Recent statistics released from Lloyds of London, the heart of the insurance world, has shown that the number of claims made under insurance policies such as Director and Officers liability policies and professional indemnity policies rose dramatically during the last twelve months.

It is perhaps unsurprising that the rise in the number of claims has coincided with the recent economic turbulence.

Most Directors or Partners are only too aware that proper risk management and training allied with appropriate reasoned advice helps minimise the number of claims made against the company or firm. However, many will grapple with the dilemma of notifying their insurers of a potential claim. Is the claim a valid one? What effect will the claim or claims have on the insurance premium?

One certainty that cannot be avoided is that without proper notification insurers may well repudiate liability and leave the company or firm with a substantial loss to meet from capital.

Most insurance policies are underwritten on a “claims made basis”. In the absence of any provision within the policy wording, the date of the wrongful act, which has given rise to the claim, is irrelevant. All that matters is that the claim has been properly notified to insurers within the policy period. It sounds simple. In practice, proper notification can be problematic.

Whilst certain claim notifications are obvious (for example the service of legal proceedings) others require consideration. Welcome to the complex world of claims notifications.

The main trigger to effect insurance cover of a claim made against the company or firm is proper notification of circumstances to insurers. Once again, many of you reading this article will not consider that there is much of an issue here. However, place yourself in the shoes of the small businessman or woman. A director is aware of an issue, which may give rise to a claim. He is caught in a dilemma. Does he notify insurers, risking a substantial hike in his insurance premium and the prospect that at renewal he must remain with the same insurers; or does he tentatively notify insurers, hoping that there will be no claim and his premium does not suffer? Equally, will his failure to notify result in the whole policy being terminated, with the prospect of any future claim being repudiated due to an absence of insurance cover?

This is precisely the problem, which confronted a firm of accountants in Scotland recently. A tax manager at HLB Kidsons raised concerns that tax schemes marketed by a subsidiary of the firm, were fundamentally flawed and could be considered as unacceptable tax avoidance. Following an attempted notification to insurers (described as “coy”), Kidsons faced the prospect of meeting the potential claims costs without insurance cover in place as a result of the ambiguous notification presented to insurers.

The matter found itself before the Court of Appeal, in the now landmark case of HLB Kidsons v Lloyd underwriters [2008] EWHC 2415.

Commenting on what was required of a policyholder to provide proper notification of circumstances, Rix LJ stated that:

1. Have such circumstances come to the attention of the insured so that he can be said to be aware of them?

2. Are the circumstances such that they may give rise to a claim?

The second question must be assessed objectively. While the policyholder may have his own views on the merits of the complaint, it is for the insurer to rate the risk not for the insured. In other words, the subjective views of the insured must be ignored.

Toulson LJ, commented that the correct approach is to view notification as an implicit requirement and where there are objective reasons for a notification, the policyholder should do his utmost to properly and fully advise insurers.
Applying this decision in a practical context can be difficult especially when problems emerge over a long period of time and the objective analysis of the grounds of each complaint can vary. Moreover, small businesses may not have the resources available to properly assess a complaint in the required manner.

An insured should give an open and honest account of the risk as it is known, in writing and continue to notify insurers of developments as the matter evolves. At the end of the policy period, Insurers must be able to assess the complaints so that they appreciate any liabilities and can set reserves to meet such liabilities. Where a purported notification is vague or so broad-brushed that no proper assessment of liability can be carried out, it is likely that insurers will argue that the notification is invalid and decline payments under the policy.

Where the precise scope of a claim may fluctuate over time, openness and honesty by the insured, will usually limit the risk of insurer’s repudiation. Being full and frank is likely to carry favour with the Court in the event of litigation.

The best advice must be that where a policyholder is in any doubt whether a complaint should be notified to insurers, he must liaise with his broker who will have practical experience of a particular insurer’s requirements and preferences. In short the broker is probably best placed to fulfil the objective test.