PROTECT

Cover to Cover

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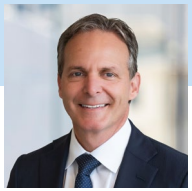
Foreword



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Welcome to the latest issue of Cover to Cover.

In this issue, we consider the Reserve Bank's proposed reforms to the Insurance (Prudential Supervision) Act, which signal a significant shift from our "light touch" insurance regulatory regime toward a more intensive and risk-based prudential framework. We also review the Financial Markets Authority's latest guidance on insurer incentives and sales campaigns and we consider the challenges of compliance when a regulator believes that prescriptive rules may not be enough to achieve desired regulatory outcomes.

Insurers should now be well under way with their preparations for the Contracts of Insurance Act 2024 coming into force next year. Its influence can be seen across many of the topics covered in this issue, including the duty of fair presentation, new obligations for policy drafting and unfair contract terms, disclosure of information and consumer rights.

We also look at other areas of law reform. Our feature on proportionate liability considers whether the insurance market is prepared to support the proposed new legislative framework for construction insurance and the importance of availability, affordability and capacity in determining its success. It is a timely reminder that legislative reform in the insurance industry can only achieve intended outcomes when it is supported by the market.

This issue includes three interesting case updates. We look at the English decision in *Cometsambre*, which offers an early indication of how courts may approach the new duty of fair presentation. We examine the *Medibank* decision in Australia and its lessons on litigation privilege in the context of insurer-commissioned reports. We also review the New Zealand High Court's decision in *Candida Trustee v Teak Construction (in liq)*, which highlights the evolving rules around claimants' entitlements to information about a defendant's insurance cover.

We conclude with a thought-provoking article which examines questions of disclosure, discrimination and policy interpretation in an unusual context. It is a reminder that insurance law often intersects with wider societal and legal issues in unexpected ways.

We hope you find this issue insightful, thought-provoking and practical.

Andrew Horne

Andrew Horne
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Proportionate liability meets market reality:

Is the insurance sector ready?

Authored by Partner Andrew Horne and Solicitor Matthew Gould

The proposed amendments to the Building Amendment Bill introduced to Parliament on 29 June 2026 will impose important new obligations and risks upon the New Zealand building industry.

At the time of its introduction, we published an article examining the shift to proportionate liability for defective building work. In short, this will make each liable party responsible for only its respective proportion of the loss. This is an important change, as parties that jointly cause a building and construction loss presently bear joint and several liability, so liability falls disproportionately upon parties that remain solvent when a claim is made.

As part of this reform, the Bill introduces new mandatory residential home warranties and professional indemnity insurance requirements.

Attention has turned to a question the Bill has left unanswered – whether New Zealand's insurance industry is positioned to deliver the cover upon which this reform depends. The adequacy, pricing, and availability of the necessary insurance will determine the success of this reform.

Two new compulsory insurance obligations

The Bill introduces two distinct mandatory insurance obligations to counteract the increased risk that proportionate liability creates for claimants, who may no longer be able to recover in full if a liable party is absent or insolvent:

- mandatory residential home warranties for residential building work with a total value of NZD100,000 or more (including GST), where the work involves restricted building work and requires a building consent. The warranty must provide minimum coverage of at least one year for defective building work and ten years for structural defects; and
- mandatory professional indemnity insurance for design consultants, being those who contribute through advice or other services to the design or compliance of building work, such as architects, designers, engineers, and surveyors. This obligation applies where the total price of the building work is NZD100,000 or more (including GST).[1]

These two obligations serve different purposes:

- The residential warranty gives homeowners direct, enforceable protection against the liable party if defects emerge (provided it remains solvent).
- Professional indemnity insurance will be available to pay claims, although it will respond only to a consultant's own contribution to a defect, consistent with proportionate liability's focus on aligning each party's exposure with its actual share of responsibility.

Providers of these products must register with Ministry of Business, Innovation and Employment (MBIE), with strict penalties for non-compliance. This adds a new layer of regulatory oversight for insurers and warranty providers operating in New Zealand, on top of the underwriting risk itself, and is a further factor bearing on whether the market can meet demand at the scale the Bill now requires.

The mandatory home warranty regime is not universal. Larger apartment buildings, where defects can be more costly, fall outside the mandatory scheme. Affected owners may be left without the direct, insurer-backed protection the reform is designed to cover, at a time when the shift to proportionate liability increases the risk of under-recovery.

Can the market deliver this cover?

The insurance market upon which the Bill relies is not deep at present. Only around 46% of new builds carry warranties or insurance today, and the largest existing schemes, Master Builders and Certified Builders, are limited in cover and are self-funded rather than insurance backed.[2]

Global insurers have historically approached the New Zealand building sector with caution. Stamford Insurance, currently the only true insurance-backed warranty product available, has already exited and re-entered New Zealand once before. The Insurance Council of New Zealand warned MBIE as far back as 2019 that this concentration could not be assumed to persist, given that this kind of market is sensitive to claims performance, financial market conditions, and regulatory change both in New Zealand and globally.[3]

Mandating cover across the sector is intended to change this dynamic by guaranteeing demand at a scale the voluntary market has not offered.

Mixed signals from the market

Whether guaranteed demand alone is enough to draw more providers into New Zealand remains unclear. MBIE has indicated that it has received informal approaches from underwriters based in Australia, London, and Paris, describing this as a positive sign of increased competition ahead of the mandate taking effect.[4]

However, the industry's more cautious voices point to structural features of the New Zealand market that guaranteed demand does not resolve. Stamford's founder has said that the insurance industry lacks the appetite to offer blanket cover and that Stamford applies a careful, selective underwriting process to every builder it insures, rather than relaxing standards to meet increased volume. New Zealand's two dominant general insurers do not currently offer specialised building warranty products, underlining the extent of the challenge.[5]

1 Building Amendment Bill (332-1) (explanatory note).
2 Jenée Tibshraeny "Insurers eye entry into New Zealand, as home building warranties/insurance due to become mandatory". The New Zealand Herald (online ed, Wellington, 29 June 2026).
3 Jenée Tibshraeny, above n 2.
4 Jenée Tibshraeny, above n 2.
5 Jenée Tibshraeny "Jury is out over whether homeowners will be left in the cold under Chris Penk's building regime overhaul" The New Zealand Herald (online ed, Wellington, 4 September 2025).

> For insurers and warranty providers, the Bill represents both an opportunity and a test."

A safety valve: The disapplication power

Recognising this uncertainty, the Bill includes a power for the Governor-General to temporarily disapply some or all the home warranty and professional indemnity insurance requirements. This power may only be exercised where there is a material impact on the availability or affordability of these products, such as a major market disruption or an insurer withdrawal, and a resulting risk to building sector continuity or housing delivery.

The inclusion of this power is an acknowledgment that the Government cannot compel private insurers to underwrite this risk, and that the reform's consumer protection framework is only as strong as the market's willingness to carry it. This offers some comfort that mandatory cover will not be required if the market cannot supply it. However, it also introduces a further layer of regulatory uncertainty for any new entrant weighing up a long-term commitment to the New Zealand market, since the very demand a mandate is meant to guarantee could be suspended if that market proves unable to meet it.

What this means for insurers, warranty providers, and consumers

For insurers and warranty providers, the Bill represents both an opportunity and a test. The prospect of guaranteed demand for qualifying residential building work is a strong incentive for the insurance industry. However, providers will need to satisfy MBIE's registration criteria and price for a ten-year coverage of structural risk in a jurisdiction with a history of costly systemic defects.

For consumers, the practical value of the reform will depend heavily on how the regulatory and industry dynamics resolve. A market with genuine competition and capacity would deliver on the Bill's promise of independent, enforceable protection. A market that remains thin would leave the consumer protection framework looking stronger on paper than in practice.

What's next?

The Bill is currently in the Select Committee stage and the detail of the registration criteria and minimum policy requirements are yet to be developed.

How the market responds in the lead-up to the regime taking effect will determine whether mandatory insurance delivers the consumer protection the reform is designed to provide.

Oliver Sutton
Senior Associate

When compliance isn't enough:

The FMA's expanding view of insurer incentives

Authored by Senior Associate Oliver Sutton

In June this year, the Financial Markets Authority (FMA) published a guidance note for licensed insurers titled *Insurer benefits and campaigns insights.* The note shares the FMA's observations on how insurers are managing incentives, in particular, non-monetary benefits such as gifts, prizes and trips, and internal short-duration sales campaigns, to ensure fair treatment of consumers under the new Conduct of Financial Institutions (CoFI) regime.

FMA's message: Compliance with the regulations is not enough

The FMA's key message in its June 2026 publication is that compliance with the specific incentives regulations may not be enough, given Conduct of Financial Institutions' (CoFI) more general overlay requiring insurers to treat consumers fairly. Whilst a bright-line rule provides apparent certainty, it cannot capture every way in which a non-monetary benefit or a time-limited campaign might distort behaviour toward consumers.

Under CoFI, financial institutions must maintain a written fair conduct programme (FCP) with effective policies, processes, systems and controls (PPSCs). For insurers, PPSCs should ensure incentives are designed and managed to mitigate or avoid adverse effects on consumers' interests. Where an incentive carries a potential adverse effect on consumers that cannot be managed under the FCP, even if the incentive is not itself prohibited, the FMA may take the view that the benefit or campaign is not appropriate.

What counts as a prohibited incentive

To recap, under the new CoFI regime and the updated Financial Markets Conduct Regulations:

- Incentives are a commission, benefit, or other incentive (whether monetary or non-monetary and whether direct or indirect).
- Incentives are prohibited if a person's entitlement to the incentive is based on a direct reference to a target or other threshold that relates to the volume or value of the services or products sold, such as a NZD1,000 bonus upon selling 100 life policies.
- Incentives are not prohibited if the entitlement is determined on a linear basis and is not tied to such a target or threshold. For example, a flat 5% commission payable on each insurance contract sold.

Australian comparison: *ASIC v Cohen*

In Australia, "conflicted remuneration" provisions were incorporated in legislation on 1 June 2013 following a parliamentary joint committee report. Conflicted remuneration is defined as any benefit that could reasonably be expected to influence the choice of financial product recommended or the financial product advice given. This definition is broader and more flexible than the bright-line approach adopted in CoFI and is therefore illustrative of how courts may approach potential claims that fall outside the explicit prohibition.

In *Australian Securities and Investments Commission v Cohen* [2025] FCA 1255, incentives were paid to insurance sales agents, including a Vespa scooter awarded to the top-selling agent and Bali trips awarded to sales agents who met individual sales targets. ASIC argued this conduct fell within the conflicted remuneration definition. The Court held that, even though the incentives caused sales agents to work harder and sell more policies, this did not establish that the content of what was said to customers was influenced. Accordingly, the conflicted remuneration case was not made out. This case is on appeal and judgment is awaited.

New Zealand's likely approach

The incentives which were the subject of the claim in Cohen would, on their face, fall within the prohibited incentive definition in New Zealand, since access to the Vespa and the Bali trips was tied directly to individual sales targets rather than being paid on a linear basis. However, if a New Zealand insurer structured a similar campaign so that it fell outside the prohibited incentive definition (for example, by paying a flat rate per sale with no target), the insurer may also need to show that its FCP and PPSCs had considered whether the campaign could produce the same kind of behavioural pressure that ASIC alleged but could not prove in Cohen. It seems likely that, if an action was taken, the Court would look at whether customers may have been influenced by the campaign.

In practice, insurers should:

1. Include a wide range of stakeholders when designing a benefit or campaign, not just distribution, marketing and campaign managers. This will highlight any potential risks earlier in the process.
2. Consider whether the campaign's likely outcomes could affect the fair treatment of consumers and, if so, whether that risk can genuinely be managed under the FCP.
3. Undertake a documented FCP/PPSC risk assessment for each benefit or campaign and consider whether the arrangement could be defended if needed.
4. Keep records of design, approval, and ongoing monitoring decisions, so they can be produced on request.
5. Build in proactive, outcomes-focused monitoring throughout the life of a campaign, rather than relying on complaints as the trigger for review.

What's next?

The FMA has said that it will actively test insurers' incentive arrangements through its supervisory and monitoring activities under the CoFI regime, and will expect prompt remediation, including changing or stopping a benefit or campaign, where its PPSCs prove inadequate. Even if an insurer's benefits and campaigns comply with the specific incentives regulations, that still might not be enough to comply with wider CoFI obligations.

The FMA has clearly signalled that insurers should be prepared for further scrutiny.

IPSA reform gathering pace:

Key changes for New Zealand insurers

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Authored by Partner Lloyd Kavanagh and Solicitor Sarah Waller

The Reserve Bank of New Zealand (RBNZ) is aiming for 2028 to bring in substantial reforms of the Insurance (Prudential Supervision) Act (IPSA), with additional standards on more than seven matters issued between 2028 and 2032.

On 15 April this year, the RBNZ issued its Exposure Draft for the IPSA as the latest step in its long running consultation, with responses closing 28 August 2026.

It is likely no accident that timing will come amidst the next Financial Stability Assessment Programme (FSAP) assessment in New Zealand (with our last FSAP, in 2016, triggering many of the topics for reform).

Summary of key changes

The IPSA reforms aim to transform our 'light-touch' insurance regulatory regime into a more intensive, risk-based approach more closely comparable to the United Kingdom, European Union and Australian regimes.

1. **New proportionality principle:** When developing its proportionality framework, the RBNZ will be required to have regard to the size, nature, and systemic importance of the insurer.
2. **Amendments to licensing perimeter:** Exempting offshore captive insurers and reinsurers who are already subject to equivalent regulatory oversight in their home jurisdictions. This proposal would enable New Zealand to better secure reinsurance capital, which is a policy priority for prudential regulation.
3. **RBNZ has the power to issue Standards on more than seven matters:**
   - Governance: Board composition and responsibilities, and whether an insurer must be incorporated in New Zealand. The Standards are yet to clarify how this interacts with APRA's CPS 320, which will be a point of contention for many New Zealand licensed insurers.
   - Solvency standard: A new 'Ladder of Intervention Framework' involving a graduated approach to solvency assessment, with the intensity of regulatory scrutiny increasing as capital levels decrease.
   - Risk management: Outline of policies and processes for specific risks the Standards will enumerate. The Exposure Draft provides no indication of whether the RBNZ will require insurers to complete an internal capital adequacy assessment process.
   - Disclosure of information.
   - Contingency and recovery plans: Covers regulations during recovery and resolution.
   - Actuarial advice.
   - Other matters, including outsourcing and related party exposures.
   - Any matters prescribed in regulations.
4. **Enhanced enforcement powers:** The RBNZ will have the power to conduct onsite inspections without notice. The proposed wording in the Exposure Draft diverges from standard international practice. For example, Australia's Insurance Act 1973 requires APRA to serve a written show-cause notice giving the insurer an opportunity within a confined 14-day window to explain why an investigation should not proceed. The enhanced enforcement powers align with the RBNZ's intention to impose greater regulatory scrutiny over licensed insurers.

5. **New declaratory power:**
   A significant change to IPSA is the proposed declaratory power allowing the RBNZ to declare borderline products of insurance a 'contract of insurance' under s 7. In its current wording, the power is broad and discretionary in scope. If the declaratory power proceeds as currently drafted, regulated entities will need to review their current product offerings and assess any implications of a declaration that a product is a contract of insurance.
6. **Pre-approvals regime:**
   The Exposure Draft proposes a requirement for insurers to gain the RBNZ's prior approval for relevant appointments. The Exposure Draft includes the introduction of a role not previously required under IPSA: the Chief Risk Officer (CRO). As drafted, the proposal sets CRO appointments as a minimum requirement.
7. **Distress management:**
   The 'Contingency and Recovery Plans' Standard does not define the 'Recovery Plan' obligation. The definitional architecture in IPSA does not specify regulatory triggers or prescribed thresholds for when an insurer moves from 'Recovery' to 'Resolution'. The 'Remedial Plan' and 'Remedial Notice' introduce novel concepts, creating a new obligation for insurers to give the RBNZ a plan setting out actions it will take to minimise contraventions of licence conditions, Standards, or IPSA requirements.

New solvency margins

The Exposure Draft introduces significant changes to distress management and reporting processes. The proposed definitions for 'failing to maintain a solvency margin' and 'failing to maintain a prudential margin' do not clarify the position for insurers operating above the Minimum Capital Requirement but below the Prudential Capital Requirement (PCR).

Insurers should be aware that the definitional architecture in the Exposure Draft diverges from generic ladder of intervention frameworks. The RBNZ has not adopted labels with which appointed actuaries will be familiar. For example, APRA sets the PCR as a regulatory minimum, with any breach engaging supervisory intervention. The current Cabinet proposal sets the 'solvency margin' as the early warning trigger, with the PCR operating below that.

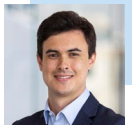
It will be important for insurers to engage closely with their appointed actuaries to understand potential changes to their reporting obligations.

What's next?

The RBNZ has not yet finalised the detailed timeline and transition arrangements for implementing the changes to IPSA. The first step would be enacting the reform legislation in 2027 to come into force in 2028. Long-term implementation timeframes will depend on how much Cabinet under the next Government prioritises IPSA reform and the outcome of the consultation.

Remaining cognisant of the RBNZ's reform proposals, and any timelines for IPSA reform, is imperative to adapting and adjusting to the new regulatory regime.

Insurers should take note of any adjustments to the Draft following the Consultation process, and then monitor progression of the reform Bill resulting from it. The Parliament Select Committee will effectively be the last opportunity to correct any unintended impacts.



Sean Dolan
Senior Associate

The CoIA's new reality:

Plain language meets unfair contract terms

Authored by Senior Associate Sean Dolan

The Contracts of Insurance Act 2024 (CoIA) and the Contracts of Insurance (Repeals and Amendments) Act 2024 (CoIRA) bring plain-language drafting and unfair contract terms closer together than ever before. Under CoIA, insurers will need to think about clarity and fairness as connected obligations, and not as separate matters.

A new plain-language requirement

Section 20 of the CoIRA inserts a new subpart 6B into Part 6 of the Financial Markets Conduct Act 2013 (FMCA), applying to consumer insurance contracts and to life or health insurance contracts. One new section, s 447A, requires the insurer to ensure such a contract "is worded and presented in a clear, concise, and effective manner". Interestingly, this is also paired with a positive obligation: in performing that duty, the insurer must have regard to whether the wording and presentation of the contract assist consumers to understand their rights and obligations under the contract. "Concise" is defined by reference to the wording and presentation of particular terms, not overall document length, so a shorter policy is not, by itself, a concise one.

Companion provisions ss 447B and 447C extend the theme, requiring compliance with prescribed form and presentation requirements and public disclosure of certain information to support consumer decision-making and transparency. Like the majority of the CoIA reforms, these provisions have been enacted but are not yet in force, with a long-stop commencement date of 15 November 2027.

Many insurers have already moved towards a more modern, plain-language style of policy drafting well ahead of any formal requirement to do so. Section 447A formalises this direction and gives it statutory backing, but it is not a wholly novel concept to the industry.

Unfair contract terms: A narrower safe harbour

The unfair contract terms changes under the CoIA reforms mark a significant shift from the current position. Sections 8 to 12 of the CoIRA amend the Fair Trading Act 1986 in ways that meaningfully recalibrate how the existing 'exceptions' apply to insurance contracts.

Under the current law, s 46L(4) of the Fair Trading Act reverses the ordinary presumption for a defined list of core insurance terms (including terms identifying the risk insured, the sum insured, exclusions, the basis for settling claims, the premium, the duty of utmost good faith, and disclosure requirements) deeming them automatically "reasonably necessary" to protect the insurer's legitimate interests. This presumption reversal will be repealed.

In its place, new s 46KA defines (and essentially limits) the concept of the "main subject matter" of an insurance contract, and therefore the aspects of the contract that are beyond unfair contract terms challenge altogether. The only matters that will be considered the "main subject matter" are set out in a closed list, similar but not exactly the same as the existing list under s 46L mentioned above.

The key takeaway for insurers is that the new regime is likely to bring a wider range of provisions, and different aspects of the contractual relationship, within the scope of unfair contract terms scrutiny than is currently the case. Terms dealing with matters such as claims-handling discretions, variation rights, or cancellation triggers that might previously have been shielded by the s 46L(4) presumption will need to be assessed afresh against the ordinary unfairness test, without the benefit of that reversed presumption.

The role of transparency

Plain-language drafting is not merely good practice, it is a key feature of the unfair contract terms test itself. A court assessing whether a term is unfair under the Fair Trading Act must consider "the extent to which the term is transparent" and the contract as a whole. 'Transparency' in the Fair Trading Act is defined as meaning a term that is:

- expressed in reasonably plain language; and
- is legible; and
- is presented clearly; and
- is readily available to any party affected by the term.

For insurers navigating the narrower exceptions described above, well-drafted, transparent terms are one of the more practical levers available for managing the unfair contract terms risk.

Watching case law develop

In the absence of case law or other specific regulatory guidance as to how the narrower s 46KA exceptions will be applied in practice, insurers are in a genuinely difficult position when assessing which terms remain protected and which do not. This uncertainty may justify a more cautious initial approach to policy wording pending clearer guidance or early judicial consideration.

This is an area we expect to develop significantly once the regime comes into effect, and we will be following it closely and with interest.

Trans-Tasman comparison

Australia offers a useful, if imperfect, point of comparison. Although the insurance-specific aspects and tests are different, the general statutory unfair contract terms tests are materially the same across New Zealand and Australia.

Australian courts considered plain-language presentation and unfair contract terms together in *Australian Securities and Investments Commission v Auto & General Insurance Company Limited* [2025] FCAFC 7. This case involved litigation over a home and contents insurance notification term and examined both whether the clause was drafted transparently enough for consumers to understand their obligations, and whether the term itself created an unfair imbalance. One of the points in dispute was the interpretation of a notification obligation on the insured, specifically a provision stated as follows: "you need to tell us if anything changes about your home or contents". The Court favoured a narrower interpretation of the provision, i.e. that the obligation did not literally extend to 'anything' having changed, and that, as a result, the alleged unfairness was not well established.

The discussion and analysis in this case highlights the importance of careful plain-language legal drafting, where the aim should always be to make sure legal certainty is not compromised when drafting is made more 'plain'. From our experience, across the full spectrum of financial services and products, this can be a challenging balancing act.

Looking ahead

Depending on where an insurer currently sits on its plain-language journey, it may need to treat plain-language drafting and unfair contract terms exposure as a single workstream rather than two, as the CoIA's implementation timeline progresses. Adherence to the new FMCA duties is likely to be one of the more effective ways of managing unfair contract terms risk under a regime that, in several respects, offers a narrower safe harbour than insurers currently enjoy.

We will continue to track how these regimes develop as the CoIA moves towards commencement.

Andrew Horne
Partner

When Jesus loves you, but your insurer doesn't

Authored by Partner Andrew Horne

Mr Simeon Chandra of Birmingham is a committed Christian. Wishing to share his devotion, he decided to express his faith with a message on his car, a 2009 Nissan Pixo. He did this by writing "JESUS Loves you" on one side and "Jesus Loves you V much" on the other, using coloured sticky tape.

Prudently, he declared this to his insurer as a 'modification' to his vehicle. Unfortunately, this caused a problem, because his insurer, GoSkippy, "declined the modification" and advised him that his policy would not remain in effect unless he removed the tape and provided evidence that he had done so.

"*Feedback from the Underwriting Department declined the modification done on the vehicle as per stickers added on the vehicle. For the policy to continue and be insured we require the stickers to be removed from the vehicle and send a dated photograph once the stickers have been removed.*" – GoSkippy

Mr Chandra objected to this and while he removed the stickers, he sought legal advice from a Christian legal centre as to whether his rights to freedom of expression and religious belief had been breached.

Similar issues had arisen in another case some years earlier when another insurer, Age UK Insurance, advised an independent Christian minister that professionally made letter stickers she had placed on her car spelling out "Christ must be Saviour" could be viewed as modifications that might invalidate her policy, when she made a claim for minor damage. In that case the insurer ultimately accepted her claim, having decided that it had not been clear enough in its request to declare all modifications.

These cases raise several issues of law relating to insurance.

May an insurer deny cover for a statement of religious belief?

Under s 21(1)(c) of the Human Rights Act 1993, religious belief is a prohibited ground of discrimination. Section 44 makes it unlawful for anyone who supplies goods, facilities, or services to the public – which expressly includes insurance facilities under s 44(2) – to refuse to provide them, or to treat a person less favourably in providing them, by reason of a prohibited ground of discrimination.

The Human Rights Review Tribunal has held that the s 44 prohibition on refusing a service is absolute and requires no comparator – a complainant need only show that the service was supplied to the public and was refused "by reason of" a prohibited ground, after which the onus shifts to the alleged discriminator to establish a statutory exception. While s 48 permits insurers to offer policies on different terms for different sexes, disabilities, or ages where the differential treatment is based on actuarial or statistical data or reputable actuarial or medical opinion, these exceptions do not extend to religious belief.

There must, however, be a genuine causative link between the prohibited ground and the refusal for liability to attach. The issue is whether cover was refused because of Mr Chandra's expressed Christian belief, or because of something unrelated, which was genuinely about vehicle risk.

Does taping a message to your car constitute a "*vehicle modification*"?

"Modification" is a term insurers use frequently and define rarely. Standard motor policies typically require disclosure of "modifications" that affect performance, value, or risk, such as the addition of turbochargers, body kits, modified exhausts or lowered suspension. Some insurers view non-original wheels or even upgraded stereo systems as disclosable modifications.

A few strips of tape spelling out a gospel message is not, on any sensible reading, a modification in the sense these clauses are aimed at: it does not alter the vehicle's mechanical performance, enhance its 'sporty' or performance characteristics, distract the driver, or otherwise add (in any measurable sense) to its risk of being involved in an incident that might give rise to a claim. It is a decoration, arguably comparable to a bumper sticker, "*Baby on Board*" sign, or an ill-advised novelty decoration. It may also be compared to commercial messages or corporate signs, which are commonly affixed to vehicles.

"Modification" clauses in New Zealand motor policies are typically drafted broadly, so there is room for an insurer to argue that they are engaged by any change to the vehicle's external appearance from its as-manufactured state. The law offers a degree of protection, however, in that under s 5 of the Insurance Law Reform Act 1977, a contract of general insurance cannot be avoided merely because a statement made in the proposal was inaccurate unless that statement was both substantially incorrect and material. "Substantially incorrect" and "material" are measured by what a prudent insurer would have considered material and relevant to the premium or the terms on which the risk would have been accepted.

It is difficult to see on what basis a prudent insurer would regard a taped message as making a statement that there are no modifications substantially incorrect and material, but there are a few possibilities.

It is possible, for instance, that some slogans or statements might increase the risk of vandalism, although Mr Chandra's wording seems innocuous. Another possibility is that the nature of the message, being tape that was fairly roughly applied, sends a message about the owner's general care of the vehicle. The difficulty with this is that insurers do not generally treat other aesthetic choices, such as a faded paint job or a vehicle being in a dirty and generally unloved (but not unsafe) state, as a modification or otherwise as a risk factor.

Will the Contracts of Insurance Act change any of this?

The Contracts of Insurance Act 2024, when it comes into effect, will change some of the principles discussed above.

It will not touch the discrimination analysis, which remains a Human Rights Act question. Where the Act will make a difference is in relation to disclosure and misrepresentation. It replaces the current framework, including the Insurance Law Reform Act materiality test, with a statutory duty regime distinguishing consumer and non-consumer insureds.

The key change is that consumer insureds will have a new duty to take reasonable care not to make an incorrect or misleading answer to insurers' requests for information. Whether vehicle changes will constitute modifications will be viewed from the perspective of the insured, rather than from the perspective of what a reasonable insurer would have viewed as substantially incorrect and material. Another important change will be that where an insured fails to disclose a material modification, the insurer's remedy will be limited to a proportionate response, such as charging an additional premium rather than declining a claim if it would not have refused cover had it known of the modification.

The Act will also extend the Fair Trading Act unfair contract terms regime to apply to insurance wordings. Practically, that means a "modification" clause that is unclear may face scrutiny if it operates to defeat reasonable consumer expectations. Insurers may need to be more transparent about what they require to be disclosed.

Conclusion

Mr Chandra's faith was not a valid basis to refuse him cover, and his tape artwork was probably not a "modification" in any material sense. An insurer relying on reasons such as these needs to tread carefully.

Case update

Candida Trustee Company Ltd v Teak Construction Group Ltd (in liq) [2026] NZHC 1352

Oliver Sutton
Senior Associate

A recent High Court decision provides useful guidance as to claimants' entitlements to information about defendants' liability insurance policies, to assist in making claims against insurers.

What happened

Teak Construction Group Ltd, a defendant in arbitration proceedings, was placed into liquidation shortly before an arbitration hearing. The arbitration was stayed by operation of the moratorium preventing continuation of proceedings against a company in liquidation without leave of the court. The plaintiffs applied under s 284 of the Companies Act 1993 for directions requiring the company's liquidators to disclose its professional indemnity policy wording, schedules, insurer/broker details, and whether indemnity had been accepted or defence costs advanced under reservation.

The liquidators' report estimated a likely surplus of around NZD6 million after preferential creditors, against unsecured claims of almost NZD8 million, suggesting a material (if partial) recovery was expected regardless of insurance.

Issues arising

Noting that s 284 is not the orthodox route for a request for documents, the Court nonetheless granted leave to bring the application, given the novelty of the point. Substantively, the Court held that insurance is generally irrelevant to liability and damages issues in an underlying claim, and declined to order disclosure on a discovery rationale, noting that the arbitration itself was stayed and any evidential dispute could be managed by the arbitrator if and when arbitration resumed.

The Court did recognise a narrow disclosure obligation: liquidators must confirm the identity of any potentially responsive insurer so a creditor can be satisfied that notice has been given under s 9(6) of the Law Reform Act 1936 to preserve a statutory charge. Other than this, nothing more was required, and no determination of quantum or acceptance of liability was needed for that purpose.

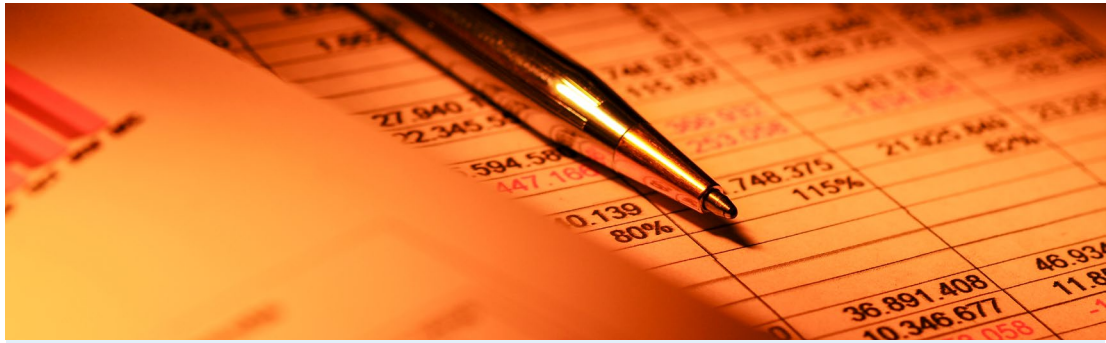
On the facts, the Court found the claimants' real motive was to obtain a negotiating advantage rather than to assess viability (unlike the Australian cases, where claims might not proceed at all without insurance funds), and inferred this from the fact that most costs of the claim had already been incurred and the estate showed a likely surplus.

The Court also gave a useful description of the interaction between the s 9 statutory charge and Part 16 of the Companies Act: a s 9 charge over prospective insurance proceeds is not "property owned by the company" and does not need to be identified or elected upon in a proof of debt form, since the charge attaches to money still under the insurer's control, not to any asset in the liquidators' hands. This confirms that a creditor pursuing a s 9 remedy is not put to an election between proving in the liquidation and pursuing the insurer, and does not need further disclosure to complete a proof of debt.

The future Contracts of Insurance Act regime

The plaintiffs also sought to argue that the policy shift under the not-yet-in-force Contracts of Insurance Act 2024 should be taken into account. CoIA introduces a new regime that governs third party claims against insurers, which is more straightforward than the current s 9 statutory charge process. Under the new regime:

1. A person who reasonably believes another is a specified policyholder with an insured liability to them may serve a written notice requesting information under Schedule 3, setting out the facts relied on.
2. That person can ask for details such as whether cover exists, the insurer's identity, policy terms, any dispute over liability, related proceedings, fund pay-outs, and any security interest over proceeds. The recipient has 28 days to provide the requested information, and if it cannot must explain why not.
3. Policy terms that attempt to prohibit or restrict disclosure are ineffective.
4. A claimant with an insured liability against a "specified policyholder" may then recover directly from the insurer in court proceedings, subject to first obtaining leave of the court, and stands in the policyholder's shoes.



Points of interest

Whilst the CoIA will provide a much more direct route than the current s 9 statutory charge mechanism, the Court held that, as this was a future regime, it was not relevant for the present application.

Currently, whilst liquidators must at least confirm the identity of a potentially responsive insurer to enable the charge notice to be given, the Court confirmed that liquidation does not itself dilute an insurer's interests in keeping its records, such as policy wording, limits, or claims history, confidential.

The analysis of the s 9 charge as attaching to a "prospective payment" rather than to company property is consistent with existing Supreme Court authority and is consistent with the charge being over money still in the insurer's hands, rather than over an asset controlled by the liquidator. A creditor asserting a s 9 charge is not put to any election in the proof of debt process, and does not need further information from the liquidator to protect that charge.

Case update

Medibank Private Limited v McClure [2026] FCAFC 38

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The Full Federal Court's recent decision in *Medibank Private Limited v McClure* [2026] FCAFC 38 is an opportune reminder of the 'dominant purpose' test for litigation privilege. The Court confirmed that where the legal purpose does not objectively prevail over competing purposes of substance, such as governance, remediation, regulatory engagement, and public communications, a privilege claim will fail.

Why is this important?

The decision is of particular significance for insurers, who routinely commission expert reports and valuations for purposes that may sit in the 'grey area' between assessing a claim and preparing for litigation in respect of it.

In New Zealand, we apply a dominant purpose test when determining whether a document is protected by litigation privilege. Medibank provides a worked example of how a court will navigate complex, layered facts to determine whether a report was truly made for the dominant purpose of preparing for litigation.

Background

In 2022, Medibank Private Limited suffered a cyber-attack that exfiltrated customer data. Medibank mobilised a legal, technical, regulatory, operational and reputational response. It engaged a law firm to provide legal guidance and to involve external advisers for an incident response and to prepare crisis communications. While Medibank's CEO was cognisant of litigation risk, including class action risk, in those initial weeks the company was investigating what had occurred so it could notify customers, shareholders, regulators, law enforcement and government agencies.

Medibank's lawyers engaged Deloitte on Medibank's behalf to produce three reports: one examining the incident, one identifying root causes, and one assessing compliance with Australian Prudential Regulation Authority (APRA) Prudential Standard CPS 234.

When customers later brought 'class action' proceedings against Medibank in respect of the breach, they sought disclosure of the Deloitte reports. Medibank resisted, arguing that they were privileged.

At first instance, the Judge found that Medibank had not demonstrated that obtaining legal advice was the dominant purpose of the reports. The key question on appeal was whether obtaining legal advice was genuinely the dominant purpose, or whether the other governance and investigatory objectives had taken precedence.

Important considerations

Medibank argued that the Judge had misapplied the dominant purpose test by treating the existence of other purposes as destructive of privilege. Medibank highlighted that, after a major cyber incident, a company facing class actions and regulatory scrutiny must inevitably deal with lawyers, regulators, the market, and its own governance all at once.

Praising the first instance Judge's assessment of the evidence of Medibank's dominant purpose, the Court agreed that the direct evidence of Medibank's Chair, CEO and General Counsel on this issue carried weight, but could not capture the whole of Medibank's institutional purpose. While each gave evidence that the dominant purpose of the Deloitte Reports was to obtain legal advice, the Court observed that "while relevant, it is not enough that a party or its officers honestly say, or even honestly believe, that the legal purpose was dominant."

The Court also found that an ASX announcement made at the point of commissioning the report, which described a review as serving managerial functions, indicated that the legal purpose was not necessarily the dominant one.

The report was not privileged. The additional functions of the report were too significant to be treated as incidental. Though a legal purpose was present, it was not the prevailing purpose.

Legal channels will not trigger privilege per se

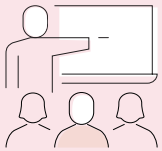
A central theme in Medibank's submissions was that the Deloitte reports were commissioned and directed by its lawyers. While the Court noted that a formal retainer is a strong indicator of purpose, simply reciting "dominant purpose" in an engagement letter does not settle the question. Otherwise, privilege would turn on how well the letter was drafted rather than on the true substance of the engagement. Courts will look past formal retainer language to assess the practical and institutional role the document was actually intended to play.

The consequences of fulfilling multiple purposes

Medibank argued that it was commercially sensible to design a single review that could serve its legal needs and regulatory interests. It argues that the first instance Judge wrongly treated this as evidence that the review was commissioned for a distinct regulatory purpose of equal weight.

The Court acknowledged that if Medibank's lawyers had decided on a legal review and then informed APRA of it, the regulatory dimension might be viewed as practical and collateral. However, Medibank had not disclosed the review to APRA passively. Instead, it actively engaged with the regulator about the review's scope and governance.

Separately, Board oversight supported the conclusion that the legal purpose did not prevail. While Board involvement was not itself fatal to privilege, the fact that the review was commissioned, structured and reported within a framework of Board oversight was indicative of its broader commercial purpose.



Key takeaways for insurers:

- **The way a report is framed is important, but not decisive:** Public statements made at the point of commissioning, the extent of involvement of external bodies about the review's scope, and the integration of the review into collateral purposes will likely be taken as evidence of purpose and may overwhelm subjective intent. Language that appears to prioritise non-legal objectives risks undermining a privilege claim.
- **Ring-fence legal reports:** Where possible, maintain a clear distinction between a report that is commissioned for litigation and one commissioned for any broader or overlapping purposes. Integrating a commissioned report into board-level reporting, remediation tracking, or regulatory response plans risks converting the legal purpose into one of several objectives where it is not the dominant purpose.
- **Document institutional purpose broadly:** Ensure that internal records and communications consistently reflect the understanding of a dominant legal purpose.

Case update

Cometsambre SA v Lloyd's Insurance Company SA HIG 5321 [2026] EWHC 1837 (Comm)

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What will non-consumer policyholders' new duty to make a "fair presentation of the risk" require once the Contracts of Insurance Act 2024 (CoIA) comes into effect?

A recent decision of the High Court of England and Wales provides an indication of how the New Zealand courts may approach this question. It is a relatively rare example of a decision in which an insurer was successful on this issue.

What happened?

Cometsambre, a scrap metal trader, experienced five fires (three on chartered vessels and two on the quayside) in an 18-month period between 2020 and 2021, but no material loss had resulted from them. Its broker had obtained Charterer's Liability insurance via a coverholder, Antwerp Insurance Claims Associates NV (AMICA), which wrote the risk on behalf of Lloyd's Syndicate HIG 5321. When renewing in 2022, Cometsambre did not disclose the fires.

A sixth fire followed, which resulted in substantial charterparty claims. When Cometsambre sought indemnity for its defence costs, the insurer purported to avoid the policy for breach of the duty of fair presentation. Cometsambre argued that there was no breach on the basis that the fires were not material, insurers were on notice to enquire, and alternatively that disclosure had been waived.

The Commercial Court rejected these arguments and held that the insurer was entitled to avoid the policy and decline the claim.

Were the fires material?

The first question was whether the five fires that had not generated claims amount to material circumstances requiring disclosure. Butcher J held that they did.

Under section 3(4)(a) of the UK Insurance Act 2015 (UKIA), mirrored in s 31(1)(a) of the CoIA, a non-consumer insured must disclose every material circumstance it knows or ought to know. A circumstance is "material" if it would influence a prudent insurer's judgement in deciding whether to accept the risk and on what terms (s 7(3) UKIA / s 32(1) CoIA).

Applying the test in *Delos Shipholding SA v Allianz Global* [2024] EWHC 719 (Comm), Butcher J confirmed that an insurer need not show that the undisclosed facts would have been decisive, but only that a prudent underwriter would have wanted to take them into account.

His Honour rejected the argument that an insurer should wait for a claim arising from an event before viewing it as material. Five fires within 18 months pointed to a significant change in risk profile, particularly when there had been no fires in the previous 12 years, so that the insurer had reasonably viewed the risk of fire as low. Indeed, fires were held to be a "paradigm example of an incident which can give rise to liability". Furthermore, the absence of an identified single cause only heightened relevance. The decision underscores that information explaining the nature, frequency or evolution of a risk is likely material, even where consequences have not fully crystallised.

Was the insurer on notice to enquire?

Cometsambre argued that the insurer knew it shipped shredded steel scrap and had never requested updated risk information, so it was on notice to enquire about incidents that had not triggered claims. Butcher J rejected this as impermissibly reversing the burden of fair presentation, which rests on the insured. After many years in which there were no fires, insurers were not on notice of the need to enquire as to a change in their incidence.

Was the insurer presumed to have had knowledge?

For reasons overlapping with the above reasoning, AMICA was not presumed to know that fires had occurred, let alone that five fires had broken out in 18 months after a long incident-free period.

Had the insurer waived disclosure?

Cometsambre argued that the insurer's conduct amounted to a waiver of disclosure under s 3(5)(e) UKIA (reflected in s 31(2) CoIA). It pointed to the fact that it was asked only for claims history at inception, was never sent a renewal questionnaire, and that renewal discussions referenced claims ratios rather than incidents.

Butcher J applied a test referred to in McGillivray on Insurance Law (16th ed) 16-086 and *Young v Royal and Sun Alliance Plc* [2019] SLT 622: would a reasonable observer have understood underwriters to have limited their concerns to claims alone? They would not. The initial liability questionnaire was prepared by Cometsambre's broker, not AMICA. In any event, the absence of renewal questionnaires was standard market practice. A request for a "claims record" could not reasonably indicate indifference to multiple fire incidents since inception even though they had not resulted in claims.

Inducement

Cometsambre argued that AMICA would have written the risk on the same terms regardless. Butcher J, noting the risk that honest underwriters may convince themselves they would have declined under a counterfactual such as this when in fact they might have accepted the risk, nevertheless disagreed. Inducement is judged on factual, not expert evidence, but the insurer's factual evidence was supported by expert evidence. Here, the repeated fires raised concerns that the risk insured may no longer have matched the risk originally presented. Given the prospect of substantial losses relative to the premium, a prudent underwriter would have wanted to assess whether changes in cargo profile or other risk factors had increased exposure.

The Court accepted that a prudent underwriter would not have wished to face the risk of another fire at all after the first five fires in which loss was avoided. The pattern of five fires in quick succession indicated that there was a potential change or quality issue with the cargo, suggesting a change in the risk profile. The Court found that AMICA would not have accepted the risk at all had the fires been disclosed. It would not have accepted the risk on different terms. It was therefore entitled to avoid the policy and decline the claim.

The New Zealand position

The duty of fair presentation under the CoIA is substantially the same as that under the UKIA. Sections 29–33 of the CoIA require disclosure of every material circumstance known or reasonably discoverable, presented clearly and accessibly, with representations of fact being substantially correct. The same carve-outs apply: no need to disclose what diminishes the risk, what the insurer already knows, or what it has waived.

The proportionate remedies regime in Schedule 2 mirrors the United Kingdom approach: avoidance and premium retention for deliberate/reckless breaches and limited remedies (contract variation, premium adjustment, proportionate claims reduction) where the breach is not innocent or negligent. Cometsambre will likely guide how New Zealand courts interpret these provisions.

Practical takeaways for insurers

- **The materiality bar is low:** Courts will not require insurers to prove that undisclosed facts would have been decisive in their underwriting decisions. It is enough that a prudent underwriter would have wanted to "take them into account", or as Butcher J noted, if they give an overall picture of the risk. Incidents that could generate claims are material, whether or not they resulted in claims.
- **Silence is not a waiver:** Not sending a renewal questionnaire, not asking follow-up questions, and focusing on claims ratios will not constitute waivers under s 3(5)(e) UKIA / s 31(2) CoIA. Insurers need not chase information to preserve their rights.
- **The burden to present the risk fairly is on the insured:** Attempts to reframe the duty as requiring insurers to ask the right questions will likely be resisted.
- **Patterns matter:** Repeated incidents within a short period may be particularly material, as they can indicate deficiencies in the insured's prevention measures and provide insight into the nature and extent of the risk being underwritten.
- **Document underwriting rationale:** Insurers who can demonstrate, with evidence, what they would have done differently in a counterfactual, such as declining cover, re-pricing or imposing conditions, will be best positioned to invoke the proportionate remedies under Schedule 2 of the CoIA.

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