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Cover to Cover

Issue 34

Our publication for New Zealand insurance professionals

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Welcome to our final issue of Cover to Cover for 2025.

In this edition, we explore a number of recent developments shaping the insurance industry.

We report on a recent meeting with professional indemnity insurers in London. While our previous discussions with them centred on the growing impact of cyber events, this year, risks arising from the increasing use of artificial intelligence or AI tools dominated the conversation.

We examine the implications of the Resource Management (Consenting and Other System Changes) Amendment Act 2025, which marks a significant shift in how environmental liability is managed and insured in New Zealand.

We provide insights into the Reserve Bank of New Zealand's proposed reforms to the Insurance (Prudential Supervision) Act 2010. These changes aim to move from a light-touch approach to a more proactive, risk-based regulatory framework, aligning New Zealand more closely with international standards such as Europe's Solvency II.

Following our previous coverage of the Contracts of Insurance Act, we offer the first of three deeper dives into its key provisions, including a closer look at the two new duties of disclosure and the introduction of a new third-party claims regime.

We look at some perennial issues in business interruption insurance and some guidance from recent caselaw.

A case study features a significant ruling from the Court of Appeal of England and Wales which clarified the treatment of furlough payments in COVID-19 business interruption insurance claims.

We conclude with an analysis of a case involving claims for loss of aircraft in Russia as a result of the conflict in Ukraine. *Aercap Ireland Ltd v AIG Europe SA & Ors* [2025] addresses the issue of when insured property may be considered "lost" when its location is known and its recovery remains a possibility.

We hope you find this issue of Cover to Cover insightful and thought-provoking. If any of the topics resonate with you, we'd be delighted to continue the conversation.

Andrew Horne
Partner

AI risks:

What do insurers want to know about your use of AI?

Authored by Partner Andrew Horne

Last month, we visited some of our professional indemnity insurers, in London. These visits are always interesting. As well as an opportunity to maintain important relationships, they offer us a window into what insurers are thinking about and what risks they are concerned about. Their focus is often on new risks, in part because they wish to learn about them, but also because they want to make sure their insureds are aware of them and are managing them appropriately. Discussions such as these are also useful for insureds, to help them to become aware of and manage new and developing risks.

When we last visited, our insurers were focused on cyber risk, which was understandable given the increasing frequency and severity of cyber events. This year, all the insurers wanted to talk about artificial intelligence or AI.

Our firm has been investing in AI-assisted legal tools since 2017, when we co-founded and invested in a legal technology company, McCarthyFinch, which created AuthorDocs, an AI-based legal drafting tool. This initial collaboration led to the development of further AI tools before McCarthyFinch was sold to a global legal management software provider. In 2023, we created an in-house gen-AI based chatbot named AIME. We are increasingly using external AI tools as well.

For insurers, this technology shift presents opportunities which we have talked about in previous editions of Cover to Cover, such as automating customer on-boarding, queries, claims, complaint responses and insurance broking. For professional services firms, it offers similar opportunities to automate and derive efficiencies from manual processes. However, it also presents risks and challenges. Insurers must ask: when a customer says "we use AI", what exactly is happening, what could go wrong, how could it result in liability, and how should that feed into risk acceptance and pricing? These concerns are not unique to insurers of professional services firms.

What insurers are looking for

We found that insurers were interested in two things in particular:

- Whether professional services firms are using AI without properly checking and verifying the outputs. Are they using it only as a useful tool, or crossing the line to allowing it to generate work product which they rely upon?
- Whether professional services firms are using confidential client data in AI tools they do not fully control. Is there a risk that client information could fall into the hands of the wrong people, or be used to educate or build an AI model in a way that risks the release of information to competitors or others?

Use of AI without proper checks

The recent New Zealand case of *Wikeley v Kea Investments Ltd* [2024] NZCA 609 illustrates the risk of using AI without a sufficient human review, with the following commentary in a footnote:

We note Mr Wikeley's original memorandum in response dated 10 September 2024 which Mr Wikeley withdrew after the apparent use of generative artificial intelligence in its drafting was drawn to our attention by respondent counsel. The use of generative artificial intelligence was not initially disclosed by Mr Wikeley, but was evident from the references to apparently non-existent cases. No further comment is necessary except to note the relevant guidance recently issued by the judiciary: Guidelines for use of generative artificial intelligence in Courts and Tribunals: Non-lawyers (Artificial Intelligence Advisory Group, 7 December 2023).

Mr Wikeley was a self-represented litigant (i.e. he had no lawyer), a class of persons who increasingly use AI to draft legal documents and who are unlikely to be insured for the consequences. Of more concern from an insurance perspective are qualified lawyers who do the same. A number of examples have emerged from the USA, but also in common law jurisdictions such as England and Wales. In *Ayinde v The London Borough of Haringey and Al-Haroun v Qatar National Bank* [2025] EWHC 1383 (Admin), two otherwise unrelated cases were referred to a Divisional Court of the King's Bench because the lawyers involved in each of them were suspected of having used AI to prepare legal documents without having carried out proper checks. The cases were referred under the Court's power to regulate its own procedures and enforce duties that lawyers owe to the Court.

The judgment begins by discussing lawyers' duties to the Court in relation to the use of AI, and sets out the various breaches of ethical obligations the improper use of AI can involve and the sanctions that may be imposed. It then discussed the circumstances of each case. In Ayinde, a lawyer cited in argument five case authorities that did not exist, suggesting that they were the result of 'hallucinations' that AI tools are known to create. The Court also noted the use of American-style language which it also took as an indication that an AI tool had prepared the submissions. A wasted costs order was made and the lawyer – who unwisely denied using AI and made further misleading statements in an attempt to extricate herself – narrowly missed facing contempt proceedings, primarily because of her youth and inexperience. In Al-Haroun, the first instance judge found that correspondence and witness statements provided by a lay client to his lawyers made numerous references to cases that did not exist, or where they did exist, cited them for propositions they did not support.

> "What exactly is happening, what could go wrong, how could it result in liability, and how should that feed into risk acceptance and pricing?"

The lawyers admitted they had used the material provided by the client without checking it. The Court referred them to the Solicitors Regulatory Authority for further investigation. Amusingly, the judgment concludes with a list of similar cases from a number of jurisdictions, including Wikeley.

This sort of thing is not limited to the legal industry. In Australia, it was recently reported that Deloitte Australia will partially refund AUD440,000 that the Australian Government's Department of Employment and Workplace Relations had paid for a report that was littered with apparent AI-generated errors, including a fabricated quote from a federal court judgment and references to non-existent academic research papers. The report was published on the Department's website in July 2025, but a revised version was published in October 2025 after a Sydney University researcher alerted the media that the report was "full of fabricated references." In fairness, Deloitte reported that their use of AI had been disclosed and their conclusions did not change when the errors were corrected.

Where lawyers or other professionals use AI tools to generate work product without adequate checking, the outcome will often be limited to embarrassment and regulatory action against the individual or firm. Where professionals use AI improperly for other substantive work, however, the consequences may be much more serious for both the professional and the client. Where a lawyer improperly uses AI to prepare important advice upon which a client relies, for instance, this could result in a substantial liability claim. An accountant or auditor could become liable for loss suffered by a client due to financial mismanagement, or an engineer or architect could face liability for works that failed or required remedy because of design defects. It is not surprising that insurers are interested in knowing whether insureds appreciate the risks and what they are doing to manage those risks.

Use of AI with confidential or legally privileged information

Confidentiality is also at risk from the improper use of AI. Generative AI systems require access to extensive volumes of data to 'train' their models. Some of this data is obtained from the information that users enter into the systems. This presents obvious risks where the information is confidential. While the information itself may not be made available verbatim, or in its entirety, it may inform the responses the AI model gives to other inquiries in a way that reveals the confidential information.

Even widely used and reputable AI tools are susceptible to this. As it is inherent in the nature of the tools, the providers of general (i.e. non-specialist) AI tools are not usually willing, in their terms and conditions of use, to agree to keep users' information confidential. Providers of specialist tools may be more willing to provide this sort of assurance.

This presents difficulties for users who wish to input confidential information to generate work product. Some professional services firms have responded to this by building their own AI tools, such as our firm's AIME. Ownership and control of the AI tool provides assurance that confidential information will not be used to educate a model that will then provide information to others. This is a limited solution, however, because for most users an in-house tool will not achieve the levels of sophistication that a well-resourced specialist provider will be able to achieve.

A related risk is that material generated with the use of AI will inadvertently contain or rely upon material that is subject to intellectual property rights or obligations of confidentiality owed to third parties. Users may need to verify the data sources and their entitlement to use them, which can be difficult where the AI tool does not provide reliable source data. If users rely upon AI generated content for their own work product, advice, designs, marketing material or other purposes, they may be exposing themselves to claims for breach of intellectual property rights or breach of confidentiality.

Specific factors insurers will want to see

Insurers will expect to see that insureds have set expectations and guidelines for the proper use of AI tools by their workforce. This will include:

- Clear guidance as to which AI tools are appropriate for use – some are more reliable or appropriate for certain tasks than others, particularly with respect to confidentiality (discussed on page 6).
- Appropriate training to educate the workforce with respect to the risks of AI-generated work product, including the risks of "hallucinations" and incorrect conclusions.
- Most importantly, rules or processes that involve a human check upon work product which has been prepared with the assistance of AI.

Insurers will want to see

Clear guidance for appropriate AI tools

Appropriate training to educate the workforce

Rules or processes that involve a human check

AI risks:
What do insurers want to know about your use of AI?

Insurers wish to see that insureds have considered these risks carefully and have put in place the necessary strategies to deal with them. At present, this work is in its infancy. In its 2024 AI Index, Datacom reported that only 13% of businesses using AI had established audit assurance and governance frameworks and fewer than half had implemented staff policies for AI usage. Only 33% provided awareness training for employees. This should raise concerns for insurers.

The New Zealand Government has issued guidance to the public sector in the form of the Public Service AI Framework. Its purpose is described as being to support Public Service agencies to explore and adopt Generative AI systems in ways that are safe, transparent and responsible, and which effectively balance risks with potential benefits. Fundamental aspects include governance, security, procurement, skills, misinformation and accountability. A separate section deals with customer service considerations, including transparency, bias, accessibility and privacy.

We expect that insurers' expectations will develop and increase as AI tools become more sophisticated and their use becomes more widespread. We expect that insurers will increasingly expect to see:

- Developed, formal procedures to govern the use of AI, including checks to ensure that those procedures have been followed.
- Evidence of specific training and education programmes that achieve required standards.
- Consideration being given to what tasks AI is appropriately used for and what are not.
- Use of reputable and recognised AI tools for confidential information.

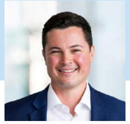
We expect insurers will also increasingly ask questions about insureds' use of AI. Topics may include the following:

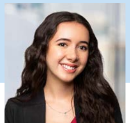
- What is AI used for? Is it used for routine, low-risk automation or administrative tasks, or higher-risk functions such as decision support for critical matters or systems, such as in professional advice, healthcare, or industrial control systems? The greater the consequences of failure, the greater the likely scrutiny.
- What is the AI system provenance and the training and data environment? Is the AI system developed and the model trained in-house, or delivered by an external vendor? What training data sets were used and are there known limitations or data-quality concerns?
- What governance & human oversight will be used? Who is responsible for AI outcomes and is there always a human reviewer for important decisions or work product?
- What validation and monitoring will be employed? Are there ongoing monitoring and validation programmes to check and validate the model? Has the insured experienced prior incidents involving AI and what remedial actions have been taken?
- What security and data protection rules will apply? How is confidential data stored and protected? Are there vulnerabilities in the system and does it rely on vendors who may be offshore?
- Is there regulatory awareness? Has the insured considered regulatory risks and is it monitoring emerging regulatory developments?

When businesses cannot provide clear, documented answers to these questions, insurers may respond with higher premiums, reduced capacity, sub-limits or exclusions. Some insurers may develop policy wording that explicitly references AI, such as, for example, introducing exclusions or sub-limits for loss resulting from AI outputs that are used without adequate human oversight.

Concluding remarks

For insurers, AI presents new liability, regulatory and business risks. We expect to see insurers adopting increasingly sophisticated approaches to interrogating customers as to their use of AI and developing expectations around governance, oversight and risk-management. Insureds who can demonstrate a professional and disciplined approach to AI risk will be well placed to manage those inquiries.


Nick Frith
Partner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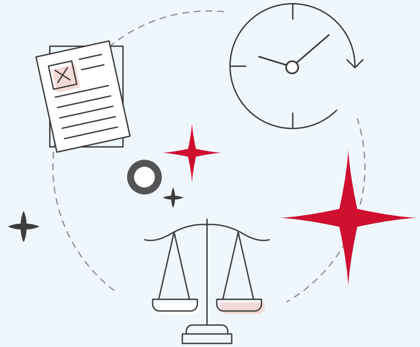


Another ban on insuring against fines:

Key changes to the RMA and what they mean for the insurance industry

Authored by Partner Nick Frith and Solicitor Leticia Alvarez

In most countries, if you are fined for breaching an environmental regulation, your insurance policy might soften the blow. In New Zealand, that safety net was removed on 20 August 2025.

Among other changes, the Resource Management (Consenting and Other System Changes) Amendment Act 2025 makes it unlawful to insure against fines for breaches of the Resource Management Act (RMA). The prohibition extends to purchasing, offering, or indemnifying another person's liability for RMA fines or infringement fees. This means that any penalty imposed must be borne directly by the company or individual.

However, legal expenses cover remains available. This marks a seismic shift for insureds and insurers in how environmental liability is managed and insured in New Zealand.

What are the changes and why are they important?

As of August 2025, it became unlawful for insurers or others to indemnify insureds for liability for fines under the RMA. Given the need for time to revise policy wordings, insurers have the next two years to remove clauses which indemnify for RMA fines. Failure to do so will itself be penalised from August 2027. This article will illuminate some of the subtle ripple effects brought by section 342A, to help insurers pre-empt these problems.

The courts have already begun to enforce the new provisions. With risk profiles shifting overnight, particularly in high-exposure sectors, insurers face pressure to adjust premiums, clarify cover for defence and remediation costs, and proactively manage client expectations to avoid disputed claims, litigation or Conduct of Financial Institutions (CoFI) risk and reputational damage.

To the extent that a stray policy entitlement currently exists in a policy, insurers need to have processes in place to make sure insureds are not indemnified.

Furthermore, premiums which previously reflected wider coverage may require a mid-term adjustment to reflect the fact that the insured risk has changed.

Insurers will need to revise their policies and clearly distinguish the cover for defence costs and remediation, while highlighting that fines are no longer covered. Brokers will need to undertake the same exercise for their base policy wordings.

Risk profiles for certain sectors have changed overnight. Underwriters will need to reassess exposure and pricing models for clients with high RMA risk, such as those involved in agriculture, construction and forestry. While at first glance, this seems to exclude such insureds from the scope of policies, the demand for defence and remediation cover will need to be matched in supply. We expect to see sentences shift to a bias towards greater remediation costs orders, as was seen with the flight to reparation orders in the health and safety context.

Another ban on insuring against fines: Key changes to the RMA and what they mean for the insurance industry

If insurers fail to update clients on the consequences of the amendment on existing policies and continue to charge premiums without providing the extent of cover initially agreed, they could be exposed to financial and reputational consequences under CoFI.

This sweeping change also presents an opportunity to lead the market. Redrafting policies to emphasise defence and remediation cover will ensure clients are supported in a new risk environment and ensure clients are informed of what is not covered. Expanding and clarifying this cover will ensure insurers remain competitive, relevant, and provide certainty in a changing landscape. If insurers act quickly, they can position themselves as leaders in environmental risk management.

A closer look

This change mirrors existing prohibitions under the Health and Safety at Work Act 2015 and the Credit Contracts and Consumer Finance Act 2003.

Penalties for environmental offences have significantly increased, while at the same time maximum imprisonment terms have decreased:

- **Individuals:** Maximum fines rise from $300,000 to $1 million.
- **Companies and entities:** Maximum fines rise from $600,000 to $10 million.
- The maximum imprisonment term for individuals has decreased from two years to 18 months, meaning all prosecutions will now be heard by a judge alone.

Any attempt to insure or indemnify RMA fines is now a punishable offence under the amended legislation, attracting fines of up to $50,000 for individuals and $250,000 for companies or other entities.

These changes position RMA offences among the most heavily penalised regulatory breaches in New Zealand.

Key dates:

- **20 August 2025:** Increased fines and the ban on insuring against fines took effect. Any fine imposed after 20 August 2025 is uninsurable, and any policy clause indemnifying against such fines is now unenforceable.
  However, increased fines will not apply to charges laid before 20 August 2025, since those proceedings fall under the previous offence provisions of the RMA.
- **20 August 2027:** The criminalising provisions take effect.

Importantly, defence costs (including expert costs), as well as remediation costs ordered by the Court are still insurable and will remain so. They will be crucial to manage financial exposure, as experience from the health and safety sector shows.

As penalties increase, we expect to see more defended prosecutions under the RMA.

A shift in the status quo

This amendment also signals a broader policy shift. Environmental harm is not viewed as a "low-tier" offence. Courts increasingly prioritise deterrence and expect businesses to internalise the true costs of environmental impacts. This signals a move toward aligning environmental compliance with corporate responsibility, where prevention, not remediation, becomes the benchmark for good practice.

Critiques of a crackdown

Insureds are now personally liable to pay higher penalties for breaches, including those arising by accident or circumstances beyond their control. As recently discussed on Radion New Zealand, a farmer spraying weeds might for instance rely on expert advice that no protected indigenous biodiversity is present. In such cases, penalising unintentional offenders does little to improve deterrence. For sectors such as farming, forestry and construction, reputational considerations and community accountability already serve to incentivise responsible practice.

Increased penalties and personal liability may also have disproportionate effects. Māori communities have historically been more affected by the criminal justice system, and harsher RMA penalties risk compounding these inequities. Without culturally informed enforcement practices or adequate support for iwi and hapū landowners navigating the resource management system, such measures could unintentionally deepen existing disparities.

However, removing the insurance safety net may leave individuals and small businesses exposed to significant compliance costs and financial risk, particularly when facing large penalties. Given current economic pressures, this change may further strain small businesses already operating within tight margins. In many cases, the inability to pay could ultimately shift costs back onto the public.

New Zealand appears to be the only Commonwealth country taking this stance in the environmental space. Several Australian states have taken a similar approach, though mainly in health and safety legislation. Across Australia, whether fines or penalties are insurable remains uncertain and is generally decided on a case-by-case basis. In Canada, cover for environmental breaches may still be available where the offence is strict liability.

The position in the UK is also complex. Unless a regulator has expressly prohibited insurance for fines, the key question is whether those fines are "insurable by law." While regulators have raised concerns about environmental breaches, environmental insurance remains widely available in the market (though cover may be limited for statutory debts or enforcement orders).

Our view

For insurers, the first priority is to remove any policy clauses providing cover for fines from current policies and ensure staff are trained to handle claims that relate to the RMA amendments. As risk profiles shift, particularly in sectors like agriculture, construction, and forestry, insurers must also reassess underwriting models, adjust premiums, and clearly define the scope of cover.

Brokers will need to ensure that they clarify what is covered and what is not, to avoid claims which may result in confusion or disputes, particularly in borderline cases. Beyond the financial loss of disputed claims, delays in updating policies risk reputational damage. Insurers and brokers will need to educate their clients and the market proactively to manage expectations.

While insuring against fines is now off the table, statutory defences for strict liability offences also remain available, meaning expert evidence on due diligence and financial capacity (often provided by accountants) will play a key role. Insurers that act quickly to clarify policy wordings, educate brokers and insureds, and expand support for defence, expert and remediation costs will be best placed to lead in this new regulatory environment. Whether other jurisdictions will follow New Zealand's lead remains to be seen.

Andrew Horne
Partner

Current issues in business interruption insurance

Authored by Partner Andrew Horne

Business interruption insurance claims often give rise to disputes. Business interruption clauses are often difficult for non-specialists to understand, increasing the likelihood that policyholders will be disappointed when they suffer a loss and find that their cover is not as extensive as they might have expected. Even experienced insurance professionals can find them difficult to follow.

In this article, we look at some issues that have recently arisen in business interruption claims and how the courts have dealt with them, with a particular focus upon business interruption claims resulting from cyber events.

Common issues in business interruption insurance

The quote introducing this article comes from an article the reinsurer Swiss Re published on business interruption insurance after holding a series of 'masterclass' workshops with more than 400 risk professionals and insurance brokers. It was apparent from those workshops that business interruption claims were viewed as especially challenging.

Business interruption cover is not merely a useful add-on. Swiss Re reported that business interruption losses often comprise well over half the value of claims for property damage. The business interruption element of material damage and business interruption (known as MDBI) policies may therefore be more important than what might traditionally be seen as the primary cover.

In part, this may be due to the effects of supply chain interdependencies and their limitations. One example Swiss Re gives is the consequences of damage to a large industrial electrical transformer. These transformers, while not especially high in value, are usually bespoke and are not readily interchangeable. With a production lead time of around 18 months, the loss of a transformer in a critical part of a business can result in a lengthy delay and a business interruption loss that is out of proportion to the value of the insured transformer.

This article does not attempt to provide a comprehensive explanation of how business interruption insurance policies work. Instead, it discusses some key issues that commonly arise.

> "Business interruption insurance continues to be a challenge and source of frustration for even the most seasoned risk professional."
>
> Swiss Re Corporate Solutions

Turnover

The purpose of business interruption cover, in general, is to put the insured in the same financial position in terms of profit and loss that it would have been in but for the loss of the insured asset (or other insured loss) that has given rise to the claim.

Typical business interruption policy wording, such as the Industrial Special Risks wording commonly used in MDBI policies in New Zealand and Australia, begins with an assessment of the insured's "Turnover". The starting point is normally known as Standard Turnover, which is the insured's actual turnover in the period corresponding to the indemnity period in the 12-month period prior to the loss. Establishing this figure is the first step in setting a baseline in a period that was unaffected by the loss event.

The Standard Turnover figure from the previous year may not reflect the turnover the insured business would have had if the loss event had not occurred. Nothing in business stays the same, and various factors may have increased or decreased turnover from the previous year. Because of this, adjustments to the Standard Turnover are necessary. These may be expressed in different ways in policy wording, but they normally provide for adjustments to reflect the "trend" of the business and circumstances that would have affected it in the year of the loss, so that the turnover is adjusted to reflect what the business would have experienced after the loss event.

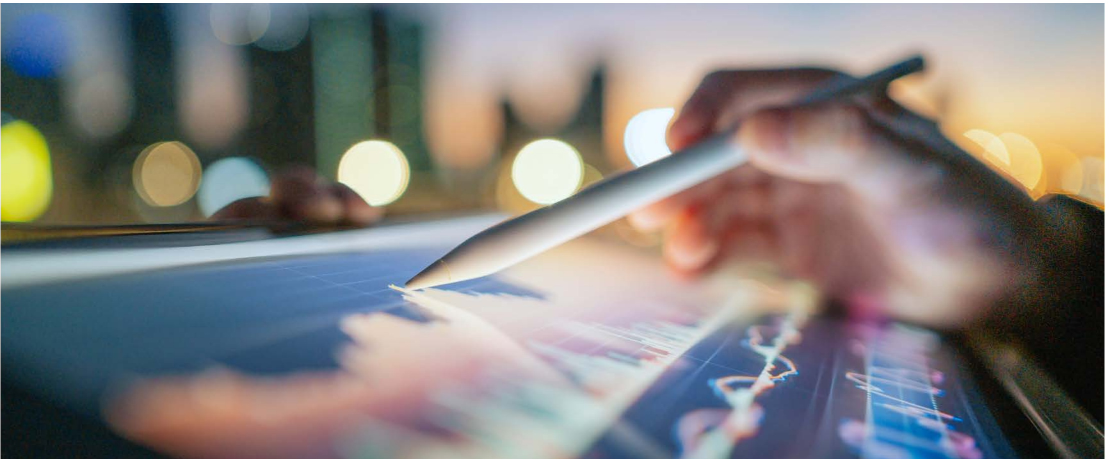
The question of what adjustments are necessary is often contentious. Business owners often have a rosy view of how well their business would have performed had it not been for the insured event, whereas insurers are typically more conservative in their assessments.

The policy wording is important in this respect. Some policies exclude trends that would have operated in the insured's favour, which will disadvantage an insured that is experiencing an upward trend in turnover. Disputes with insurers can also arise as to whether, even where an insured's turnover would have remained constant had it not been for the loss event, this would have been the net result of both positive and negative circumstances affecting the business, and whether the insurer is entitled to reduce cover because of the former.

A recent case that considered the effect of a trend cause was the decision of the UK Supreme Court in the well-known Covid-19 test cases, reported as *Financial Conduct Authority v Arch Insurance (UK) & Ors* [2021] 1 UKSC 1. One of the many issues in that case was whether, as the insurers argued, the "trends" clauses in the business interruption policies reduced policyholders' entitlements because the uninsured effects of the Covid-19 pandemic would have reduced their turnover some time before the insured consequences of the pandemic took effect. For example, where a policy insured a business only when it was compelled to close, but the Covid-19 pandemic had caused a loss of custom well before that date, the insurers argued that the business was suffering a downward trend, so the starting point for its turnover had to be adjusted down accordingly. These were referred to in the judgment as "pre-trigger" losses. The Court rejected the insurers' argument, holding that to reduce the insureds' entitlement to reflect a reduction in turnover caused by uninsured effects of the pandemic would amount to a refusal to indemnify the insured for loss caused by the insured peril. The Court's reasoning was that the loss was proximately caused by both uninsured (but non-excluded) and insured perils with the same originating cause.

Another interesting case involved a claim against an insurance broker, *Eurokey Recycling Ltd v Giles Insurance Brokers Ltd* [2014] EWHC 2989 (Comm). There, the insured was a waste recycling company whose premises were damaged by a fire in May 2010. Its turnover had risen dramatically, from GBP3.2 million in 2005, to GBP8.18 million in the financial year ended August 2007 and to GBP16.8 million in the financial year ended August 2009. It claimed that it would have achieved an even higher turnover of GBP25 million to August 2010, had it not been for the fire. The problem was that the broker had placed cover on the basis of turnover of only GBP11 million. The claim in this respect turned largely on factual issues as to what the insured had told the broker, and the claim failed on the basis that the broker had given a sufficient explanation of how the cover worked and was bound to follow the insured's instructions to place cover for a turnover of GBP11 million. The Court observed that a broker is not generally expected to conduct a detailed investigation into a client's business, particularly where a client appears to be well-informed about their own business.

Policyholders should be aware that satisfying their insurer as to the turnover they would have experienced had it not been for the loss event may be challenging, and they will need to have sufficient evidence to show how any relevant trends or circumstances would have affected the business. Statistics New Zealand publishes some useful information about credit card spending on particular classes of business that may be of use in some claims.



Gross Profit

Another issue that arose in Eurokey was the meaning of "Gross Profit" in a business interruption policy. In that case, the insured claimed that the broker had not given a sufficient explanation of the term, but the Court found that this criticism was not justified.

It is important to understand that Gross Profit in a business interruption policy is not the same as gross profit in accounting. A typical policy definition will look something like this:

Gross Profit is the amount by which:

a. the sum of the Turnover and the amount of the Closing Stock and Work in Progress shall exceed

b. the sum of the amount of the Opening Stock and Work in Progress and the amount of the Uninsured Working Expenses as set out in the Schedule.

This formula takes Turnover as a starting point and then adjusts it by the difference between opening and closing stock and WIP to net off the effect of any difference. There is then a further adjustment for Uninsured Working Expenses. These are costs of the business which will not be incurred if it is not operating, so the insured does not need business interruption insurance to cover the lost revenue that would have covered those costs, and the sum insured may be reduced to save premium. These costs may include, for instance, the cost of power for a business that uses power when operating, salaries and wages of staff who can be laid off when the business is closed, and the cost of raw materials that will not be purchased while the business is closed. It will be important for the insured to make an accurate assessment of the costs it will save if the business is not operating. If it does not estimate this accurately, it risks being underinsured, or paying an unnecessarily high premium for cover it does not need.

Deferred revenue

Some businesses, particularly those dealing with non-urgent work that customers may defer if the business cannot perform it, may experience difficulties in satisfying insurers that their revenue was permanently lost, rather than merely deferred, with customers returning to after the period of interruption ends. That is a challenge for businesses that do not have unlimited resources and would have been busy with work in any event.

Another area in which difficulties can arise is where businesses accept advance bookings, such as the hospitality industry. A hotel operator will commonly accept bookings months in advance. A loss event such as a cyber event may prevent bookings from being accepted for a period of time. The loss from these missed bookings will not be incurred immediately, but will be spread over time, as bookings would have been made at various times in advance. This may result in lost bookings not being covered by the business interruption cover, as the indemnity period in a cyber policy is typically much shorter than it is under an MDBI policy, as we discuss below.

Cyber business interruption policies

In a report issued in September 2025, the insurer Allianz reported that business interruption losses account for over 50% of cyber claim values. This is not surprising, as cyber events do not normally cause physical damage, although the costs of expert assistance to reinstate IT systems can be substantial.

Business interruption cover in cyber insurance policies often features different terminology to that used in MDBI policies. One explanation we have seen for this is that many cyber policies are developed from US wording.[1] The authors of that commentary express the view that some cyber business interruption policy wording is unclear and recommend that insurers and brokers review their wording. Certainly, it is unhelpful that cyber business interruption policies use different wording, and take a different approach, to traditional MDBI policies.

1 Clyde & Co LLP, Cyber Business Interruption – all is not as it seems, 31 July 2019

The primary difference is that whereas MDBI policies normally provide cover based on an assessment of Gross Profit, as discussed above, cyber policies often insure "Net Profit", sometimes called "Business Income". Gross Profit, in short, equates to business revenue less avoidable costs; the insurer assesses the revenue the business would have earned but for the event and deducts its saved costs. Net Profit is different – it essentially equates to Gross Profit less operating expenses, which are then insured as a separate line item. It is commonly dealt with in terms such as the following:

- Net Income (Net Profit or Loss before income taxes) that would have been earned; and
- Continuing normal operating expenses incurred.

The normal operating expenses that are also covered should include those that are necessary to resume the operations of the business, although the usual separate cover for increased cost of working is also normally present.

Whether cover is provided on the basis of Gross Profit or Net Profit wording, the cover should be the same. Issues can arise, however, where insurers dispute what operating expenses are covered by the cyber wording.

Cyber business interruption insurance also typically features the following differences from traditional MDBI cover:

- The waiting period is often shorter, sometimes as little as six hours, whereas a traditional policy might have a waiting period of 72 hours. Cyber events can be short and sharp, and loss usually begins immediately.
- The insured period is often shorter as well. Cyber events can be enormously disruptive but they can also be shorter in duration. Some policies limit cover to only three months, whereas MDBI policies may extend cover for two or more years.
- Some care may go into defining when the affected period comes to an end. It may be less clear when the effects of a cyber event end, compared with property damage causing a loss of business.
- It may also be challenging to identify the effects of the cyber breach. Some custom may be lost through a loss of confidence in the business that has been affected by the cyber event.

Concluding remarks

Business interruption insurance is a complex and challenging insurance product. The traditional Gross Profit assessment provided for in MDBI policies can be confusing, not least because it uses terminology in a way that differs from the way in which the same terms are used in accounting practice. The different approach taken to business interruption cover in many cyber policies adds to the complexity and potential for confusion. While it is always ambitious to suggest a wholesale departure from tried and tested terms that are well understood by the market, if not by customers, it may be time to take a fresh look at business interruption insurance.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IPSA reforms:

Will New Zealand follow Europe?

Authored by Partner Lloyd Kavanagh, Consultant Saskia Besier and Solicitor Darelene Hu

On 11 September 2025, then Reserve Bank Governor, Christian Hawkesby, announced at the Financial Services Council Annual Conference that Cabinet had agreed to a set of recommendations to progress an amendment bill to make changes to Insurance (Prudential Supervision) Act 2010 (IPSA). These documents were released two weeks later on the Reserve Bank's website, available here.

The Reserve Bank has proposed a comprehensive package of reforms following a multi-year review that began in 2016. These proposals were outlined in the Omnibus Consultation launched in September 2023 and are intended to modernise and strengthen the regulatory framework for insurers in New Zealand.

Summary of reform proposal

The IPSA reforms aim to move from the current relatively "light touch" model to a more proactive, intensive, and risk-based one, more closely aligning New Zealand with international practice in selected jurisdictions. The proposals are grouped into nine high-level areas of legislative change and are designed to ensure the maintenance of a sound and efficient insurance sector and promote public confidence in the sector.

1. **Purposes and principles**
   The proposal includes adding two principles to IPSA: a commitment to proportionality in regulation and the need to consider international guidance. This is coupled with a requirement for the Reserve Bank to publish a proportionality framework to guide the tailoring of standards to different insurers, ensuring regulatory burden is appropriate for the scale and nature of the business.

2. **Adjusting regulatory scope**
   The regulatory perimeter is being adjusted to require all New Zealand-incorporated insurers to be licensed, regardless of policyholders' location. Licensing requirements are proposed to be removed for overseas captives and overseas entities acting only as reinsurers. Other key proposals require overseas insurers operating through branches to incorporate locally where they meet a specified size and importance threshold, and non-operating holding companies of insurers will be subject to a licensing regime — facilitating a "group supervision" approach to insurers.

3. **Solvency framework and ladder of intervention**
   The current regime will transition to a graduated, risk-based solvency framework featuring a Prescribed Capital Requirement (PCR) and a Minimum Capital Requirement (MCR). This structure forms the basis of a "ladder of intervention" which enables the RBNZ to take proportional action as an insurer's capital level declines.

4. **New prudential standards power**
   To facilitate a more intensive supervisory approach, the Reserve Bank will gain the power to issue enforceable "standards". These standards will set clearer rules across key prudential areas, including governance, risk management, data and disclosure, outsourcing, connected exposures, actuarial advice, and distress management preparedness.

5. **Fit and proper requirements**
   The regime is being strengthened by extending fit and proper requirements to the Chief Risk Officer (CRO). Pre-approval by the Reserve Bank will be required for the appointment of directors and all key "relevant officers" (CEO, CFO, CRO, and appointed actuaries). Insurers must also notify the Reserve Bank of any concerns regarding a relevant officer's fitness or propriety.

6. **Regulatory approvals regime**
   The process for approving transactions involving insurance businesses will be simplified and align more closely with similar regulatory frameworks. The existing separate approval processes for specific types of transactions will be managed by one set of provisions applying to all those transactions.

7. **Graduated supervisory powers**
   The Reserve Bank is seeking an expanded and graduated toolkit for proactive oversight. This includes new powers for on-site inspections and a wider range of enforcement measures, such as imposing pecuniary penalties, issuing remediation notices, and requiring the publication of Reserve Bank warnings. A new duty of due diligence for directors and branch CEOs on prudential compliance is also proposed.

8. **Refined distress management**
   The proposals include modernising distress management provisions to prioritise policyholder and public interest during statutory management.

9. **Miscellaneous changes**
   Other proposed changes include introducing an obligation for the Reserve Bank to consult with the Financial Markets Authority when making decisions on significant transactions and issuing or cancelling insurer licences.

Alignment with international standards

The Reserve Bank's proposals represent a clear move towards aligning the New Zealand regime with international best practice, especially the principles embedded in the European Union's Solvency II directive. The United Kingdom also applies a Solvency II inspired approach. There is also expected to be an alignment with the Australian Prudential Regulation Authority's Prudential Standards and solvency approach.

This alignment is most evident in the shift to a more risk-based, intensive, and proactive supervisory model. Specifically, the introduction of the two-tiered solvency control levels (PCR and MCR) and the corresponding "ladder of intervention" closely mirrors Solvency II's system of solvency capital requirement (SCR) and MCR thresholds. Furthermore, the emphasis on strengthening governance and risk management through new Reserve Bank-issued Standards — which will cover areas like outsourcing and corporate structure — directly corresponds to the crucial Pillar 2 (on governance and supervisory review) requirements of the European framework, ensuring a stronger focus on internal controls and a clear accountability regime for senior management.

The ladder of interventions

In our view, some of the key changes to highlight relate to the proposed "ladder of intervention" measures, the Reserve Bank's new powers for on-site inspections without notice, and the Reserve Bank's power to issue enforceable standards.

The ladder of intervention changes provide the Reserve Bank with a range of potential interventions moving from the current single solvency margin, to a graduated, risk-based solvency framework within IPSA. We are looking forward to seeing more details on PCR and MCR levels and how the Reserve Bank will tie regulatory actions to specific levels of solvency — how many levels there will be on the "ladder", and the degree of severity incurred within each one. The specific thresholds that trigger the Reserve Bank to shift from monitoring to intervention will be a key focus point.

Enabling the Reserve Bank to conduct on-site inspections without notice would be a significant shift in the supervision of licensed insurers. How the Reserve Bank would use its new onsite power in practice will be indicative of its new approach to supervision. We are looking forward to guidelines detailing when and how the power will be exercised to ensure it is targeted and does not impose an undue or unnecessary burden on compliant insurers.

We will be interested to see if its supervisory approach will be more aggressive in how it enforces expectations, and how the Reserve Bank's relationship charter will be adapted to incorporate the new more robust powers.

Finally, we are interested to see how the Reserve Bank's proposed new extended power to issue enforceable standards, will impact operations and compliance costs — particularly for the governance, risk management, actuarial advice, and distress management preparedness areas. The proposals potentially allow the Reserve Bank to impose a lot of change on insurers, which would require significant and expensive uplift for many insurers. These standards will more clearly allow the Reserve Bank to focus their influence on how insurers are run, covering areas like Group dynamics, actuarial assessment, distress management and board composition. We look forward to the Reserve Bank's proportionality framework being applied in practice, ensuring that smaller insurers are not burdened with the same level of compliance complexity as large, systemically important institutions. The specific details of these standards, which constitute a significant part of the new prudential regime, will ultimately define the new minimum expectations for corporate conduct and operational resilience across the entire sector.

What next – and likely timeline?

The next step is expected to be a consultation on an Exposure Draft on the IPSA Amendment Bill, likely in the first quarter of 2026. The timing of steps after that will depend on the response to the consultation.

An Amendment Bill is currently proposed by Government to be introduced in the Parliament in June or July 2026. That is an ambitious timetable which does not leave much time to take into account the responses to the consultation.

Even if that is achieved, it is not clear whether there would be time to complete the usual legislative timetable before the next election. We think it more likely the Bill needs to be carried over into the next Parliament as usually the House rises by August in an election year. We would expect a full Select Committee process which implies enactment in late 2027. We would also expect a transition period to follow for some but not all of the Bill. However, it is always possible for the Government to accelerate the usual timetable.

Get in touch with one of our experts if you would like to discuss the IPSA recommendations and how they might impact your business.


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1 15 November 2027 at the latest, or earlier by Order in Council.

Contracts of Insurance Act deep dive:

Fair presentation of the risk — A new duty of disclosure for non-consumer insurance contracts

Authored by Partner Hannah Jaques, and Solicitors Raksha Tiwari and Sione Roberts.

In previous issues of Cover to Cover we provided an overview of the key changes in the Contracts of Insurance Act (Act). Ahead of the Act's commencement,[1] we are taking a deep dive into these key changes in a three-part series.

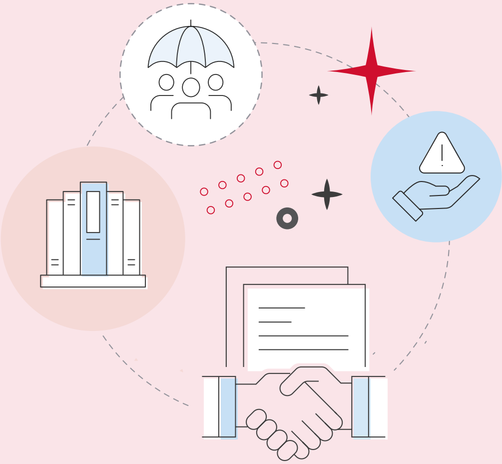
This, the first instalment, delves into the duty owed by policyholders of non-consumer insurance contracts to give *"a fair presentation of the risk"*.

Helpfully, the same standard has been in place in the United Kingdom since August 2016, under the Insurance Act 2015 (UK Act). Since then, aspects of the duty have been clarified through a number of cases. We look at three of these cases and discuss the guidance they provide as we move towards the commencement of our new legislative scheme.

Recap of the duty in the Act

A key feature of the Act is the new distinction between consumer and non-consumer insurance contacts. This distinction focuses on the purpose of the contract. A non-consumer insurance contract is defined by reference to what it is not. It is not a contract of insurance ordinarily entered into by a policyholder wholly or predominantly for personal, domestic, or household purposes. Regulations may deem certain contracts of insurance consumer or non-consumer insurance contracts, but this has not yet occurred. Most non-consumer insurance contracts will be those entered into with companies for business purposes.

Section 29 of the Act sets out the disclosure obligation on policyholders of non-consumer insurance contracts. It requires them to make "a fair presentation of the risk" before entry into or variation of the insurance contract.



The Act describes a "fair presentation of the risk" as:

- containing every material circumstance the policyholder knows or ought to know or providing sufficient information to put an insurer on notice to make further inquiries to reveal those material circumstances (s 31(1)) – knowledge is addressed in ss 36 to 39 and constructive knowledge in s 40;
- not requiring a policyholder to disclose a circumstance if (s 31(2)):
  - it diminishes the risk;
  - the insurer knows it;
  - the insurer is presumed to know it;
  - it is something as to which the insurer waives information;
- where:
  - "circumstance" includes any communication made to, or information received by, the policyholder (s 31(3));
  - "material" means something that would influence the judgment of a prudent insurer in determining whether to take the risk and. if so, on what terms, and may include:
    - special or unusual facts relating to the risk;
    - any particular concerns that led the policyholder to seek insurance cover for the risk;
    - anything that those concerned with the class of insurance and field of activity in question would generally understand as being something that should be dealt with in a fair presentation of the risks of the type in question;
- reasonably clear and accessible to a prudent insurer (s 30);
- every material representation as to a matter of fact is substantially correct (s 30);
- every material representation as to a matter of expectation or belief is made in good faith (s 30).

Guidance from the application of the UK Act

These sections of the Act borrow heavily from the UK Act. Sections 3 to 8 and Schedule 1 of the UK Act impose a near-identical duty for policyholders of non-consumer insurance contracts to make a fair presentation of the risk to insurers prior to entering into the insurance contract or before a variation to it. Given the concurrency of the statutory frameworks, recent UK cases addressing the scope of this duty provide useful guidance.

We look at three recent cases below in which the courts were required to consider the scope and application of the fair presentation duty. Specifically, the materiality of the non-disclosure, inducement of the insurer, knowledge of the matter failed to be disclosed and waiver of the duty. Each case involves a failure to disclose a *"moral hazard"*.

Case study 1:
Berkshire Assets (West London) Ltd v AXA Insurance UK Plc [2]

Berkshire sought an indemnity under its business interruption and contractors' all risks policies with AXA.

Berkshire was a joint venture developing a residential complex. Mr Sherwood, a director of Berkshire, invested in the proposed joint venture following his retirement from the partnership of Goldman Sachs. Mr Garside was the other director and he largely conducted the day-to-day management of Berkshire.

Mr Sherwood was the subject of criminal charges in Malaysia relating to his position as director of a number of Goldman Sachs companies in and around that jurisdiction. Between approximately 2009 and 2014, Roger Ng, and certain co-conspirators, of Malaysia laundered billions of dollars and fraudulently diverted funds raised in 2012 and 2013 through three bond transactions that his company, 1MBD, executed with Goldman Sachs. The schemes involved the payment of more than GBP1 billion in bribes to 12 government officials in Malaysia and the United Arab Emirates to obtain and retain lucrative business for Goldman Sachs, including the bond deals. The charges against Mr Sherwood were later dropped.

However, Goldman Sachs entered into an agreement settling claims relating to the bond scheme and a former managing director of the Goldman Sachs Group Inc, and former Southeast Asia Chairman was sentenced to 10 years in prison for his role in the scheme.

The 2019 renewal documentation for the business interruption cover included a term requiring that Berkshire make a fair presentation of the risk to be insured. Additionally, AXA's quote for the 2019 renewal schedule was expressed as subject to Berkshire confirming the information in the quote summary was correct and required Berkshire to disclose any information that could influence AXA's renewal offer. It made clear that if Berkshire was unsure if something was important, it should advise its insurance adviser. At its 2019 insurance renewal, Berkshire failed to disclose that Mr Sherwood was subject to criminal charges in Malaysia.

In January 2020, water damage caused physical and business interruption losses at the residential complex and Berkshire made claims under its BI and CAR policies.

AXA sought to avoid the policy upon discovering that Mr Sherwood had been charged in Malaysia over fraudulent bond dealings. The charges related to an alleged fraudulent scheme that Goldman Sach's entities, including some of which Mr Sherwood was a director, were allegedly involved. There was no suggestion that Mr Sherwood was personally aware of the alleged fraudulent scheme.

AXA considered that Berkshire's failure to disclose this information breached its duty to make a fair presentation of the risk. Berkshire challenged this finding, arguing that the charges were unrelated to its business and unknown to the (different) director who was involved in Berkshire's insurance.

At issue was:

a. whether Mr Sherwood's criminal charge was a material circumstance for the purposes of the duty of fair presentation; and

b. whether the non-disclosure had induced AXA to enter into the insurance contracts.

When looking at the materiality of the non-disclosure, the Court applied the following principles from the common law:

- Materiality is a factual question that must be assessed based on the specific circumstances of each case.
- Materiality is judged at the time of placement, not in hindsight or by reference to subsequent events.
- Facts that raise doubts about the risk are considered material, even if they do not ultimately affect the risk.
- The 'prudent insurer' test means that materiality and fair presentation are assessed primarily from the insurer's perspective, focusing on what a hypothetical prudent insurer would consider relevant.
- A circumstance does not need to be decisive for a prudent insurer in determining whether to accept the risk or on what terms. It is sufficient that the information could influence the insurer's decision.

2 [2021] EWHC 2689 (Comm)

Following evaluation of the above principles, the Court held that Mr Sherwood's criminal charges were a material circumstance. The Court cited with approval an earlier case regarding failure to disclose offences: *"When accepting a risk underwriters are properly influenced not merely by facts which, with hindsight can be shown to be have actually affected the risk, but with facts that raise doubts about the risk"* [3]. Materiality was assessed at the time of placement and judged from the perspective of a prudent insurer. The charges, involving dishonesty and fraud, raised doubts about the risk and should have been disclosed—even if ultimately irrelevant to Berkshire's operations.

Inducement

On whether AXA would have insured Berkshire had the charges been disclosed, the Court found it would not have. AXA's internal underwriting guidance explicitly excluded risks involving criminal allegations. Berkshire's arguments about broker relationships and Mr Sherwood's reputation were rejected. The Court upheld AXA's right to avoid the policy due to breach of the duty of fair presentation.

Case study 2: *Delos Shipholding SA v Allianz Global Corporate and Specialty SE* [4]

Delos Shipholding was a case that concerned a failure to disclose that the sole director of the insured special purpose vehicle, Mr Bairactaris, faced criminal charges in Greece. The charges related to the detention of a ship called the NOOR 1 on arrival from the UAE in what was apparently one of the largest ever intercepted heroin shipments to Europe.

In this case, the claim arose when a bulk carrier, WIN WIN, was unexpectedly detained by Indonesian authorities for anchoring without permission. The insurers accepted that the detainment would give rise to a constructive total loss under the war risks policy, under which a payment of USD37.5 million would be required. However, it sought to avoid cover on the basis that the insured breached its duty of fair presentation by failing to disclose the criminal charges prior to the entry into the insurance contract.

Mr Bairactaris was a solicitor of a maritime law firm in Greece which acted for the family business that owned the ship and effectively controlled the relevant SPV and other ship-holding SPVs. He denied the charges, had not been found guilty of any offence, and remained a registered member of the Piraeus Bar Association *"with an apparently thriving practice"*.

The High Court held that there was no breach of the duty of fair presentation, so insurers were not entitled to avoid the policy. It found that:

1. **No actual knowledge:** The insured SPV did not have knowledge of the criminal charges at the time of entry into the policy and was not required to disclose that which it did not know. The High Court considered the attribution provisions in the UK Act, which provide that an insured who is not an individual knows only that which is known to one or more individuals who are part of the insured's senior management or responsible for the insured's insurance. The High Court found that Mr Bairactaris was neither, despite being the sole director of the insured SPV. The Court clarified that it was the substance of Mr Bairactaris' role rather than his title that mattered and he did not play any real role in the day to operations of the SPV or the ship it owned nor of the broader group and its insurance. Mr Bairactaris was appointed a nominee director for convenience, so that he would be available to sign transactional documents quickly as and when required. The legislation was concerned with the organisation of the activities of a company, not its paperwork.
2. **No constructive knowledge**: The insured SPV also did not have constructive knowledge for the purpose of the UK Act. The High Court accepted that the test, which was whether the information should have been revealed by a reasonable search of information available to an insured (the equivalent of s 40(1) of the Act), was an extension of the previous common law duty of disclosure. However, it said that what is reasonable must depend on the context and the type of business which the insured is conducting. The Court found, including by reference to what other shipping groups did, that it was not reasonable for the insured SPV to make the enquiries of Mr Bairactaris that would have elicited the criminal charges. Therefore, the information would not and should not have been revealed by reasonable searches.
3. **Not material:** Materiality under the UK Act was "substantively the same" as under the common law. Where the argument is that information should have been disclosed, the Court is assessing a hypothetical. It is therefore legitimate for

3 *Brotherton v Asegurados Colseguros (No. 2)* [2003] EWCA Civ 705.

4 [2024] EWHC 719. See also the appeal decision: *Delos Shipholding SA v Allianz Global Corporate and Specialty SE* [2025] EWCA Civ 1019 upholding the High Court's decision.

the Court to consider other exculpatory information that the insured would have provided to the insurer together with the disclosure. In this instance, the Court found that in the hypothetical circumstance in which the position had been disclosed, the insured would have disclosed Mr Bairactaris' firm belief that the charges were without foundation and his position as a nominee director with no role in the running of the business or operation of the ship, among other things. The Court was satisfied that a prudent underwriter would have dismissed the charges as having no relevance to the assessment of the risk in that context. The criminal charges could not plausibly have increased the risk of detention of the ship nor of the risk of a fraudulent or inflated claim given Mr Bairactaris played no part in the insured's insurance.

4. Finally, although the comment was made obiter, the Court was not impressed by the insurers' evidence that had the criminal charges been disclosed, they would have declined to provide cover. There was an air of unreality about the evidence presented and a suggestion from the Court that, having put their stake in the sand, insurers' witnesses had convinced themselves retrospectively of the steps they would have taken in the hypothetical.

The Court of Appeal declined AXA's appeal.

Neither the High Court nor Court of Appeal appears to have been referred to the Berkshire decision discussed above regarding materiality. However, a key distinguishing factor in Delos was the substance of the role played by Mr Bairactaris compared with Mr Sherwood, the fact that the charges against Mr Bairactaris appeared shaky at best, and the lack of clear underwriting evidence in Delos when compared with the evidence in Berkshire.

Case study 3: *Young v Royal and Sun Alliance Insurance Plc* [5]

The case of *Young* considered as a preliminary question whether the duty of fair presentation had been waived in respect of Mr Young's ties to insolvent companies. Section 3(5)(e) of the UK Act provides that a policyholder is not required to disclose a circumstance if it is something about which the insurer waives information. Section 21(2)(e) of the Act is in the same terms.

Mr Young sought GBP7.2 million from Royal and Sun Alliance following a fire that allegedly destroyed premises relating to a property development. Royal and Sun Alliance purported to avoid the policy on the basis that in breach of the duty to make a fair presentation of the risk, Mr Young had failed to disclose that he had previously been a director of four companies that were insolvent at the time of entry into the policy. The companies were not related to the insured property development entity.

The market presentation prepared by Mr Young's brokers included a question "Select any of the following that may apply to any proposer, director or partner of the trade or business for its subsidiary companies if they have ever, either personally or in any business capacity". The broker's software then provided seven possible responses, one of which was "Been declared bankrupt or insolvent or have been the subject of bankruptcy proceedings or insolvency proceedings". The response "None" had been selected from the list. The presentation as given to Royal and Sun Alliance included only the question, followed by "None"; it did not show the list of options given to the insured.

The lower court found for the insurer, but Mr Young appealed, arguing that the insurer had waived its right to this information by responding to a market presentation with terms that he misunderstood as only applying to the current company.

Mr Young alleged that Royal and Sun Alliance had waived its right to disclosure of his ties with the insolvent companies because:

1. the questions put to and answered by Mr Young in the proposal form prepared by his brokers limited the information considered material and that was accepted by insurers; and
2. insurers' email containing an offer of insurance was insufficient to elicit the information from Mr Young.

The Court acknowledged that the common law of waiver in the insurance context applied equally to the new statutory duty requiring fair presentation of the risk. It would therefore be possible for an insurer to waive their right to certain information that would otherwise require disclosure pursuant to the duty.

The most common form of waiver was implicit waiver through the limited nature of an insurer's enquiries, usually through a proposal form. For example, if a proposal form specifically asked about any motor vehicle accidents that had occurred in the last five years, the intended insured may be justified in not disclosing an accident that occurred seven years previously.

5 [2019] CSOH 32. See also the decision on appeal: *Young v Royal Sun and Alliance Insurance Plc* [2020] S.C. 567 (2020).

Whether waiver has occurred depends on a true construction of the proposal form in context. The test is whether a reasonable person reading the proposal form would be justified in thinking that the insurer had restricted his right to receive all material information, and consented to the omission of the particular information in issue. Further, if an insured provides information that would prompt a reasonably careful insurer to make further enquiries and they fail to do so, waiver may arise to the benefit of the insured. Although this would likely also be addressed on the basis that there has been no breach of the duty to make a fair presentation, which requires that the policyholder provide disclosure of sufficient information to put a prudent insurer on notice to make further enquiries (s 31(1)(b) of the Act and s 3(4)(b) of the UK Act).

The Court found there was no waiver in this case. The insurer had not prepared the insurance presentation and did not know what options were available on that form for the insured to select. Further, the insurer's email offer of cover included preconditions to cover, including that the insured had never been declared bankrupt or insolvent or had a liquidator appointed. It did not purport to limit the extent of what was material.

Key takeaways

For insurers

"Moral hazards" will not always be material.

Clear, contemporaneous underwriting processes and policies are relevant to establishing materiality and inducement. In the UK cases, the underwriting evidence was significant contributor to the different results reached in *Berkshire* and *Delos Shipholding*.

When assessing knowledge, materiality and inducement the enquiry is on the substance of the role played by the relevant individuals related to a corporate insured.

Insurers should have a good understanding of the substantive role played by individuals involved in a potential breach of the fair presentation duty and any exculpatory information that would have been presented in the hypothetical before determining their response to a claim.

Common law waiver remains relevant. Insurers should therefore be careful not to unnecessarily limit the information sought in proposal forms, risking waiver, which will be assessed in the context of other communications and the nature of the insurance.

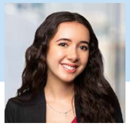
For insurance brokers

The cases reinforce the risk of broker-prepared proposal and presentation materials. For example, in *Young v Royal and Sun Alliance*, the brokers who prepared the insured's presentation to insurers put themselves in the firing line by introducing a further opportunity for miscommunication through their market presentation software and final product.

Where there are clear industry expectations regarding the types of matters that require disclosure, particularly in relation to moral hazards, brokers should advise their clients of this and the risks of withholding information.

The observations in the cases regarding materiality are relevant to brokers who have a duty under s 63 of the Act to disclose every material circumstance known by the broker or someone who works for the broker in relation to the relevant contract of insurance.


Olivia de Pont
Senior Associate


Leticia Alvarez
Solicitor

Russian aircraft claims:

When are assets "lost"?

Authored by Senior Associate Olivia de Pont and Solicitor Leticia Alvarez

Can property be "lost" for the purposes of an insurance policy, even if you know where it is? This has been the dilemma facing aircraft lessors in the wake of Russia's invasion of Ukraine, with twelve billion dollars' worth of leased aircraft stranded in Russia.

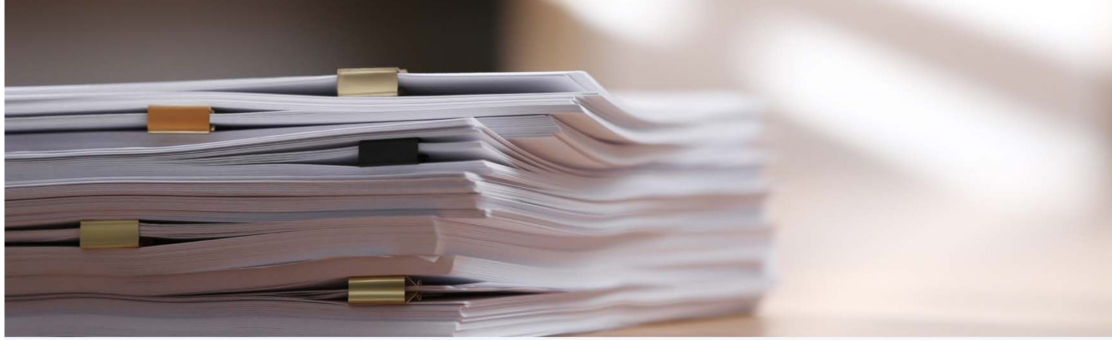
In June 2025, the UK High Court issued a highly anticipated decision on six multi-billion dollar insurance claims by various aircraft lessors, after Western sanctions and retaliatory Russian measures left their aircraft in Russia, out of reach. This case addressed a number of issues, including how courts determine when property is "lost" for insurance purposes. The test laid down by the Court could shape how loss is assessed in a range of commercial contexts, internationally and in New Zealand – including "losses" arising from exports bans, sanctions, theft or conversion.

Background to *Aercap Ireland Ltd v AIG Europe SA & Ors* [2025] EWHC 1430 (Comm)

Timeline of key events

Following the Russian invasion of Ukraine on 24 February 2022, the United States (US), European Union (EU), and United Kingdom (UK) moved quickly to impose sanctions. These sanctions included bans on aircraft leasing, maintenance services, and the export of aviation-related goods and technology to Russia. The EU's amendments to Regulation No. 883/2014 and the UK's Russia (Sanctions) (EU Exit) (Amendment) (No. 3) Regulations 2022 effectively forced Western aircraft lessors to terminate their leases with Russian airlines.

In March 2022, Russia retaliated against western sanctions, issuing Presidential Decree No. 100 and Government Resolutions Nos. 311 and 312, which banned the export of aircraft and engines. The Federal Customs Service enforced these measures, supported by the Federal Security Service and National Guard Troops. Russian authorities re-registered foreign-leased aircraft domestically, nationalising hundreds of foreign-leased aircraft.



It soon became apparent that the war would not end quickly. Russian airlines retained formerly leased aircraft without consent, and the Russian government extended export bans through to 2025. Western lessors pursued insurance claims on the basis that the sanctions and retaliatory action had eliminated any realistic prospect of maintaining the continued airworthiness of these aircraft. While limited settlements were reached with Russian insurers under state-backed schemes, most claims were rejected by insurers, who argued that the aircraft were not physically destroyed and that lessors had not demonstrated that they had been permanently deprived of their aircraft. The resulting litigation brought before the Courts the question of when property is "lost".

When is property "lost"? Insights from a century of case law

In his decision, Butcher J considered a century of case law and examples to hone in the test for determine when property is "lost" for insurance purposes.

The first case referred to by Butcher J was the oft-cited case of *Moore v Evans* [1917] 1 KB 458 (CA), [1918] AC 185 (HL). This case concerned the consignment of jewellery on a "sale or return" basis, with the owner retaining title to the goods. The jewellery was consigned to customers in Brussels and Frankfurt in June and July 1914, however as war tensions escalated, the owner requested the return of the jewellery by registered post. The Brussels customer responded that postal services were disrupted and the jewellery had been placed in a bank for safekeeping. The Frankfurt customer did not reply. The owner then made a claim under its policy on the basis that the jewellery was lost. When proceedings were issued nearly seven months later, in February 1915, the inability of the plaintiff to recover possession or control of the goods was likely to continue for an indefinite time.

Considering the question of loss, the Court in *Moore v Evans* considered a number of hypothetical scenarios. For example, if jewels are buried under rubble due to bombardment, or inaccessible due to military control, the owner may be deprived of access, but the jewels are not necessarily "lost" for the purposes of an insurance policy. There was no evidence of damage, misfortune, or dishonest appropriation. The goods remained safe and undamaged. "Loss" in non-marine insurance requires more than inconvenience or delay. There must be a practical and probable inability to recover the property.

Butcher J discussed a number of other cases with interesting fact patterns:

1. *Holmes v Payne* [1930] 2 KB 301: This case concerned misplaced and later discovered jewellery – the Court commented, in obiter, that subsequent discovery or recovery does not, of itself, disprove loss.
2. *Webster v General Accident Fire and Life Assurance Corporation Ltd* [1953] 1 QB 520: Here, the claimant had been induced to part with a car through fraudulent misrepresentation. The car was then sold, but the owner knew where it was. The Court considered the car was lost when, after taking all reasonable steps to recover the chattel, recovery was uncertain.
3. Dawson's Field Award: This was an arbitration which considered a reinsurance claim in respect of the hijacking of four aircraft by members of the Popular Front for the Liberation of Palestine. One was then destroyed in Cairo, and three at Dawson's Field. The question arose as to whether the planes were "lost" when hijacked or only when later blown up. The Court held that this was a "wait and see" situation, and the aircraft were not total losses until they were blown up.
4. *Kuwait Airways v Kuwait Insurance* [1996] 1 Lloyd's Rep 664: The Court considered the overrunning and capture of a private fleet by Iraqi forces. The key question was one of aggregation – i.e. whether there was an aggregate loss of all aircraft when Iraqi forces overran the airport, or whether the taking of each airplane was a separate loss. The Court found that the aircraft were lost when the airport was overrun, determined by the Iraqis' intent to "make (the aircraft) permanently their own as an exercise of war-time plunder".
5. *Scott v Copenhagen Reinsurance Co (UK) Ltd* [2003] EWCA Civ 688: The Court considered whether a single aircraft stranded in a Kuwait airport following the 1990 Iraqi invasion was lost. It was held that the aircraft was not lost as a result of the invasion, there being no hostile intent towards by it from the invading forces. Rather, it was lost by destruction in February 1991.

Following his survey of the case law, Butcher J identified a number of key principles:

- The insured must prove that a deprivation has occurred but also that the deprivation will, more probably than not, be of sufficient permanence to constitute a “loss”.
- Permanence should be assessed against the standard of “more probably than not”.
- Subsequent discovery will not disprove the loss.
- An item will be lost if recovery is uncertain, even after all reasonable steps to recover the item have been taken by the assured.
- When the circumstances at the time of deprivation of possession are still evolving, it may be appropriate to adopt a “wait and see” approach until the situation stabilises and becomes clearer, before determining whether the test has been met.

In the context of a claim involving aircraft, Butcher J commented that permanence is to be assessed against the commercial life of the asset. Butcher J acknowledged that while a theoretical possibility of the aircraft’s return may exist, this would not preclude a finding of permanent deprivation, provided the insured can demonstrate that recovery is unlikely within the aircraft’s operational lifespan.

Furthermore, in determining when a loss occurred, Butcher J acknowledged that a court may consider material in hindsight, in two ways. First, there may be an evidential “wait and see” period, following which the court may assess whether a loss had occurred at the outset, taking into account events occurring during the wait and see period. Alternatively, subsequent events may be used as a sense check, either reinforcing or challenging any preliminary conclusion about whether a loss was sustained on day one.

On the facts of this case, Butcher J concluded that the aircraft were “lost” on 10 March 2022, when GR 311 was issued. That resolution expressly prohibited the export and therefore the return of aircraft, and no aircraft were returned thereafter, except in a handful of cases involving approved settlements. Under an authoritarian government, it was not realistic to expect that airlines would disregard or defy the terms of GR 311 and accordingly, the Court was satisfied that from that date, the lessors had been permanently deprived of their aircraft.

Our view

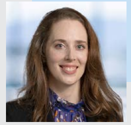
The High Court’s decision helpfully pulls together case law arising from disparate scenarios — from misplaced jewellery to hijacked planes — and identifies principles for determining when property has been “lost”. However, the discussion in this case also highlights the complexity of assessing when property is “lost” for insurance purposes, which must be determined on the facts of each case and therefore gives rise to uncertainty for insureds and insurers, exacerbated by the “wait and see” approach approved by the Court.

Case study

Deductions of furlough payments from insurance entitlements:

Court of Appeal clarifies the position

Authored by Senior Associate Olivia de Pont and Solicitor Raksha Tiwari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What is the effect of an insured business receiving Government support in circumstances where they would otherwise have been entitled to a business interruption (BI) insurance payment? Unsurprisingly, the answer is that an insured who receives Government support that relates directly to the insured peril has not suffered loss to the extent of that support, so it must be deducted from its BI insurance claim. It cannot be treated as a separate gift or windfall that does not impact upon its insurance claim.

In a recent decision in *Bath Racecourse Company Limited & Ors v Liberty Mutual Insurance Europe SE & Ors* [2025] EWCA Civ 153, the Court of Appeal of England and Wales delivered a ruling on the treatment of furlough payments in COVID-19 BI insurance claims. While the case also addressed composite policy limits, the headline was the Court's decision that government support provided to businesses under the Coronavirus Job Retention Scheme (CJRS) must be deducted from BI insurance payouts.

The Appeals: Two sides, two issues

The case involved appeals from both insurers and insureds:

- The insurers challenged the High Court's finding that each insured under a composite policy was entitled to a separate limit of indemnity, rather than a single aggregate limit.
- The insureds contested the ruling that CJRS payments should be deducted from their BI claims under the policies' savings clauses.

While the composite policy issue was swiftly dismissed, the Court's detailed analysis of the furlough deduction issue provides crucial guidance for future BI claims.

Furlough payments: A saving, not a windfall

Under the CJRS, employers could recover up to 80% of wages paid to furloughed staff during pandemic-related restrictions. Many businesses claimed under both the CJRS and their BI policies. Insurers argued that CJRS payments reduced wage costs and should therefore be deducted under savings

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clauses such as the following example:

"If any of the charges or expenses of the Business payable cease or reduce in consequence of the Damage, such savings during the Indemnity Period shall be deducted from the amount payable."

The insureds pushed back, making the following arguments:

1. **Wages were not reduced:** They were still paid in full.
2. **CJRS payments were not caused by the insured peril**: They were a separate government initiative.
3. **CJRS payments were collateral benefits:** Akin to gifts, and not deductible from insurance entitlements.

Did wage costs "cease" or "reduce" for the purposes of the policies?

The Court's answer to this was "yes". Even though wages were paid, the CJRS reimbursed 80%, effectively reducing the insureds' wage expenditure. That reduction was a saving, and the savings clause applied: *"The economic reality is that the wage bill was reduced. That's a saving, and it must be deducted."*

Were CJRS payments "In consequence of" the insured peril?

The Court applied the causation test from *FCA v Arch Insurance* [2021] UKSC 1 (which we discuss in another article in this edition, which links the insured peril to:

- COVID-19 cases near the premises;
- Government restrictions; and
- Hindrance in using the premises.

It found that CJRS payments were directly tied to the Government-imposed restrictions, which were part of the insured peril. The Scheme was introduced to mitigate the very losses the insurance covered.

Were CJRS payments collateral benefits?

The insureds likened CJRS payments to benevolent gifts, arguing they should not reduce the insurance payout. The Court firmly rejected this, commenting that:

"There is no analogy whatsoever with benevolent gifts. CJRS was not a windfall — it was a targeted mitigation measure."

Unless a third party intends to benefit only the insured (to the exclusion of insurers), such payments must be deducted.

Key takeaways

This decision confirms that CJRS payments and other similar Government support payments must be deducted from entitlements under standard BI policy savings clauses where the insured peril is the same. The Court emphasised commercial realism and policy wording, reinforcing that government support aimed at reducing loss must be factored into indemnity calculations.

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*From 1 July 2025, subject to meeting New Zealand Law Society requirements.

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