of Insurance in relation to Injury to Property) Regulations 2016

Financial Services and Pensions Ombudsman Act 2017

Financial Services and Pensions Ombudsman (Compensation) Regulations 2018

General Data Protection Regulations 2016

Insurance (Miscellaneous Provisions) Act 2022

Judicial Council Act 2019

Marine Insurance Act 1906

Mediation Act 2017

Occupiers Liability Act 1995

Personal Injuries Assessment Board (Amendment) Act 2019

Personal Injuries Assessment Board (Amendment) Act 2007

Personal Injuries Resolution Board Act 2022

Road Traffic Act 1961

Road Traffic Act 2016

Rules of the Superior Courts (No. 6) (Disclosure of Reports and Statements) 1998

Safety, Health and Welfare at Work Act 2005

Social Welfare and Pensions Act 2013

Acronyms

Organisations/bodies/regions	
Data Protection Commission	DPC
Department of Social Protection	DSP
European Union	EU
Financial Services Ombudsman	FSO
Financial Services and Pensions Ombudsman	FSPO
Financial Services Provider	FSP
Garda National Economic Crime Bureau	GNECB
Insurance Compensation Fund	ICF
Insurance Fraud Enforcement Department	IFED
Insurance Fraud Coordination Office	IFCO
Integrated Information Data Service	IIDS
Insurance Institute of Ireland	III
Insurance Ireland	II
Managing General Agent	MGA
Motor Insurers' Bureau of Ireland	MIBI
Personal Injuries Assessment Board	PIAB
Terminology	
alternative dispute resolution	ADR
automatic number plate recognition	ANPR
beyond economical repair	BER
common bench	CB
Consumer Protection Code	CPC
driving other cars	DOC
end of life vehicle	ELV
first notification of loss	FNOL
guaranteed asset protection	GAP
General Data Protection Regulation	GDPR
global positioning system	GPS
incurred but not enough reported claims	IBNER
incurred but not reported claims	IBNR
Justice (as little)	J
Lord Justice	LJ
Legal Services Regulatory Authority	LSRA
Minimum Competency Code	MCC
no claims discount	NCD
National Fleet Database	NFD
periodic payment order	PPO
personal public service number	PPSN
private investigator	PI
Recovery of Benefits and Assistance Scheme	RBA
special investigation unit	SIU
Statutory Instrument	SI
transcutaneous electrical nerve stimulation	TENS
third-party administrator	TPA
value added tax	VAT

Glossary of Key Terms

abandonment	legal situation where the salvage can be left in the hands of the insurer
ab initio	Latin term meaning 'from the beginning'. Used to describe where a policy is null and void, as though it never existed – *'void ab initio'*
accident report form	preferred term for a claim form used in motor and liability insurance(s)
act of God	term used to describe an accident or event resulting from natural causes, without human intervention
adequacy of sum insured	term used to examine whether the property is sufficiently insured in policies where the average condition applies
agency	a legal relationship where one party, the principal, grants authority for another party, the agent, to act on their behalf
agent	one who is authorised by a principal to bring that principal into a contractual relationship with another, a third party
aggregate deductible	a limit or maximum amount the insured can pay as deductibles on claims over a specified period
agreed additional costs	additional items or fees that may be covered under the policy
agreed value policy	insurance arrangement in which the value of an item insured is agreed in advance and (usually) a formula agreed for partial losses
alternative dispute resolution	various methods by which cases can be settled without resorting to the courts
apportionment of liability	the sharing of responsibility between parties to an incident
approved repairer	motor repairer that an insurer includes within a scheme to guarantee workmanship, labour rates and discounts on parts, and to reserve the right to reduce a policyholder's claim payment if they do not use the approved repairer
arbitration	a less formal but still quasi-judicial process whereby cases are heard by an arbitrator rather than a judge in court
arson	the deliberate act of setting fire to property
assessment	process by which a file is considered by PIAB, and a term for the damages award figure arrived at
'average' clause	a clause in an insurance policy stating that, where a sum insured is inadequate, a claim settlement is reduced in proportion to the percentage of underinsurance
barrister	a type of lawyer who specialises in court advocacy and the giving of legal opinion
betterment	any improvement in the value of a damaged building or other goods as a result of reinstatement or repair
business description	an overview of key points of your business
business interruption insurance	insurance that protects a commercial policyholder against loss of profits and other expenses following insured damage to their property
catastrophic injuries	very serious, life-changing injuries, e.g. paraplegia, quadriplegia and brain damage

Central Bank	financial regulatory body in Ireland responsible for the authorisation and supervision of financial service providers
chain of events	sequence of events that follow one from the other without anything new starting and influencing the outcome
civil law	term encompassing all the laws that deal with how individuals relate legally with each other, e.g. the law of contract, the law of torts, trust and property law, family law and the law of succession
claimant	person or entity making a claim
claim form	document designed to elicit from the policyholder all relevant information surrounding the circumstances of a loss caused by an insured event
claims investigator (inspector)	an individual who is skilled, experienced and qualified to investigate the circumstances of individual claims
'claims made' wordings	liability policy cover that is triggered when the third party (claimant) makes a claim against the policyholder
common law	system of laws that has been built up over centuries by judges deciding individual cases
concurrent causes	two or more perils operating at the same time (to bring about a loss)
concurrent wrongdoers	defendants jointly liable to a claimant
consent	defence (in torts law) that applies when the plaintiff agrees to a deliberate act by the defendant that would be a tort if no consent had been given
consumer	definition of the Central Bank in its Minimum Competency and Consumer Protection Codes: • a person or group of persons, but not an incorporated body with an annual turnover in excess of €3 million in the previous financial year (a group of persons includes partnerships and other unincorporated bodies such as clubs, charities and trusts), or • incorporated bodies having an annual turnover of €3 million or less in the previous financial year (provided the incorporated body is not part of a group with a combined turnover of more than €3 million) and includes a potential 'consumer'
Consumer Protection Code	code issued by the Central Bank of Ireland setting out requirements that regulated firms must comply with in order to ensure a similar level of protection for consumers
contemptuous damages	damages awarded when a court wishes to show its low opinion of the claim or of the plaintiff
contribution	the right of an insurer to share the cost of an indemnity payment among similarly (but not necessarily equally) liable parties
contributory negligence	a percentage reduction in damages when a plaintiff is found to be responsible in some way for the incident giving rise to the action
counsel	a barrister or other legal adviser conducting a case
counterclaim	claim made by a defendant, which alleges that they too suffered losses as a result of the incident and that they wish to claim against the original claimant for those losses
credit insurance	a type of commercial insurance that covers losses caused by unpaid debts

criminal law	term encompassing all the laws that apply to the control of behaviour for the benefit of society, the breach of which is usually punishable by fines or imprisonment
damages	financial compensation fixed by the court according to the seriousness of the injury or damage caused
data protection	term used to describe the individual's fundamental right to privacy of data kept in relation to them, and to their legal right to access and correct that data; also refers to the legal obligation by those who keep data to comply with data protection principles under the **Data Protection Acts and GDPR**
'day one' reinstatement	a means of countering the effects of inflation by providing an automatic increase in sum insured based on an accurate reinstatement sum insured on the first day of the cover
defendant	person or entity against whom a claim is made
delegated authority	authority granted to the agent of an insurer, usually in the context of a scheme arrangement, to issue policy documentation and possibly carry out limited underwriting and claims functions
desktop claims handling	form of claims handling that takes place without a visit to the scene of the accident and generally without face-to-face meetings with any of the parties, including the insured
discovery	legal process allowing a party to a legal action to seek specific information relevant to the claim
dual insurance	occurs when there is more than one active policy covering the subject matter of insurance
durable medium	any instrument that enables a recipient to store information addressed personally to the recipient in a way that renders it accessible for future reference, for a period of time adequate for the purposes of the information and which allows the unchanged reproduction of the information stored
efficient cause	the particular act that set about a specific effect
endorsement	a written document, usually incorporated within a policy wording, and referenced on the schedule, which modifies the policy in terms of the cover being afforded by the insurer
engineers	professionals of various disciplines who offer analytical services in the claims investigation
Excess (deductible)	first part of each and every claim that must be paid by the insured
excluded peril	cause specifically listed in the policy as not being covered
exclusion (exception)	policy provision that defines circumstances or types of loss that are not covered
***ex-gratia* payment**	claim payment made when there is no indemnity under the policy
expert witness	a witness called to give specialist evidence to help the court make a decision in a case
external expert	professional, e.g. solicitor, claims investigator or motor assessor, who is employed by an insurer on a per-claim basis but does not work directly for the insurer
fidelity guarantee insurance	a type of commercial insurance that covers the loss of money or property through fraud, theft or dishonesty by employees or other specified persons

Financial Services and Pensions Ombudsman (FSPO)	an office that deals independently and impartially with unresolved complaints from consumers about the conduct of a regulated financial service provider
first-party claim	any claim brought by the insured
first notification of loss (FNOL)	the centre or team that sets in motion the claims process once a claim has been notified
franchise	a minimum amount of loss that must be incurred before insurance coverage applies (similar to an excess except that once the amount of the franchise is exceeded, the whole of the claim is paid)
fraudulent misrepresentation	making representation with the intent to deceive, in the knowledge that it is false
frequency (of losses)	how often an event will (or is likely to) happen
friendly arbitration	informal process, entered voluntarily, using an expert to resolve a one-off specific issue, whereby the parties agree to accept the finding
general damages	court award for pain, injury, suffering and/or inconvenience
gross profit	the amount by which i) the sum of the amount of the turnover and the amounts of the closing stock and work in progress shall exceed ii) the sum of the amounts of the opening stock and work in progress and the amount of the uninsured working expenses (variable charges)
incurred but not enough reported (IBNER)	claims that have been reported to the insurer and, although the insurer has opened a case reserve within its books, the value of the case reserve proves to be inadequate in relation to final settlement
incurred but not reported (IBNR)	amount owed by an insurer to all valid claimants who have had a covered loss but have not yet reported it
indemnity	financial compensation sufficient to place the insured in the same financial position after a loss as they enjoyed immediately before the loss occurred
independent causes	causes arising separately without one leading to the other
independent liability	a method of contribution whereby the liability of each insurer is assessed as though its policy were the only one in force and is then shared in proportion to the independent liabilities of the two insurers
inner limit	an indicator of the largest payment that will be made under a specific insurance policy heading (expressed either as a monetary amount or a percentage of another limit)
innocent misrepresentation	exists where the statement is false, but there is no intention to mislead the other party
insurable interest	the legal right to insure arising out of a financial relationship recognised at law between the insured and the subject matter of the insurance
InsuranceLink	a database of past claimants, maintained by Insurance Ireland
Insurance Ireland	an industry body that represents Irish life and non-life insurers
insured peril	a cause that is listed in the policy as being covered
jointly and severally liable	where two defendants both have a liability and the plaintiff may pursue 100% of the obligation against either of them
judgment	written or spoken decision of the court

law of torts	a body of rights, obligations and remedies that is applied by courts in civil proceedings to provide relief for persons who have suffered loss or harm from the wrongful acts of others
Legal Costs Adjudicator	an independent and impartial person appointed by the Irish Government to assess legal costs incurred by an individual or company involved in litigation
legal interest	one that the law recognises and will support
legal expenses insurance	insurance to cover the cost of defending or pursuing certain civil actions
limit of indemnity	insurer's maximum liability for any one incident/claim (usually under the terms of a liability policy or section of a policy)
loss adjuster	expert in processing claims from start to finish (and appointed by the insurer)
loss assessor	expert in dealing with insurance claims, appointed by the insured to prepare and negotiate a claim on their behalf
loss of earnings	past and future financial losses arising from the claimant's inability to work as a result of the injuries suffered
loss ratio	the ratio of total losses incurred in claims plus adjustment expenses divided by the total premium earned
lost years	the time lost to a person's life if they are alive at the date of hearing but are thought likely to die prematurely as a result of the accident or illness suffered in the incident giving rise to the claim
managing general agent (MGA)	intermediary who has been given delegated underwriting authority by a risk carrier or insurer to accept risks on their behalf, and who may also act as a wholesaler to other intermediaries
mandatory injunction	court direction demanding a person do a particular thing
manufacturers' stock	relates to goods held by a manufacturer at various stages in the process
matching pairs and sets clause	refers to the exclusion of undamaged items in a pair or set such as a single earring or the couch in a three-piece suite
material fact	any fact that would influence an underwriter/insurer in either accepting or rejecting a risk and in deciding what terms to impose
maximum liability	means of apportioning losses where the contribution applies in proportion to the maximum amount of cover available under each policy
maximum indemnity period	a period of time chosen by a policyholder under a business interruption policy as the maximum time necessary for the business to recover to its future expected trading position
measure of indemnity	assessment of financial compensation that is appropriate to place the insured in the required financial position
mediation	informal method of dispute resolution involving the help of a neutral mediator, who helps the parties work out their own solutions to problems with no apportioning of blame or right and wrong
misrepresentation	untrue statement of fact, either innocent or fraudulent, made during negotiations
mitigation	reducing a loss by taking action to stop it or minimise its effect
motor damage assessor	a motor industry professional that inspects damaged vehicles to determine the extent of the damage, the repair costs and/or the vehicle pre-accident value

Motor Insurers' Bureau of Ireland	body set up between motor insurers and the government, which aims to ensure that innocent victims of road accidents are properly compensated in circumstances where no effective motor insurance is in force (uninsured or untraced vehicles)
necessity	defence in tort meaning that the act which is alleged to be a tort was carried out in order to avoid a greater evil
negligence	failure to take reasonable care in certain circumstances
negligent misrepresentation	misleading information or advice given by a professional person in the course of their business, and which is likely to be relied on by others
'new for old' cover	cover providing replacement of lost or damaged items with new equivalent versions
'new intervening act'	(*novus actus interveniens*) refers to a situation where the sequence of causation is broken and something entirely new happens to bring about the loss
nominal damages	token sum awarded in a case where there has been no real loss caused to the claimant
notice for particulars	legal document issued seeking more information about the claim being made
obiter dictum	('said by the way') something that is said usually as part of a judgment, which, though not binding, is often regarded as an important guide for future cases
obsolete buildings	old buildings, e.g. churches and mills, often of massive construction and no longer used for their original purpose
occurrence wordings	liability policy covers that are triggered when the incident occurs (which could be over a period of time)
operative clause	clause(s) that describes the standard scope of cover of each section of an insurance policy
partial loss	any loss other than a complete loss of the insured item
pecuniary insurances	those insurances that cover financial loss
periodic payments	payments made by agreement with the claimant from time to time having assessed the likely financial needs and in an effort to meet those needs in an appropriate way
personal data	any information about a living person, where that person either is identified or could be identified. It can cover various types of information, such as name, date of birth, email address, phone number, address, physical characteristics, or location data – once it is clear to whom that information relates, or it is reasonably possible to find out[33]
Personal Injury Guidelines of the Judicial Council	guideline principles governing the assessment and award of damages for personal injuries with a view to achieving greater consistency in awards
Personal Injuries Assessment Board (PIAB)	independent statutory body set up to assess compensation due to an injured party when someone else is to blame for the injury
policy condition	a provision in an insurance policy that must be complied with

[33] Data Protection Commission, Data Protection Basics, July 2019, www.dataprotection.ie.

policy limit	monetary amount establishing the largest financial payment that can be made under that policy
policy period	dates between which the policy is operative
privilege	the freedom to make statements in certain contexts, e.g. government and legal proceedings, that might otherwise be considered defamatory
prohibitory injunction	a court order to refrain from doing a particular act
proximate cause	main or dominant cause of the loss or the cause that is most powerful in its effect
public authorities clause	refers to cover provided for improvements that are forced on the insured by the requirements of the law
public liability cover	insurance that covers injury or death to anyone on or around the policyholder's property
public place	under the Road Traffic Acts, this is 'any place where the public have access with vehicles'
pure economic loss	a loss that is purely financial and not accompanied by any physical damage to the plaintiff or their property
pure indemnity	a strict application of the principle of indemnity
rate of gross profit	the percentage ratio of the insurance gross profit to the turnover
rateable proportion clause/condition	condition stipulating that the insurer will be responsible to pay only its share of the loss
regulated entity	a financial services provider authorised, registered or licensed by the Central Bank or other EU or EEA Member State that is providing regulated activities in the State
rehabilitation	medical or vocational intervention to try to improve the life of the injured person, with a view to returning them to normality, or as close to that as can be achieved
reinstatement	when a property is restored or rebuilt to the same condition as when new
reinstatement cover	provides cover for the cost of rebuilding or replacing the property to a condition similar to when it was new and to be no more extensive than prior to the loss
reserve	a stated amount that an insurer must have set aside to cover claims from current insurance policies and any other outstanding liabilities
respondent	a term used by PIAB referring to the defendant
salvage	what remains of the subject matter of insurance after an insured event where the insurer treats the claim as a total loss
schedule	tailored section (of a policy) that provides the policy number and all variable information about the policyholder, period, premium and subject matter, and highlights any special terms, conditions or exclusions that apply
severity (of losses)	the seriousness (size/consequences) of an event (also referred to as 'impact')
setting down	the date sought for the case to be heard

special category personal data	data that refers to a person's racial or ethnic origin, political opinions, religious or philosophical beliefs, physical or mental health, sexual life or sexual orientation, genetic and biometric data, and/or trade union membership.[34]
special damages	'out of pocket' expenses or quantifiable monies the plaintiff has lost as a result of the incident
statutory authority	a defence suggesting that the defendant was given a legal right to commit the wrong complained of
statutory instrument	a form of delegated legislation, which provides detailed rules that implement the more general provisions of a particular European Directives or Acts of the Oireachtas
striking out	occurs when a court dismisses an action and removes it from legal lists
subject matter of insurance	item or event insured (e.g. car, house, valuables, factory stock, or liability for acts of negligence)
subrogation	the right of an insurer, following payment of a claim, to take over the rights of the insured to recover payment from a third party responsible for the loss
suspensive condition	condition that, if breached, suspends the insurer's liability for the period of the breach
technical provisions (reserves)	reserves held so that assets are matched with known and estimated future claims liabilities and associated expenses
territorial (geographical) limits	those countries or territories where the policy cover will operate
themed inspections	inspections conducted by the Central Bank to ensure entities are meeting very specific aspects of the CPC
third-party administrator	an independent organisation engaged by an insurer to administer all or part of the insurance process on the insurer's behalf
third party claim	a claim brought against the insured party by a person or entity (party) that was not connected with the original policy
time limitation	the requirement to bring a legal action within specific time periods, e.g. the 2-year period allowed for injury claims
tort	a civil wrong
total loss (write off)	a judgement, by the insurer, that the value or repair cost of a damaged property exceeds the value of its policy
trespass	intentional interference with people, goods or land
turnover	income generated from the business at the business premises
underinsurance	policy that has been effected, requiring full value as the basis for cover but where a lower figure has been declared
uninsured losses	expenses such as a policy excess, car hire or loss of earnings that are not covered by an insurance policy
unliquidated damages	amounts of money that cannot be accurately determined until after an event has occurred

[34] Definition derived from Data Protection Commission (www.dataprotection.ie).

utmost good faith	the positive duty to voluntarily disclose, accurately and fully, all facts material to the risk being proposed, whether requested or not
value at risk	the total financial value of potential losses arising if the insured event occurs
verifying affidavit	a specific legal document furnished by each side in a case promising that the things they have alleged are truthful
vicarious liability	when one person is held liable for a wrong committed by another
volenti non fit injuria	a defence in tort, stating that if someone knowingly places themselves in a position where harm might result, they are not able to bring a claim against the other party
vulnerable consumer	a natural person who: a. has the capacity to make their own decisions but who, because of individual circumstances, may require assistance to do so (e.g. hearing impaired or visual impaired persons) b. has limited capacity to make their own decisions and who requires assistance to do so (e.g. persons with intellectual disabilities or mental health difficulties) Consumer Protection Code (Definitions)
waiver of subrogation	when the insurer agrees to give up its right to subrogation
warranty	term (in an insurance contract) that, if broken, automatically voids the contract as a whole from the date of breach
witness	any person who is in a position to give evidence about the circumstances of an incident or the losses that the claimant has incurred (or not)

Formulae

Rate of gross profit:

$$\frac{\text{Gross profit}}{\text{Turnover}} \times 100 = \%$$

Underinsurance:

The formula used for the application of average is:

$$\frac{\text{Sum insured at time of loss}}{\text{Value of risk at time of loss}} \times \text{Amount of loss} = \text{Value of loss}$$

Maximum liability method of contribution calculation

The formula used to calculate each insurer's contribution is:

$$\frac{\text{Policy sum insured}}{\text{Total sum insured (under all policies)}} \times \text{loss}$$

Independent liability method of contribution calculation

The formula used to calculate each insurer's contribution is:

$$\frac{\text{Independent liability}}{\text{Total of independent liabilities}} \times \text{loss}$$