BELL GULLY

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Ministry of Business, Innovation and Employment

Attention Financial Markets Policy: Building, Resources and Markets

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Submission in response to Insurance Contract Law Review Options Paper (April 2019)

This submission has been prepared by Bell Gully in response to MBIE's April 2019 Insurance Contract Law Review Options Paper (the **Options Paper**).

We are a leading New Zealand law firm with significant expertise and experience in the law relating to insurance contracts, and we welcome the opportunity to make submissions on the Options Paper.

We set out our views in relation to a number of the questions asked by MBIE in the Options Paper. In summary, we agree that it is timely that aspects of New Zealand's law relating to insurance contracts are reviewed. However, it is important to ensure that the costs and benefits of potential reforms are carefully considered and weighed against the status quo. It is critical that MBIE obtain and analyse relevant data and information from the insurance industry in respect of each aspect of the review before making any regulatory decisions.

In addition, it is important that any reforms are consistent with other parts of New Zealand's insurance contract law, so that each part of the law works cohesively rather than in tension. It is therefore important that MBIE consults widely in respect of any proposed regulatory decisions.

This submission has been prepared by David Friar, Glenn Joblin and Gabriella Garcia. The views in this submission are those of members of our firm involved in the review of the Options Paper. They do not represent the views of our clients.

We look forward to continued opportunities to comment on the detail of any proposed reforms as part of MBIE's review of our insurance contract law.

Yours faithfully
Bell Gully

David Friar / Glenn Joblin
Partner / Partner

Question 2: Options for disclosure by consumers

In our submission, the options presented by MBIE in relation to consumers' duty to disclose raise the following questions.

Should insurers be limited to specific questions?

The first issue is whether insurers should be required to ask specific questions of consumers, and only entitled to exercise a disclosure remedy if the consumer fails to answer the question correctly.

In our view, this issue should be determined by considering:

(a) Whether insurers are generally able to formulate specific questions in order to obtain the information they require; or

(b) Whether it is impractical for insurers to formulate specific questions in order to obtain relevant information.

We do not take a position on this issue. We submit that MBIE should closely review and analyse insurers' responses on this issue in order to assess whether it is practical to limit insurers' disclosure remedies to circumstances in which consumers answer specific questions incorrectly.

Assuming insurers are not limited to specific questions, what should the test be?

If insurers are not limited to asking specific questions, Option 2 proposes a test under which a consumer should be required to disclose what a reasonable person in the circumstances would consider to be relevant to the insurer. This mirrors the current approach in Australia, and can be contrasted with the current position in New Zealand, which requires the consumer to disclose all information that would influence the judgment of a prudent underwriter.

We support a change to Option 2, for the reasons set out in the Options Paper. In summary, Option 2 imposes a more reasonable expectation on consumers, as they cannot be expected to know what a prudent insurer would consider to be material. In our view, Option 2 will make it easier for consumers to understand what needs to be disclosed.

Assuming insurers are limited to specific questions, what should the test be?

If insurers are limited to asking specific questions, Option 1 proposes a test in which the consumer must take reasonable care not to make a misrepresentation. This reflects the position in England, and is a significant change to the current law in New Zealand.

We strongly submit that if insurers are limited to asking specific questions, then Option 1 should be modified, so that the consumer must not make a misrepresentation (rather than only applying if the consumer fails to take care in making a misrepresentation).

As currently proposed, Option 1 only requires a consumer to *take care* in answering the insurer's questions. It does not matter that the consumer provides false or incorrect information to the insurer in making a misrepresentation, as long as the consumer is careful in making that misrepresentation. We submit that, if insurers are limited to asking specific questions, it is reasonable to require consumers to provide correct information, whether or not they are being careful.

There are a number of reasons for this.

First, MBIE's proposed Option 1 effectively allows consumers to make non-negligent misrepresentations (also known as innocent misrepresentations) to insurers. But this is inconsistent with the remainder of New Zealand's law concerning misrepresentations, which makes parties (including consumers) liable for innocent or non-negligent misrepresentations. For

example, in respect of misrepresentation under the Contract and Commercial Law Act 2017, negligence and fraud are irrelevant in actions between the contracting parties whether they be for damages or cancellation of the contract. Sections 35 and 37 of the Act both confer remedies in contract for misrepresentation "whether innocent or fraudulent": Burrows, Finn and Todd *Law of Contract in New Zealand* (6th ed, LexisNexis, Wellington, 2018) at [11.2.7].

MBIE's proposed Option 1 would put insurers in a significantly inferior position in comparison to all other parties at law in New Zealand. In any other situation, if a party makes an innocent misrepresentation, this will give rise to an action in misrepresentation. However, under Option 1 as currently proposed, insurers will not be able to rely on an innocent misrepresentation by a consumer in respect of an insurance contract. In our submission, there is no good reason to have such a significant discrepancy between insurance contract law and other contract law, and to provide insurers with fewer remedies than others.

Second, MBIE's proposed Option 1 appears to be taken from the position in England, where insurance consumers must take reasonable care not to make a misrepresentation. However, the position in England in relation to insurance contracts is consistent with the position more generally in England, where parties cannot bring a claim in contract law for an innocent misrepresentation: Joseph Chitty and HG Beale *Chitty on Contracts* (33rd ed, Sweet & Maxwell, London, 2018) at [7-103]. In New Zealand contract law, by contrast, there is no distinction between innocent and negligent misrepresentation. Any test as to misrepresentation in respect of insurance contracts should reflect New Zealand's law more generally in relation to contracts, and not England's law, which has taken a different direction.

Third, a duty on consumers to take reasonable care will require an insurer to prove not only that false or incorrect information was provided by the insured, but that the consumer failed to take reasonable care in providing that information. It is likely to be challenging and costly for insurers to prove that a customer has acted unreasonably. An insurer will be required to investigate an insured's actions, review what the consumer did and compare that against the standard of a reasonable consumer, and seek to prove that the consumer was unreasonable if there is a dispute. These are all additional costs that are likely to be borne by insurers, and ultimately passed on to other consumers.

Use of medical records to underwrite

Option 3 proposes the use of medical records to underwrite. In our submission, this Option should not be pursued. While medical records may be a useful tool to insurers in specific situations, we submit that it would be difficult and costly to require insurers to utilise records in all cases. There are likely to be significant practical difficulties in respect requiring insurers to underwrite based on medical records in all cases:

- Patient records may not be centralised if patients have received treatment through multiple providers.
- There may be situations where medical records are not available at all, such as where insureds are new migrants or records have been lost.
- There is likely to be flow on effects for medical practitioners and their administrative costs.
- Insurers would be required to manually review potentially long medical record documents.
- The direct and indirect costs to insurers of obtaining and reviewing the records are likely to be high.

Additionally, as the Options Paper notes, this option would only address non-disclosure in situations where an issue is actually addressed in the medical records. It does not address non-disclosure in other circumstances, and so could not be a complete answer to the question of non-disclosure in any event.

Question 3: Should insurers be required to warn of the duty to disclose?

We support an obligation on insurers to warn consumers of the duty to disclose (and the consequences of failing to disclose) in writing, such as in the proposal form and/or policy document. We understand that this is consistent with current industry practice. The proposed option is limited to disclosure in writing, and we submit that it is important to ensure that the proposed reform is expressed in this way.

Question 4: Should insurers be required to advise of third party information access?

Insurers have general obligations under the Privacy Act 1993 in respect of obtaining personal information from other sources. We submit that no additional obligations are required.

In particular, we submit that a statutory requirement that insurers inform consumers about whether and when they will access third party records is likely to be impractical and offer little benefit to insureds.

This is because every application for cover by an insured is different and will need to be assessed on a case-by-case basis. It is unlikely that insurers will be a position to advise insureds upfront as to what third party information will be required, when it will be required and whether it will ultimately be used as part of an underwriting decision. As a result, it is likely that insurers will be required to disclose any decision to access third party information on a rolling basis. This would create additional steps in the underwriting process, delay the assessment of applications, and increase costs with little identifiable benefit to insureds.

Questions 5-7: Should there be similar disclosure obligations in respect of businesses?

In our view, this should be driven by a consideration of the same issues we have addressed in respect of consumers, and in particular whether, as a general matter, it is practical for insurers to ask specific questions in relation to insurance offered to businesses.

In our view, there is much to be said for consistency of the law as it applies to all insureds, if that is possible. However, if the data and information provided by insurers suggests that it is not possible to ask specific questions of businesses in such a way as to obtain the information required, then we would support a different duty in respect of businesses.

If is practical for insurers to ask specific questions, then we support Option 3 for businesses (the same as for Option 1 for consumers), modified to ensure that there is a duty not to make a misrepresentation (rather than a duty to take reasonable care), for the same reasons set out in relation to consumers.

If is not practical for insurers to ask specific questions, then we support Option 1 for businesses (similar to Option 2 for consumers).

Question 8: What remedy should apply for non-disclosure?

We do not support the current position, which allows insurers to avoid a contract in all circumstances where there is material non-disclosure (even if it would have had no effect on the decision to offer cover).

In our submission, any reform should encompass parts of each of the three options presented by MBIE for consideration. In particular:

(a) We agree with a remedy that allows an insurer to apply proportionate remedies as set out in Option 1. This effectively allows the insurer to re-underwrite for a material non-disclosure, by (for example) varying the terms, offsetting the claim amount by the higher premiums that would have been changed, or avoiding the policy if the insurer would never have entered into the policy. However, Option 1 appears to limit the circumstances in which this remedy can

be exercised. In our submission, and in accordance with Option 3, this re-underwriting remedy should be available to the insurer in all cases of material non-disclosure, including for intentional misrepresentations and innocent misrepresentations.

(b) We also agree that, in addition to re-underwriting, the insurer should also been entitled to avoid the insurance contract for intentional non-disclosure as set out in Option 1. In our view, the importance of deterring intentional non-disclosure means that this remedy should be available in all cases of intentional non-disclosure (although we expect that it will be exercised rarely, given the difficulties of proving such a claim).

Question 9: Unconnected claims

While we agree that any non-disclosure must be material in order to exercise a re-underwriting remedy, materiality should be assessed by asking whether the non-disclosure would have made a difference to the insurer's decision to offer the policy on the terms that it did, even if it would not have made a difference in respect of the particular claim at issue. Otherwise, there will be an incentive for insureds to withhold information from insurers when obtaining cover in the hope that, even if the information would have been relevant to the insurer's decision to offer the policy, it may not specifically relate to a later claim. That would allow the insured to make a claim despite their failure to comply with their disclosure obligations, and therefore give an incentive not to disclose when seeking cover.

In respect of intentional non-disclosure, we submit that an insurer should be entitled to avoid the policy whether or not the fraud was material, given the important of deterring fraud.

Questions 10-11: Other remedies

In our submission, it is important to ensure that there are remedies available for non-disclosure. Accordingly, we support the availability of remedies where there is no claim, and in respect of past claims, as set out in the Options Paper.

Question 12: Contract and Commercial Law Act 2017 (CCLA)

We submit that it is critical that the law relating to insurance contracts is consistent with the CCLA. For this reason, Option 1 in relation to disclosure should be amended to apply to all misrepresentations, and not just negligent misrepresentations.

Section 35 of the CCLA provides for a remedy in damages for a misrepresentation. The overlap between this section and any proposed remedies in the Options Paper will need to be considered carefully and addressed. Likewise, there are other sections in the CCLA, such as section 37 (which provides for a remedy in cancellation for a misrepresentation) that may also overlap and will need to be considered.

However, it is not clear that it is as simple as saying that these sections of the CCLA do not apply to insurance contracts. For example, what if the law is amended to require insurers to ask specific questions only (with disclosure remedies only in relation to those specific questions), but where an insured makes a misrepresentation separately to its answers to those questions that induces the insurer to enter into the insurance contract? We would submit that there should be a remedy available to the insurer in such circumstances.

Further work will be required in relation to overlap with the CCLA once a preferred reform option is selected.

Question 13: Insurance Law Reform Act (ILRA)

We submit that the provisions in the ILRA relating to avoidance of life policies for misrepresentations should be abolished, and that the proposed reforms should apply to life policies.

Questions 14-15: Reform of Unfair Contract Terms (UCT)

We submit that the current position in respect of insurance exceptions to the UCT regime should be retained.

As an initial matter, it is important to note that the insurance exceptions to the UCT regime only carve-out only certain specific terms. The regime does not exclude insurers or insurance contracts as a whole.

The terms that are currently carved out were considered by Parliament to be critical to insurers' assessment of risk and reflect the unique nature of the operation of insurance contracts. These may be standard policy terms that arguably do not define the main subject matter of an insurance contract per se (and so do not automatically fall under the standard UCT exceptions), but which are central to an insurer's ability to assess the risk, accurately price it, manage the risk over the life of the contract, and efficiently settle any claims. For example, terms imposing ongoing disclosure obligations and providing remedies where there has not been proper disclosure of matters relevant to the risk / scope of cover / claim and terms; permitting an insurer to adjust cover if the risk changes during the life of the policy; etc.

Insurance contracts differ from other types of contracts in that in order to operate, insurers need to have a clear understanding of the extent of risk they are taking on. Insurers attempt to define the parameters of risk, and price them accordingly, through the terms of the insurance contract. Such terms include exclusions, which may be used to ensure that insurance is only covering unforeseen claims, and ensure that all consumers in the pool are treated equally. Premiums are then priced based on these factors.

It is important to understand that the insurance contract is the product itself, and so differs from other types of products. Insurance policies can be contrasted with, by way of example, gym memberships (where use of the gym is the product, and the contract simply sets the terms relating to the product) and phone networks (which the particular phone and use of the network is the product, and the contract again simply sets the terms). By way of contrast, the product is the insurance contract itself, and the terms of that contract are integral to the very product itself.

Unlike other standard form consumer contracts, in assessing the insured risk an insurer is dependent on the accuracy, completeness, and honesty of the information provided by the insured at commencement and during the life of the contract. That is, there is a significant information asymmetry for insurers even where the value of the insured risk is large (e.g., house and contents cover, liability to pay income protection for a long period if an individual suffers an insured illness comparatively early in life).

If terms are later found to be unfair, this will have a retrospective effect on the appropriateness of the premium already addressed and determined by the insurer. If insurers are unable to accurately price risk, they may cease to offer cover or increase premiums to cover the risk that they may not be entitled to reply on the terms of cover. Accordingly, the insurance-specific exceptions to the UCT provisions are necessary to protect the legitimate interests of insurers. They are also in the interests of consumers, as insurers may decide not to offer cover (or to provide cover at a price for which consumers may not want to pay).

Further, the availability of cover in New Zealand depends materially on the provision of reinsurance by overseas reinsurers to local insurers. The capital of reinsurers is mobile and sensitive to uncertainty, risk, and return. Reinsurers typically approve the terms of policies provided by insurers and may not be obliged to meet claims where an insurer has provided cover outside of the scope of the policy (or procedures) approved by the reinsurer.

Finally, we note that that MBIE is considering self-enforcement of UCT provisions for standard form contracts, as referred to at paragraph 74, footnote 7 the Options Paper. We submit that consumers should not be enabled to bring actions under the UCT provisions in respect of insurance contracts. It would mean that whenever there is a dispute between an insurer and a consumer over a decision to decline cover, the consumer will also have the option of arguing that the exclusion relied on by

the insurer is unfair. This will lead to a significant increase in costs and uncertainty, with the potential for significant litigation. This will all be a cost to insurers and, ultimately, to all consumers by way of increased premiums. In our submission, this cost is not justified.

Question 16: Understanding and Comparing Policies

We have a number of overlapping concerns that to the five options presented by MBIE in relation to understanding and comparing policies:

- Policy wordings are legal contracts. It is critical to have precise wording. Plain language interpretations may dilute the clarity and effectiveness of policies from a legal perspective. For example, in *Tower Insurance Ltd v Skyward Aviation 2008 Ltd* [2014] NZSC 185, William Young J (on behalf of the Court) stated that the "plain-English style" policy in question made for "some difficulty in terms of analysis and description" (at [12]).

- It is inherently challenging to accurately translate complex insurance terms into plain language, especially where complex medical terms are involved.

- Plain language policies are likely to still be long. For example, Australia requires plain language product disclosure statements for insurance products. These are often 90+ pages long. They result in high costs and impose significant compliance obligation on insurers. We question the extent to which such statements actually assist in helping consumers understand their cover.

- It is difficult to determine what terms are "core" or should be included in a summary statement. Insurance policies differ in their wording, and are further modified by specific exclusions or endorsements. Premiums generally reflect the level of risk that the insured wants cover for (e.g. basic cover versus premium cover). In our view, it is very difficult to accurately summarise a policy in a way that captures all of the relevant details of cover without referring back to the policy wording.

In summary, attempts to convert insurance wording to "plain" language, to define the "core" policy wording, to provide a "summary" statement, or disclose "key" information are likely to come at a high cost to the industry, with little benefit to insureds.

We also submit that it is impractical to require insurers to work with third party comparison platforms:

- The format of third party comparison platforms is not easy to apply uniformly across the insurance industry, as different types of policies vary in terms of complexity.

- Definitions are not consistent between insurance providers, and a comparison platform is unlikely to be nuanced enough to detect when there are differences between definitions and other terms.

- Current comparison websites provide limited information about insurance products themselves, and are limited in the extent to which they have the ability to take a customer's personal circumstances into account.

Questions 17-19: Should insurers be deemed to know matters known by intermediaries?

Section 10 of the Insurance Law Reform Act 1977 provides that an insurer is deemed to have notice of matters known to a "representative" of the insurer, and that a "representative" of the insurer includes any person entitled to receive a commission from the insurer.

MBIE has asked whether it is unreasonable for the insurer to bear the cost of an intermediary's failure to pass on information on the basis of an entitlement to commission.

Section 10 was introduced as part of the Insurance Law Reform Bill, which came into force in July 1977. In reviewing the Bill, the Contracts and Commercial Law Reform Committee reported in July 1975 that clause 10 was directed towards insurer representatives such as a "commission agent or a clerk behind the counter of the company's office".

As recognised in the Options Paper, intermediaries are paid a commission by an insurer, even if that intermediary is a broker selected by the insured to arrange insurance on behalf of the insurer, and even if the broker is not closely associated with by the insurer. These intermediaries are caught by section 10 on the basis that of being entitled to a commission, despite the fact they are not an agent of the insurer, a clerk behind the counter, or otherwise closely connected with the insurer.

The Contracts and Commercial Law Reform Committee report noted that intermediaries, when filling out proposal forms based on information provided by a customer, may not relay all the relevant information on to the form (and therefore to the insurer), allowing insurers to rely on non-disclosure. If the intermediary was not an agent of the insurer, this would allow the insurer to take advantage of "the wrongful act of its employee". The Committee therefore considered that persons employed or retained by the insurers should when completing proposal forms and like documents and generally in relation to the negotiation of a contract of insurance should effectively be regarded as agents of the insurer not the insured.

In a more modern context, the mischief which section 10 was designed to overcome has been described as "the avoidance of contracts by insurers where an insured had made full and accurate disclosure to a person negotiating the contract and receiving commission, or some other form of consideration, from the insurer but who was, at law, the agent only of the insured": *T&G Processed Foods Ltd v Hawk Packaging Ltd* [2019] NZHC 643 at [219].

We do not take a position in relation to the options for reform. We submit that the relevant considerations that MBIE should take into account in evaluating whether to reform the law in relation to intermediaries include:

- The extent to which the adviser model within the industry has shifted from a system where advisers were tied to insurers (with insurers providing systems, processes, training and administrative support) in the late 1970s to a system with many different models for distributing insurance, with a number of different types of intermediaries today.

- The extent to which section 10 provides an important customer protection function that should be retained, and whether customers will have the benefit of other sources of protection in any event (such as under the new financial advice providers regime in the Financial Services Legislation Amendment Act 2019).

Question 20: Unrelated exclusion

We support a further review of potential law reform options in relation to unrelated exclusions, for the reasons set out in the Options Paper and by the Law Commission.

Questions 21-22: Late claims

We support reform of the law in relation to claims made policies, for the reasons set out in the Options Paper and by the Law Commission.

Questions 22-23: Third Party Claims

Section 9 of the Law Reform Act 1936 provides for a charge over insurance proceeds in certain circumstances for the benefit of a person who has been wronged by the insured. The effect of the section on liability policies, as interpreted by the Supreme Court in *Steigrad*, is that the charge may prevent the insured from accessing their cover for defence costs under the policy, in order to allow the person wronged by the insured to access the insurance proceeds.

This raises two competing policy concerns:

(a) First, the insurance policy is taken out by the insured for the benefit of the insured, including so that the insured has cover for their defence costs if they are sued. The section as interpreted by the Supreme Court does not reflect this purpose. Indeed, it has the effect of potentially leaving the insured with no cover whatsoever for defence costs but with funds to pay a third party if that party brings a claim against them, meaning that by taking out insurance, the insured provides an incentive for a third party to being a claim but without any protection in the form of defence costs cover for the insured.

(b) Second, if there is no charge, then the insured can exhaust all of their insurance policy in paying for defence costs, leaving nothing to pay the wronged party if successful. This is illustrated by the facts of *Steigrad*. The directors of Bridgecorp had taken out $20 million in cover under a directors and officers policy. Bridgecorp investors (thought the receiver) sued the directors for breach of their duties as directors. In the absence of a charge, the directors may have exhausted their entire insurance cover in defence costs, leaving nothing for Bridgecorp investors – even if those investors were successful in their claim. The Supreme Court's decision meant that the $20 million was instead available for investors.

We do not make any submission on which policy should prevail. The reform option in the Options Paper gives priority to the first policy, while section 9 as currently expressed gives priority to the second policy.

We make the following comments as to the operation of section 9 in the insurance market following the Supreme Court's decision in *Steigrad*:

- New Zealand insurers now typically offer two liability policies to insureds: a traditional policy and a defence costs only policy. In our view, this has addressed the concern that insureds may not have access to defence costs. However, it has come at a cost. Insureds now need to take out two polices rather than one, and the allocation of cover between liability and defence costs when taking out the cover means that there are effectively sub-limits on each where none existed before.

- There is a discrepancy between the position that applies to New Zealand insurers under the Supreme Court's decision in *Steigrad* (who need to offer a defence costs only policy to address section 9) and the position of overseas-based insurers under the Court of Appeal's decision in *Bridgecorp Ltd (in rec and liq) v Certain Lloyd's Underwriters* ([2014] NZCA 571, [2015] 2 NZLR 285). In that case, the Court of Appeal said section 9 does not apply to overseas insurers, even if the insured is in New Zealand. This means that, under the law as currently stated by the Court of Appeal, insureds do not need to pay for defence costs only policies if they insure offshore, but do if they insure in New Zealand. In our view, this discrepancy is unfair. Whether section 9 remains as currently expressed or whether it is reformed as proposed, it should at least be amended to apply to all insurers offering cover to insureds in New Zealand, whether or not the insurer is based in New Zealand.

- We do not consider that the remaining points raised at paragraph 147 of the Options Paper to require reform of section 9.

Question 26: Duty of utmost good faith

We strongly submit that the status quo should be retained in respect of any duty of utmost good faith.

The Options Paper cites Justice Gendall's decision in *Young v Tower* to say that, at common law, the duty is an implied term of the insurance contract, that it applies to claims handling, and that it can give rise to a claim in damages.

However, the decision in *Young v Tower* has not been considered by the Court of Appeal or Supreme Court. It is by no means clear that such a duty does apply in the way expressed by Justice Gendall. Indeed, there is a long line of authority in which the New Zealand Courts have specifically declined to rule that such a duty applies: see, for example, *State Insurance Ltd v Cedenco Foods Ltd* (CA 216/97, 6 August 1998 at 2), where the Court of Appeal declined to rule on the point, and *Pegasus Group Ltd v QBE Insurance (International) Ltd* (HC Auckland CIV-2006-404-6941, 1 December 2009) in which Justice Winkelmann stated that it remained unclear as to whether insurers hold a contractual duty of good faith and, if so, what the content of that duty is.

Indeed, such a duty would be inconsistent with the common law relating to insurance contracts as expressed in England, where the Courts have held that an insured has no claim for damages in a claim for breach of the duty of good faith: *Drake Insurance plc v Provident Insurance plc* [2003] EWCA CIV 1834. The obligation of good faith in the insurance relationship has traditionally been found by the Courts not to be an implied term of the contract, but an obligation which the common law imposes as an incident of the relationship between the parties to the insurance transaction (e.g. *Banque Financiere de la Cite SA (formerly Banque Keyser Ullmann SA) v Westgate Insurance Co (formerly Hodge General & Mercantile Co Ltd)* [1991] 2 AC 249 (HL)). There is no authority to support the wide-ranging obligations which the Court sought to imply into every insurance contract in *Young v Tower*.

Further, if a duty of good faith is codified, this would the status quo in relation to the duty of disclosure for insureds (which forms part of the duty of utmost good faith). Codifying any duty would therefore be inconsistent with the concerns identified by MBIE in respect of the duty of disclosure, as well as its proposed options for reform.

Indeed, by codifying the duty of good faith in respect of the duties on an insurer (as set out in *Young v Tower*), while reforming the duty of disclosure as set out in MBIE's Options Paper, MBIE would be narrowing the duty in respect of obligations on an insured (in relation to disclosure), and broadening it for insurers (in relation to claims handling). We submit that this is not justified.

Finally, we submit that a statutory duty of good faith is likely to be inherently vague and nebulous, and will result in an increase of litigation before the Courts. We consider that this is likely to result in an increase of costs to insurers, which will ultimately be passed on to insureds.

Accordingly, until an appellate court has ruled on whether such a duty applies, we submit that it would be premature for MBIE to propose that duty be codified. Instead, the development of the common law in relation to the duty of utmost good faith is best left with the Courts.

Questions 26-30: Other issues

We support the consolidation of the statutory provisions relating to insurance contracts into marine and non-marine insurance statutes.

We support the repeal of redundant provisions, but we submit that there should be a careful review of provisions said to be redundant, as a number may still have some application.

We make no submissions in relation to the remaining miscellaneous issues identified in the Options Paper at paragraphs 164 to 166.