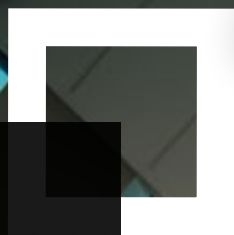


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Cover to Cover

Issue 35

Our publication for New Zealand insurance professionals

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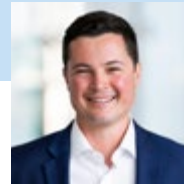
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Foreword



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In this edition of *Cover to Cover*, we take a closer look at legal developments shaping the insurance sector.

We provide timely insights into how insurers are responding to an increasingly demanding claims environment, marked by procedural reform, heightened disclosure obligations and evolving claimant behaviour.

We begin with an examination of the new High Court Rules, which introduce a fundamentally different approach to civil litigation. By front-loading costs and requiring earlier, more substantive engagement with the merits of a case, the new framework has immediate implications for reserving, excess structures and litigation strategy, as well as longer term consequences for settlement negotiations and claim volumes.

We then take a deep dive into the incoming duty on policyholders of consumer insurance contracts to take reasonable care not to make a misrepresentation.

Drawing on recent UK authorities that are likely to be influential in New Zealand, this article highlights the critical role of clear underwriting questions, rigorous application processes and robust underwriting evidence as insurers prepare for the commencement of the Contracts of Insurance Act.

We also discuss the implications of insurers' recent decisions to pause offers of new insurance in loss-prone postcodes.

We explore the growing challenge of obsessive and vexatious claimants, a trend increasingly amplified by the use of AI tools.

We conclude with a recent High Court decision that addresses an important procedure available to financial services providers dealing with external dispute resolution problems.

Our internationally recognised Insurance team is best known for operating at the intersection of insurance disputes, financial services regulation and major commercial risk. We are regularly instructed on matters that raise novel legal issues, heightened regulatory scrutiny, and reputational exposure.

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.



Hannah Jaques
Partner

The new High Court rules: The status quo and proposed law changes

Authored by Hannah Jaques, Partner

A new procedural framework that governs ordinary civil proceedings commenced in the High Court from 1 January 2026.

The High Court (Improved Access to Civil Justice) Amendment Rules 2025 represents the most significant overhaul of civil litigation procedure in recent memory, with sweeping changes intended to streamline proceedings, reduce costs, and advance proportionate and efficient resolution of disputes.

Crucially, while the new rules are designed to reduce the overall cost of litigation, they do so by front-loading costs and procedural demands at the outset of proceedings.

They will have substantial implications for the insurance industry.

Impact of the new rules on the insurance industry

Before turning to the detail of what has changed, it is worth identifying at the outset the key areas in which we expect the new procedural regime to affect insurance operations and strategic decision-making.



1. Reconsideration of excess levels and reserving

The front-loading of legal costs under the new rules is perhaps the most immediate and significant practical implication.

Under the new regime, parties – and in particular defendants – face substantial early expenditure: enhanced initial disclosure

obligations must be completed at the time of filing initial pleadings, factual witness statements must be served early in the proceeding, and parties must engage deeply with the substance of their case from the outset.

This means that the cost curve of litigation has changed materially. Costs that were previously incurred over a longer period – spread across discovery, interlocutory skirmishes, and evidence preparation – will now be concentrated in the early weeks and months of a proceeding.

For insurers managing claims on behalf of insureds, this has two immediate implications:

- **Reserving must be recalibrated.** Initial reserves can no longer be set on the basis that significant costs will only be incurred as a matter approaches trial. Early reserves will need to reflect the reality that meaningful legal expenditure commences almost immediately upon the filing of proceedings.
- **Excess levels warrant review.** Where an insured's excess is set at a level calibrated to earlier, more gradual cost profiles, those thresholds may be reached more quickly than anticipated. Insurers and their insureds should consider whether existing excess structures remain appropriate under the new regime.

Impact of the new rules



Reconsideration of excess levels and reserving



Need for good document management and recall systems



Earlier settlements may be more attractive



Careful consideration of subrogated claims



Potential increase in claims against insurers

The new High Court rules: The status quo and proposed law changes



2. Need for good document management and recall systems

The timeframes for provision of enhanced initial disclosure are relatively tight, particularly for defendants. It will be crucial to claims brought against insurers (and against insureds under liability policies) that key documentation is able to be readily retrieved and collated to comply with the disclosure obligations. In particular, the new requirement to disclose “known adverse documents” as part of enhanced initial disclosure incorporates an obligation on parties to establish whether a person within their organisation involved in the events and circumstances the subject of the proceedings is aware of adverse documents. Reasonable steps to check the position with such individuals, including those who have left the organisation, are required.

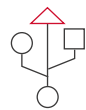


3. Earlier settlements may be more attractive

The combination of front-loaded costs and the new judicial issues conference (JIC) process is likely to create stronger incentives for early settlement.

When parties are required to commit substantial resources to evidence preparation and disclosure at the start of proceedings, and when a judge will convene a substantive early conference to identify determinative issues and discuss potential resolution, the dynamics of settlement negotiation shift considerably.

Parties faced with significant upfront expenditure and an early, informed judicial assessment of the issues in dispute may find that the economics of early settlement are more compelling than under the old regime. For insurers, this represents both an opportunity and a discipline: those who engage early and constructively – as the new duty to co-operate requires – will be better placed to reach favourable settlements before costs escalate further. Conversely, insurers who adopt a “wait and see” approach may find that the cost advantages of early settlement diminish rapidly once the front-end expenditure has been committed.



4. Careful consideration of subrogated claims

The new rules also warrant careful thought in the context of subrogated claims. When an insurer steps into the shoes of its insured to pursue a recovery, it assumes responsibility for the conduct

and costs of that litigation. Under the new regime, the front-loaded cost profile means that insurers must make an early and well-informed commercial decision about whether a subrogated claim is worth pursuing – and must be prepared to commit meaningful resources to that pursuit from the outset.

The enhanced initial disclosure requirements, the obligation to serve factual witness evidence early, and the tight timeframes imposed on defendants (who must complete checks for adverse documents and prepare evidence within prescribed periods) mean that subrogated claims cannot be approached incrementally. A thorough cost-benefit analysis at the point of instruction – rather than as costs accumulate – will be essential. Insurers should also ensure that their panel solicitors are well-versed in the new procedural requirements and are resourced to meet early deadlines.



5. Potential increase in claims against insurers

One of the express objectives of the new rules is to improve access to civil justice by making litigation cheaper and more efficient overall. If the reforms achieve that goal – and particularly if the

overall cost of proceedings is reduced for matters that progress through to trial – it is reasonable to anticipate that the threshold at which claimants consider litigation a viable option may decrease.

For insurers, this could translate into an increase in the volume of claims brought against them or their insureds, as plaintiffs who might previously have been deterred by the prohibitive cost of High Court litigation find proceedings more accessible. The increased use of AI by self-represented litigants is likely to give further momentum to an increase in claims.

This is a medium to long-term risk that insurers should monitor as the new regime embeds. The rules are designed to deter tactical, low-value proceedings through heavy upfront costs – and parties involved in disputes valued at NZD1 million or less may indeed be deterred from issuing proceedings – but for higher-value claims the overall cost reduction is a genuine incentive to litigate.

The new High Court rules: The status quo and proposed law changes

What has changed: The key reforms

The new rules apply to ordinary proceedings. Ordinary proceedings are proceedings that are commenced under Part 5 of the rules. They exclude bankruptcy, liquidation, appeals to the High Court, and proceedings brought under the specialist jurisdictions in Parts 18 and 19.

Proportionality as the overriding objective

The new regime places proportionality at the heart of procedural decision-making. While retaining the goals of just, speedy, and inexpensive resolution, the rules now require the court to consider how best to deal with a proceeding in ways that are, and at a cost that is, proportionate to the nature and issues of the dispute — and the need

to allocate court resources fairly across its caseload. This proportionality touchstone is expected to influence disclosure, witness evidence, and trial length, limiting cases in which full discovery-style disclosure is required.

A new duty to co-operate

A general duty of co-operation now applies to parties and their legal representatives, embedded throughout the rules and at key procedural steps including disclosure, judicial issues conferences, and preparation of the common trial bundle. The duty is designed to encourage constructive early engagement, reduce unnecessary interlocutory disputes, and refocus proceedings on the core issues in contention. The court has a range of tools to enforce compliance, including adverse costs orders.

The evidence-first model

Perhaps the most transformative reform is the reversal of the traditional procedural sequence. Previously, discovery and interlocutory skirmishes preceded the exchange of substantive written evidence, often resulting in voluminous, costly, and only partially relevant material. Under the new rules:

- Parties must complete enhanced initial disclosure at the time of filing their initial pleadings, including documents referred to or used in preparing the pleading, documents they intend to rely on at trial, and – critically – all adverse documents they know exist or have good reason to believe exist.
- Factual witness statements and a new draft chronology must be served early in the proceeding – for plaintiffs, by 25 working days after service of the last initial pleading; for defendants, by 45 working days after that. Factual witness statements should not include a detailed explanation of relevant documents that the witness was involved in creating or receiving. Instead, they should focus on material issues and the witness's recollections. A separate chronology of documents will be prepared for use at trial that will include all relevant documents.

- Further disclosure may be sought through targeted requests, with court involvement only where agreement cannot be reached.

This front-loading of substantive preparation is intended to encourage early engagement with the merits, reduce interlocutory delays, and enable the court to give better-tailored directions. Expert witness statements are intended to be exchanged later in the proceeding when all factual evidence and documentation is available. However, there may be some cases with very high values, which are document heavy, and therefore require discovery more akin to the previous process.

Dispositive interlocutory applications

The rules now distinguish between dispositive and non-dispositive interlocutory applications. Only dispositive applications – those that would dispose of the proceeding or materially change its nature or parties, such as protests to jurisdiction, summary judgment, strike-out applications, and security for costs applications – may be determined before factual evidence is filed and have the effect of delaying that obligation.



The new High Court rules: The status quo and proposed law changes

The judicial issues conference

Following the service of factual evidence in a defended ordinary proceeding, a judicial issues conference will be convened. This is a substantive fixture – attended by parties and their lawyers – designed to identify the determinative issues, discuss potential settlement or alternative resolution, and set the timetable through to trial. The conference agenda includes consideration of whether further disclosure is needed and the resolution or timetabling of any remaining interlocutory matters.

Amendments to the content of evidence and hearing of evidence at trial

The Court expects that the new procedures implemented at an earlier stage will lead to a more disciplined focus on the central issues in dispute in the proceedings.

Relevant documents will be included in chronologies and in narratives of events presented as part of the opening submissions. This is intended to reflect the removal of labourious narrative factual witness statements and the inclusion in those statements of submissions and other inadmissible evidence.

Further, witness statements will now be taken as read, which is expected, together with the highly-focused content of such statements, to reduce the time taken up at trial with evidence in chief.

The Court will also more closely monitor and enforce compliance with the requirements for witness statements and deal with objections as to those statements and as to admissibility of documents proactively. The rules now empower judges to use enforcement provisions to “sanction” breaches of these rules.

The cost dynamic: Front-loading and overall reduction

It is important to understand the two-part cost dynamic that underpins the new regime. The reforms are designed to reduce the overall cost of proceedings that progress through to trial – by eliminating much of the costly interlocutory skirmishing, narrowing discovery obligations, and focusing proceedings on the real issues in dispute.

However, they do so by front-loading costs – requiring parties to commit significant legal expenditure at the outset rather than spreading it across the life of the proceeding. This distinction matters for insurers. The headline benefit (overall cost reduction) does not eliminate the challenge of increased early expenditure. Insurers and their insureds must be financially and operationally prepared to meet those early demands, even where the total cost of a matter that runs to trial is ultimately lower than it would have been under the old regime.



Conclusion

The High Court (Improved Access to Civil Justice) Amendment Rules 2025 represent a genuine structural shift in civil litigation in New Zealand. For the insurance industry, the changes are not simply a matter of procedural adjustment – they require a rethinking of how risk is priced, how claims are managed, and how litigation strategy is approached. The front-loading of costs creates immediate challenges for reserving and excess calibration, while the overall cost

reduction and improved access to justice carry longer-term implications for claim volumes and settlement dynamics.

Those insurers who move quickly to understand and adapt to the new landscape will be best placed to manage their exposure and support their insureds effectively. Those who do not may find themselves navigating an unfamiliar procedural terrain with inadequate preparation.

This article is intended as a general overview of the recent changes to the High Court Rules 2016 by way of the High Court (Improved Access to Civil Justice) Amendment Rules 2025 and their potential implications for the insurance industry. It does not constitute legal advice. Specific legal advice should be sought in relation to any particular matter.



Hannah Jaques
Partner



Contracts of Insurance Act 2024 Dissecting the new duty

Authored by Hannah Jaques, Partner

Our previous edition of *Cover to Cover* explored the “fair presentation” duty on policyholders of non-consumer insurance contracts, in advance of the Contracts of Insurance Act’s commencement on 15 November 2027.

In this instalment of our deep dive series, we consider the duty owed by policyholders of consumer contracts to “take reasonable care not to make a misrepresentation”.

Overview of the duty: Section 13 of the Act

1. A policyholder (or other person to whom the duty applies) must take reasonable care not to make a misrepresentation.
2. The duty applies to:
 - a. policyholders of consumer insurance contracts;
 - b. beneficiaries of group policies where if the beneficiary had entered into the policy directly with the insurer, it would be a consumer insurance contract; and
 - c. persons whose life or health is insured but is not a party to the insurance contract, but only in respect of

information that depends on the state of mind, knowledge, circumstances or characteristics of the individual.

3. Consumer insurance contracts are contracts of insurance ordinarily entered into by a policyholder, wholly or predominantly for personal, domestic or household purposes. In large part these are likely to correspond to an insurer’s “retail” or consumer offerings. Certain types of insurance contracts can be deemed consumer insurance contracts under regulations, but there is no suggestion that deeming regulations will be in force at the Act’s commencement.
4. The duty applies before a consumer insurance contract is entered into or varied. It is not a continuing duty throughout the period of insurance. However, entry into an insurance contract includes policy renewals.

Contracts of Insurance Act 2024 Dissecting the new duty

5. The standard of care required is that of a reasonable policyholder who enters into a consumer contract. That standard may be adjusted if there are particular characteristics or circumstances of the actual policyholder that the insurer knew or ought to have known (e.g., limited understanding of English, where English is the language of the insurer's proposal form and the primary means through which the insurer communicates with the insured).
6. Whether a policyholder has complied with the duty must be determined with regard to all relevant circumstances.
7. Section 14(1) of the Act contains a non-exhaustive list of the matters a court may consider when determining whether reasonable care has been taken. They include the type of consumer insurance contract at issue and its target market, as well as how clear and specific any questions from the insurer were. The majority of these focus on actions taken or not taken by the insurer, rather than the policyholder.
8. A misrepresentation made dishonestly will always be taken as showing lack of reasonable care.

9. A failure by a policyholder to comply with the insurer's request to confirm or amend particulars previously given is capable of being a misrepresentation.

United Kingdom consumer duty: Closely aligned

Usefully, this new duty closely reflects the duty imposed by sections 2 to 5 of the Consumer Insurance (Disclosure and Representation) Act 2012 (UK Act). The similarities in the statutory language between the incoming Act and UK Act mean decisions testing the provisions in the UK provide important guidance. Specifically, cases in the UK have grappled with:

- what qualifies as a 'misrepresentation' under the Act;
- what a policyholder must do to show they took "reasonable care" not to misrepresent to their insurance provider; and
- any remedies that are available to an insurer where reasonable care has not been taken.

There are also significant similarities with the consumer duty in sections 20A to 20C of the Insurance Contracts Act 1984 (Cth).

We look at three UK case studies below addressing these issues.



Case study 1: *Jones v Zurich Insurance plc*¹

Facts: Mr Jones made a claim under his household insurance policy with Zurich for a vintage Rolex Daytona watch with a sought-after "tropical dial" which he lost while skiing in Aspen, Colorado. The watch had an agreed value under the policy of GBP190,000. Zurich declined the claim and treated the policy as void. It considered that Mr Jones had breached his duty to take reasonable care not to make a misrepresentation because he had failed to disclose to Zurich a previous GBP15,000 claim for a broken diamond ring in 2016. Zurich's position was that had Mr Jones disclosed this prior claim, it would not have been willing to provide him with insurance at all.

The Court identified three issues for determination:

1. Whether Mr Jones made a misrepresentation to Zurich.
2. If so, whether the misrepresentation was made in breach of his duty to take reasonable care not to make a misrepresentation; and
3. Whether Zurich had shown that without the misrepresentation it would not have underwritten the policy, or would have done so on different terms.

Issue 1: Did Mr Jones make a misrepresentation to Zurich? The Court found that Mr Jones had misrepresented the true position to Zurich by failing to disclose his 2016 insurance claim. Zurich's proposal form asked whether Mr Jones had "any losses or claims in the last five years".

1. *Jones v Zurich Insurance plc* [2021] EWHC 1320 (Comm).

Contracts of Insurance Act 2024

Dissecting the new duty

The proposal form was completed on behalf of Mr Jones by Mr Trautmann, his uncle and his assistant, with full knowledge of the details of the prior claim. Regardless, the answer given to Zurich was “no”. Further, when Zurich provided a quotation for the policy, it included a statement of facts which it made clear formed the basis of the quotation. Zurich requested confirmation of the accuracy of the statement of facts as a condition of providing cover. One of Mr Jones’ brokers, Bluefin Network, also made false representations in telephone calls with Mr Green of Zurich, both as to whether Mr Jones had made any claims in the last five years, and whether he had a claims history while living with his parents

Issue 2: Had Mr Jones failed to take reasonable care? Mr Trautmann, acted as an intermediary between Mr Jones and his brokers. Under cross-examination, Mr Trautmann accepted that he passed on to the brokers information that Mr Jones knew to be incorrect. The Court found Zurich had “gone out of its way to make clear the information that was required” by Mr Jones. Specifically, Zurich:

- asked whether he had “Any losses or claims in the last five years”;
- asked whether he had any “claims history” while previously living with his parents;

- followed up with a telephone call to Mr Jones’ broker to reinforce these questions; and
- encouraged him to check that the information provided by him on the statement of facts was correct prior to accepting Zurich’s quotation.

The questions posed by Zurich were specific, unambiguous and repeated across multiple stages of the underwriting process.

The Court applied an objective standard: what would a reasonable policyholder in Mr Jones’ position have done? It found that Mr Jones had failed to do what a reasonable policyholder would have done. The Court placed significant weight on Mr Jones’ cumulative failures to correct the record, together with Zurich’s thorough process (as noted above).²

Issue 3: Whether Zurich had shown that without the misrepresentation it would not have written the cover at all, or would have done so on different terms? The Court identified two limbs to the third issue:³

“a misrepresentation will be a qualifying misrepresentation if either Zurich would not have entered into the policy at all or if it would have done so on different terms, whereas even if the misrepresentation is a qualifying misrepresentation, Zurich is not entitled to avoid the policy unless it establishes that it would not have entered

into the policy on any terms had Mr Jones complied with his duty.”

This largely aligns with the statutory language of s 23 and schedule 2 of the New Zealand Act.

The Court accepted Mr Green’s evidence that, given Mr Jones’ young age, high value jewellery risk, and lack of prior relationship with the broker, his insurance proposal was already borderline. Further, knowledge of the previous substantial jewellery claim for the diamond ring would have tipped the decision into a declination.⁴

The Court addressed the nature of underwriting evidence. Drawing on previous UK decisions, the Court noted that an underwriter’s evidence about what they would have done had they known certain information is, by its nature, hypothetical, and therefore may tend toward exaggeration.⁵ However, the Court held that this does not make such evidence immaterial. Even if an underwriter’s evidence is exaggerated, it can still be sufficient to establish that the undisclosed information was material.

2. At [35] – [39].

3. At [41].

4. At [54].

5. *North Star Shipping Limited v Sphere Drake Insurance Plc* [2005] 2 Lloyd’s Rep 76; *Pan Atlantic Insurance Company Limited v Pine Top Insurance Company Limited* [1995] 1 AC 501.

6. At [49].

7. At [49] – [50].

The Court also identified that Mr Green’s evidence was credible because of the extensive contemporaneous underwriting notes he kept, as well as his transcript of his call with the broker. Evident in both was his concern about providing cover for Mr Jones.

Counsel for Mr Jones argued that Zurich’s failure to disclose a macro-enabled version of the underwriting spreadsheet and any internal underwriting guidelines was significant.⁶ The Court disagreed. The key question was whether Zurich would have declined cover or offered it on materially different terms had the prior jewellery claim been disclosed. Given the nature of the risk, Mr Jones’ personal history, and the direct relevance of his prior claim to the jewellery being insured, the Court found it almost inevitable that Zurich would have either declined cover or imposed a substantially higher premium than the 25 per cent loading Mr Green had already applied.⁷

Further, the Court held that the spreadsheet tool was not a decision-making system, as it produced an indicative premium only and left Mr Green with full discretion

Contracts of Insurance Act 2024 Dissecting the new duty

over the final underwriting decision. Mr Green's quoted premium was already 25 per cent above the tool's output. The Court accepted Mr Green's evidence that reflecting the prior claim in the tool would have increased the indicative premium by a further 20–30 per cent, and that the ultimate decision always rested with Mr Green personally.⁸

Both parties called underwriting experts. Mr Pipe, Mr Jones' expert, considered it unusual though not impossible to decline cover on the basis of the earlier claim for the diamond engagement ring. That concession from Mr Jones' own expert

was significant.⁹ Mr Coates, Zurich's expert, considered no prudent underwriter would have offered terms, noting that Zurich was a high value net-worth household insurer rather than a specialist valuables underwriter and treated high jewellery exposure cautiously even where the insured was claim-free.¹⁰

The Court sided with Mr Coates, finding that Mr Green would have sought more information from the broker about the prior claim and that, on learning the full details, he would have declined to offer cover. Ultimately, the Court held that Zurich was entitled to avoid the policy.

Case study 2: ***Gillian Cowie v. Vitality Corporate Services Limited***¹¹

Facts: *Cowie v Vitality* is a recent UK decision concerning a life insurance policy in which the insurer, Vitality, sought to avoid liability on the basis that the insured, Mr Cowie, had failed to disclose a pre-existing medical condition – Barrett's Oesophagus – and abnormal liver results when completing his proposal form. Following his death from a brain haemorrhage, his widow, the executrix of his will, pursued a claim under the policy.

Mr Cowie's death certificate recorded a liver condition as a contributing factor. Mr Cowie's widow made a claim for GBP500,000 plus interest under the Vitality policy. When considering the claim, Vitality sought authority to access Mr Cowie's medical records. Those records revealed a history of gastrointestinal and abnormal liver function. Mr Cowie had not disclosed these issues when seeking life insurance from Vitality. Ultimately, Vitality declined the claim on the basis that Mr Cowie had not taken reasonable care not to make a misrepresentation. It said that had it been aware of Mr Cowie's previous

gastrointestinal and liver issues it would have required a GP's report and upon reading that, would have refused to provide Mr Cowie with life insurance.

The Court applied the tripartite inquiry from *Jones v Zurich*, which required it to determine the following:¹²

1. Had Mr Cowie made a misrepresentation to Vitality?
2. If so, was the misrepresentation made in breach of Mr Cowie's duty to take reasonable care not to make such a misrepresentation?
3. Had Vitality established that, absent the misrepresentation, it would have acted differently at the time of placement?

Issue 1: Did Mr Cowie make a misrepresentation to Vitality? The first stage required the Court to determine objectively what the questions in the proposal form meant – specifically, what a reasonable person in the position of the proposer would have understood them to be asking. That interpretation would then determine whether any answer given was objectively wrong and therefore constituted a misrepresentation.

8. At [51] – [54].

9. At [60] – [61].

10. At [58].

11. *Gillian Cowie as Executrix-Dative of the late Mark Fraser Alexander Cowie v. Vitality Corporate Services Limited, trading as Vitality Life, Castlebank Financial Planning Limited Paul Reynold* [2025] CSOH 52.

12. *Jones v Zurich Insurance Plc* [2021] EWHC 1320 Comm, [2022] Lloyd's Rep IR 219 at [31].

Contracts of Insurance Act 2024 Dissecting the new duty

The proposal form contained two relevant questions:

- Whether, apart from any condition he had already told Vitality about, Mr Cowie had, in the last five years, suffered from any disorder of the digestive system, liver, stomach, oesophagus, pancreas, colon or bowel (with various conditions listed by way of example); and
- Whether, apart from anything he had already told Vitality about, Mr Cowie had within the last two years undergone any investigation such as blood tests, scans or biopsies and was the result normal?

The Executrix argued that the questions were not sufficiently clear for two reasons. First, because the word “*including*” in the first question had a limiting effect, confining the scope of the question to the conditions expressly listed, which did not encompass Barrett’s Oesophagus. Secondly, because the phrase “*apart from conditions you have disclosed to us*” extended to disclosures made outside the proposal form itself — in particular, disclosures Mr Cowie had previously made to Vitality (or its predecessor) in connection with other policies. The executrix argued that as Mr Cowie had disclosed acid reflux and oesophagitis some five years earlier, he had not made a misrepresentation by answering the proposal form in the manner in which he did.

The Court rejected both arguments, finding that the questions were clear on their face. Further, the prior disclosure of acid reflux and oesophagitis was not regarded as in any way equivalent to the distinct condition of Barrett’s Oesophagus.

Separately, the Court found on the evidence that in 2010 – just within the five-year period covered by the question – Mr Cowie had been treated for residual elements of Barrett’s Oesophagus which had survived an earlier treatment. His denial of this condition therefore constituted a misrepresentation. The Court further found a misrepresentation in relation to the question about abnormal test results. By the end of 2014 Mr Cowie’s follow-up tests had produced abnormal results, which should have been disclosed.

Issue 2: Had Mr Cowie failed to take reasonable care? The Court acknowledged at the outset that it did not find certain aspects of the 2012 Act “*particularly easy to understand or apply*” but made clear that the legislation does not permit unlimited judicial discretion. Specifically, the Court was concerned with the relevance and weight of the various considerations listed, which largely mirror those in the New Zealand Act.

In assessing the standard of care, the Court had regard to a number of considerations:

- **Nature of the contract:** Life insurance is a long-term arrangement concluded on the basis of information provided at inception, without periodic reassessment. Given the likely importance of such a contract to a consumer, it would be clear to any reasonable person that the state of health of the life insured would be of considerable importance to an insurer’s willingness to accept the risk and the terms on which it would do so. This somewhat heightened the degree of care expected.
- **Target market:** The Court considered the target market but found that it added nothing of substance, as it was described in broad terms.
- **Clarity of the questions:** The proposal form questions were found to be amply clear and specific, leaving no material room for doubt in the mind of a reasonable reader as to what was being asked.
- **Role of the agent:** The agent had no appreciable input into the completion of

the proposal form and therefore did not alter the analysis.

- **Mr Cowie’s profession:** Vitality was aware that Mr Cowie was a lawyer. The Court declined, however, to scrutinise his conduct more closely than that of an average consumer by reason of his professional background. Since the questions had already been found to be clear and specific, any additional benefit that might be attributed to a legally-trained mind was simply irrelevant. No additional weight was given to this factor.
- **Recollection of Barrett’s:** The Court acknowledged genuine difficulty with the question of whether a reasonable consumer would have recalled in 2015 a diagnosis of Barrett’s Oesophagus made at the end of 2010 and which appeared to have largely been dormant or cleared up by 2015. On that basis, it stopped short of finding dishonesty. Nevertheless, it concluded that a reasonable person would have been careful about the five-year cut-off period in the proposal form and would have checked the relevant dates against their records or with their doctor. Mr Cowie’s failure to do so amounted to a lack of reasonable care.

Contracts of Insurance Act 2024 Dissecting the new duty

Issue 3: Whether Vitality had established that, but for the misrepresentations, it would have acted differently at placement? The Court recognised that the question of what Vitality would have done was inherently hypothetical. As it observed, all that the witnesses could meaningfully do was point to the underwriting guidelines then in force within Vitality as an indication of what ought to have happened. The Court went on, however, to consider whether those guidelines would in fact have been followed – a matter of inference from the evidence as a whole.

The evidence for Vitality was compelling. That was largely because Vitality had underwriting requirements imposed on it by its reinsurer and a process that meant the reinsurer was required to review any proposed placement falling outside its requirements.

Interestingly, the Court disregarded the evidence of the underwriter directly involved, making an adverse credibility finding against him. It was apparent from his answers that he was protecting his own position and advocating for Vitality's case, rather than giving independent evidence.

Ultimately, the Court found that the evidence clearly established it would have

been highly unlikely for the underwriters to have departed from the guidelines on not one but two grounds – the Barrett's Oesophagus and the liver abnormalities. Vitality therefore succeeded in establishing that it would have refused the risk.

Case study 3: ***Southern Rock Insurance Company Limited v. Hadar Hafeez*** **[2017] CSOH 127**

Facts: *Southern Rock v Hadar Hafeez* concerned the validity of a car insurance policy provided by Southern Rock Insurance Company Limited (Southern Rock), and whether its coverage could be voided due to an alleged misrepresentation by the policyholder, Mr Hussain Hafeez (Mr Hafeez). Mr Hafeez had applied for car insurance by stating that his residential address, and therefore the address where he parked his car, was in a suburb named Giffnock (Giffnock Address). Evidence during the proceedings revealed that Mr Hafeez had, at times during the insurance period, resided in a suburb named Govanhill (Govanhill Address). Mr Hafeez lodged an insurance claim after his relative had driven the insured car without his knowledge or permission, and crashed it into three high-value parked cars.



Southern Rock sought to avoid the insurance claim on the ground that the Mr Hafeez had misrepresented his residential address, to influence Southern Rock's judgement in determining whether to agree to provide insurance, and what the appropriate level of risk, and hence premium, would be. Indeed, the premium for the Giffnock Address was substantially lower than the Govanhill Address, being GBP1,649.34 for the former as opposed to GBP2,899.08 for the latter.¹³

¹³ *Southern Rock Insurance Company Limited v. Hadar Hafeez* [2017] CSOH 127, at [3].

Contracts of Insurance Act 2024 Dissecting the new duty

In arguing that Mr Hafeez resided at the Govanhill Address, and not the Giffnock Address, Southern Rock relied on documents produced by Mr Hafeez that were all addressed to him at the Govanhill address, including copies of Mr Hafeez's driver's licence, bank statements and utility bills.¹⁴



14. At [7].
15. At [17].
16. At [19] – [21].
17. At [23].
18. At [73].
19. At [75] – [76].

In response, Mr Hafeez argued that he had leased the property at the Govanhill Address for his siblings, and while he occasionally stayed there, it did not mean that he no longer resided at the Giffnock Address.¹⁵ Further, Mr Hafeez had obtained the car insurance for his vehicle through an online provider, after using two insurance quote comparison websites through the Google search engine.¹⁶ One of the quote comparison websites directed him to a quote from an insurance broker named "GoSkippy". GoSkippy had an online electronic form which asked Mr Hafeez two key questions regarding his residential address, as follows:

1. "Address"; and
2. "Address where car is kept".

Mr Hafeez answered with the Giffnock Address for the first question, and stated that he had not seen the second question on the online form that he had submitted it. He further stated that if he had seen the second question, he would have answered with the Govanhill Address.¹⁷

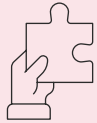
Issue 1: Did Mr Hafeez make a misrepresentation? The Court held that the insurer had not established a misrepresentation. The onus is on the insurer to prove that the insured either deliberately or recklessly misrepresented his

address. In assessing whether a deliberate or reckless misrepresentation as to Mr Hafeez's address had been made, all circumstances must be taken into account, including the type of communication used, and the terms of any question put and opportunity given to the consumer to qualify or particularise any response, or provide non-standard information.¹⁸ In assessing all circumstances of this case, the Court found that neither Southern Rock nor Mr Hafeez could produce a precise copy of the questions answered by Mr Hafeez as at the time he was applying for car insurance through GoSkippy. Counsel for the insurer accepted that computer website interfaces and changed and updated on a regular basis, and there was no evidence vouching for the format or content of the website with which Mr Hafeez had interacted. Compounding this was a failure by the insurer to provide a copy of the questions and answers for Mr Hafeez's review and confirmation prior to cover being placed. Further the Court found that Mr Hafeez genuinely believed that his address was the Dinard Street Address.

Given these findings, it was not necessary for the Court to consider the second and third issues in the three-stage analysis.

The Court outlined the advantages and disadvantages of purchasing insurance coverage online. While on one hand, there is the advantage of concluding a contract for insurance immediately online, the key disadvantage is that there is no clear record of the precise wording of the questions that obtained key information for the risk assessment of a consumer's application.¹⁹ This can become of particular importance in circumstances such as this case.

This will be an important factor for insurers in New Zealand to consider when weighing the benefits and risks of making their products available on comparators websites. Insurers will want to make sure that the websites are keeping accurate records of any questions posed and answers given, including to initial questions used to limit results, which do not constitute insurance applications, the completed application and any other explanatory material on the website. Insurers should also be confident that comparator websites contain appropriate messaging notifying potential policyholders of their duty of disclosure.



Key takeaways

For Insurers

- Draft clear, specific questions and well-drafted policy documents.
- Ask policyholders clear questions from the outset of an insurance contract or any variation; failure to do so may increase the difficulty of establishing a misrepresentation.
- Provide policyholders with a copy of the questions and answers in the application and ask them to review and confirm the accuracy of those answers; this will strengthen any argument that a misrepresentation has occurred.
- Where coverage or variation is offered through both hard-copy proposal forms and online equivalents, ensure that the same targeted questions appear on both versions.

- Ensure consistency between versions; inconsistency may result in a policyholder unknowingly purchasing or varying their coverage on the lesser-detailed version of the proposal form, which may mean no misrepresentation has occurred on their part.
- Preserve a copy of all versions of a proposal form in all formats, as these may form a vital part of evidence in Court proceedings.
- Note that where underwriting questions are specific, targeted, and comprehensible, Courts expect consumers to exercise a higher degree of diligence in answering them accurately.
- Maintain clear underwriting guidance and training focused on ensuring compliance with that guidance.
- Ensure underwriters keep good contemporary documents that record compliance with the underwriting guidelines.

For Insurance Brokers

- Verify clients' claims histories, as passing on incorrect information to insurers on behalf of your client may jeopardise your client's cover.
- Where questions focus on specific time-limits, for example, claims in the last five years, make clear to clients that those time-limits apply on a strict basis, so that careful checks of dates and records are undertaken.
- If you notice that an insurer offers coverage or variation through both hard-copy and online proposal forms, ensure that the online proposal form on your platform directly reflects the key questions asked by the insurer on the hard-copy form.
- Any variation between the hard-copy form and the online equivalent may give rise to confusion for the client, which will not amount to a misrepresentation where the answers collected via the online form were incorrect.

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Insurers dial back flood risk exposure: Where will this lead?

Authored by Partner Andrew Horne and Solicitor Hasaan Malik

In April 2025, we published an article on the Los Angeles wildfires and the under-insurance crisis they exposed. In case you missed it, you can find it [here](#).

To recap, last year, a number of major insurers withdrew cover from some residential areas in Los Angeles which they had assessed as facing unacceptable risks from wildfires. The insurers had monitored climate patterns and had become concerned that there had been several years with good rainfall, followed by a dry period, which had produced vegetation which was ready to ignite. Many homeowners found their policies cancelled mid-term and were uninsured when the devastating fires swept through the city, in some instances only a short time later.

There had been prior warnings that insurers were retreating from the most fire-prone areas in Los Angeles, where residents had been finding it difficult to obtain insurance for some time.

When we published our article last year, we identified similar issues that may arise in New Zealand, given the number of severe weather events in the last few years, along with some potential solutions. Recent events indicate that the New Zealand insurance market is beginning to deal with these issues. Similar problems to those seen in Los Angeles are emerging in the New Zealand market, with significant increases in premiums, reduced participation by property owners and increased difficulty in obtaining cover, and evidence of underinsurance for severe weather events.

Westport

Late last year, AA Insurance made a public announcement that it would temporarily suspend issuing new home insurance policies for houses that it did not already



insure in one postcode in the West Coast town of Westport, because of concerns about the town's flood risk. This may signal the start of a new type of insurance retreat from high-risk areas in New Zealand.

Westport is a town which has been increasingly flood-prone in recent years. Residents have faced increasing difficulty in obtaining affordable insurance at least since 2005, when insurers began using flood mapping to assess risk. Those difficulties

escalated significantly after a major flood in 2021 which left more than 100 homes uninhabitable and 463 homes red or yellow stickered. Residents were evacuated again the following year, and in 2023 there was also localised flooding. It is easy to see why insurers are concerned.

In December 2025, AA Insurance confirmed that it had temporarily ceased offering new home, business and landlord insurance policies for properties within a key Westport

Insurers dial back flood risk exposure: Where will this lead?

postcode because of its flood risk limits. Importantly, AA Insurance was careful to assure its customers that its pause was temporary, and that it would not only continue to renew existing policies, but would also offer cover to buyers of properties currently insured by its existing customers if the owners wished to sell.

Following on from its Westport announcement, in early February 2026, AA Insurance also paused issuing new policies in the Canterbury community of Woodend, north of Christchurch, on the basis that it had reached its maximum exposure to seismic risk at that location. Previously, in late 2025, it had done the same for two postcodes in Lincoln and Rolleston. AA Insurance explained that its ability to write cover would change over time as customers moved. Again, as in Westport, it remained willing to renew existing policies and also to offer cover to buyers if its customers wished to sell.

Another major insurer has also reportedly ceased offering new policies to certain postcodes. More generally, for some Westport residents, even those not in particularly flood prone areas, insurance premiums have increased to the point that they are unaffordable. Home buyers in the region face an increasingly common problem that few, if any, major insurers will offer them a policy if they are in a postcode that insurers have identified as high risk, unless there is an existing insurance relationship with the property. Both examples illustrate the emergence of what might be called “postcode insurance syndrome” – where insurers apply blanket area-based exclusions based on postcodes, rather than assessing individual property risks.

Dr Belinda Storey, from the consultancy firm Climate Sigma, has predicted that there will be more locations, such as the lowest

elevations in coastal inundation zones, or the bottoms of bowls of floodplains, where insurers will be increasingly reluctant to continue providing cover.

What this means for the New Zealand insurance market more broadly

This is the most visible sign yet of a broader trend: insurers in New Zealand are increasingly applying risk-based decisions to determine whether they will offer cover in areas that are exposed to heightened natural hazard risk. This is not surprising given the range of severe weather events New Zealand has experienced in recent years, including major storms, flooding and cyclones. The trend is likely to extend to other flood-prone and hazard-exposed areas across New Zealand.

While thus far, pauses on offers of new insurance have been described as a temporary measure, their increasing prevalence must give rise to concerns about the future availability and affordability of home insurance in New Zealand.

This appears to be a global trend, with similar responses also being seen in Australia. There, some insurers have at times temporarily withdrawn insurance from certain regions until flood defence infrastructure is improved. This may provide a solution for some locations in New Zealand, such as Westport, where infrastructure improvements may help reduce risk, but it is less likely to be possible to address other risks, such as earthquake, in this way.

Insurers dial back flood risk exposure: Where will this lead?



Looking forward-where to from here?

In our last article, we highlighted a range of potential solutions to grapple with these issues in New Zealand. These included:

- Expanding the scope of cover provided by the Natural Hazards Commission – Toka Tū Ake
- Increased collaboration between private insurers and government bodies
- The California Sustainable Insurance Strategy solution, which is to require all private insurers to commit to offering at least 85% of their average amount of cover to policyholders in specified high risk wildfire areas, which socialises the cost of insuring high risk areas

The challenge will be deciding what risks are truly uninsurable and are not appropriate to socialise across all insureds.

A scheme like the Californian approach may become necessary in New Zealand. Such an approach, however, may have the disadvantage of reducing disincentives to build in loss-prone areas, or reducing incentives to invest in infrastructure that would reduce risks.

In all possible solutions, addressing underinsurance and ensuring the availability of affordable property insurance in the face of increasing natural disaster losses will require coordinated efforts involving policy changes and innovative insurance solutions.

This may become an election issue. Former Westport mayor and current parliamentary election candidate, Jamie Cleine, was recently reported as suggesting that some funding for flood defences ought to come from insurers, arguing that they benefit from risk reduction investment but are not required to contribute to its cost. Insurers will take the view that their role is to insure against loss, not prevent it, and that they do

not benefit from a reduction in risk, which would ordinarily be reflected in reduced premiums.

The insurance crisis revealed by the Los Angeles wildfires, and more recent domestic experiences such as the challenges in Westport, highlight the growing challenge of securing property insurance in an era of increasing natural disaster losses. As New Zealand grapples with increasingly severe weather events, similar issues are emerging, with rising premiums, reduced coverage availability and growing gaps in insurance protection.

Insurers' responses in places such as Westport are the most visible sign yet that the insurance retreat dynamics seen overseas are now playing out in the New Zealand domestic market. The question is whether New Zealand's policy makers will respond proactively. We will continue to monitor developments.



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Obsessive claimants

Authored by Andrew Horne and Hasaan Malik

The insurance industry seems to attract more than its fair share of determined claimants and obsessive litigants. In part, this may reflect the nature of the industry, where policyholders' obligations can be complex and difficult for them to understand and the consequences of misunderstanding them can be disastrous. It may also reflect the character of some policyholders, as those who are economical with the true nature and circumstances of their risk to gain cover on favourable terms may also be inclined to challenge decisions and pursue claims obsessively. In any event, declined insurance claims are fertile ground for longstanding grievances.

Most litigation lawyers will have experience with obsessive claimants. Recently, their numbers seem to have increased, not only in the insurance market. One factor driving this may be the ready availability of misleading or simply wrong advice on internet forums, now supplemented by free AI tools. These are capable of producing an argument or submission to support a claim that, to the uninformed, appears compelling, but is without merit.

All of this presents new challenges for insurers, brokers and other potential targets.

Increasingly aided by AI tools, persistent and often irrational claimants may use a range of channels to pursue and draw out meritless claims. Insurers are increasingly faced with prolonged battles that consume internal resources and generate costs which, over time, may outweigh the value of the underlying claim.

It is more important than ever for insurers and others who are targeted by obsessive claimants or litigants to understand the strategies and options available to them.

Who are they?

Obsessive claimants are typically people who have suffered a loss for which their insurer has declined cover, often alongside other negative outcomes such as an unwanted retirement, a collapsed business or a failed personal relationship. Sadly, these events often mean that they have time on their hands to obsess about their misfortunes and pursue obsessively those whom they view as responsible.



There are certain characteristics that distinguish obsessive claimants from other dissatisfied policyholders:

- Persistence – they will pursue claims and complaints obsessively for years.
- Inability to see any issue from a perspective other than their own.
- Fixations on individuals – within the insurer or others such as regulators or external lawyers.
- Ingenuity in finding new and different ways to try and bring pressure upon the insurer.
- Familiarity with legal processes and ways of circumventing barriers.
- Increasingly offensive or outrageous statements or conduct.
- Not afraid to lose – so they are not dissuaded by cost.

While not all obsessive claimants fit this description, a disproportionate number seem to be retired men, many of whom once occupied positions of influence which they lost with the end of their career. Such people may seek purpose and meaning by finding a cause to fight for, however wrongheaded it may be.

Obsessive claimants will pursue meritless claims through every available channel they can find, often including the following:

- Insurance and Financial Services Ombudsman (mostly for insurers)
- Financial Services Complaints Limited (mostly for brokers)
- Financial Markets Authority
- Commerce Commission
- Insurer's boards and CEOs
- Media
- Courts

They tend to be driven by an unshakeable belief that their cause is just and that they have been wronged, which they maintain despite never enjoying success in any of their efforts to pursue their claims. They live in hope that they will find a person within one of the various institutions to which they complain who will take the time to investigate and understand their complaint, and who will come to see things the way they do. Very often they are charming and solicitous to a new person who becomes involved in their matter, only to turn against them as – inevitably – that person disappoints them.

They often file multiple complaints, proceedings or applications and appeal or seek review of every decision that goes against them. They file new complaints or proceedings whenever existing ones are dismissed, sometimes against the decision-makers. They may interpret failures as evidence of a cover-up or conspiracy against them. This can go on for years.

Obsessive claimants

The enabling role of AI

Obsessive claimants are increasingly relying on AI tools to assist them in responding to insurers, identifying potential arguments and preparing claims and responses. They also use AI tools to generate what, at first glance, appear to be well-constructed arguments on policy wording, or submissions to regulators or dispute resolution bodies. In addition, AI tools may give them false encouragement by giving wrong advice, and by identifying potential causes of action, drafting submissions and preparing other court documents that seem compelling to the uninformed.

While AI tools may be perceived as a helpful aide to claimants who do not have access to qualified lawyers, their output is generally so inaccurate that it does more harm than good. The material generated, while confidently and eloquently expressed, is usually wrong. At times the source material may be 'hallucinated', meaning the AI tool has generated fake reference material to satisfy the wishes of the user. It may also be voluminous, meaning it can take a considerable amount of time to unpack and address the points raised. Judges are reporting that they are required to deal with increasingly large and detailed documents filed by obsessive litigants that appear to have been generated by AI.

Strategies for dealing with obsessive and vexatious claimants



Understand who you are dealing with and their likely patterns of behaviour

Obsessive claimants are not rational actors. They cannot be persuaded that their complaints are without merit and should be abandoned. It is futile to try. Often, engagement is what they are seeking and does no more than encourage them.

It is important to understand the following elements of their psychology:

- Obsessive people cannot be persuaded that their claims cannot succeed. No amount of escalation by decision-makers will help.
- The steps in a formal complaints process or legal proceeding can provide these individuals with a sense of control that they would otherwise lack. This is not affected by failure at every step.
- This can manifest itself in challenges being made to every decision in a variety of ways, including complaints against decision makers and others who are involved in the matter, including lawyers.
- They may not believe that they will prevail – but that will not necessarily discourage them if they achieve satisfaction merely from pursuing their claim.
- The initial complaint is typically met with a measured, courteous response which expresses understanding or sympathy for their position. The claimant takes this as encouragement and disregards those parts of the response that are not consistent with their own views.
- They escalate their complaint, often by contacting senior people such as a chief executive or board members. When they reach a new contact, they treat that person's professional courtesy as an invitation to start over.
- The cycle repeats, and when the claim or complaint is again declined, their frustration turns personal.
- Senior leaders may step in, expecting to resolve the matter through authority or goodwill, but this does not work. Their ability to persuade and influence others has little benefit when dealing with irrational claimants.
- When their internal avenues of complaint as exhausted, they begin with external bodies, such as dispute resolution schemes, regulators and the courts.

A standard toolkit for resolving disputed claims and legitimate disputes will not work. A different approach is required.

Their claims often follow a typical pattern:



Practical guidance for dealing with obsessive and vexatious claimants

It is very difficult to shake off a determined claimant. We recommend that insurers consider employing the following strategies where there is a concern that a person may become an obsessive claimant.

In the early stages of engagement

- Listen to them politely at first, and keep responses concise, neutral and factual, where possible. Avoid over-explaining, as this provides material for further complaints.
- Limit engagement only to what is strictly necessary.
- Document all interactions and carefully follow all internal policies when dealing with claimants. A failure to follow procedures will give a complainant more to work with.
- Be realistic about what you are likely to achieve by engaging with them. It is a mistake to think you are likely to persuade them that their complaint has no merit.

Once a decision has been issued

- Inform the complainant in writing that the matter has been determined and that your organisation will not be corresponding further on it.

- Then keep further engagement to a minimum. It is not necessary to respond to every email or phone call. This helps reduce the encouragement they receive from the process.
- Designate a single internal point of contact. Insist that only that person deals with the claimant where possible and warn other likely points of contact that the claimant may contact them. They should be provided with clear instructions not to engage or keep engagement to a minimum.
- If more than one person must deal with the claimant, have a clear position in response to each element of the claim or complaint and ensure consistency in communications.
- Ensure that all information provided is accurate. If an error is made, correct it promptly in writing, as errors may be seized upon as a new issue for dispute.

Things to consider

- Consider whether a request for documents or personal information should be treated as a Privacy Act request. Where possible, comply with deadlines for responding to such a request to prevent a claimant escalating it to the Privacy Commissioner.
- Maintain professional standards in all internal communications. Assume

anything written about the complainant may ultimately have to be disclosed to them.

- Brief front-line staff so they can identify the individual and know the appropriate protocol.
- If there is any concern for staff safety, act immediately and involve the Police where threats have been made.
- Keep in mind the potential reputational impact, particularly if the complainant goes to the media, and how to manage this.
- Keep records of all communication. This may be helpful to rebut allegations about the way your organisation has handled the complaint or dispute.
- If complaints are made to external bodies, keep responses brief and to the point, and do not respond to additional material provided by the complainant unless that is necessary. Advise them of any other complaints to other regulators that have been made (subject to confidentiality).

Legal tools are limited

- Harassment Act 1997 – requires a pattern of behaviour directed against another person that involves specified acts, which include making contact with that person by phone, correspondence, electronic communications or any other way. Civil restraining orders are available and criminal penalties apply if there is a threat to safety.
- Courts have power under s166 of the Senior Courts Act to restrain vexatious litigants, and orders can now be sought by private persons for up to 3 years (formerly only the Attorney-General could apply and “persistent” proceedings were required). There are:
 - Limited orders: Relating to a particular matter only
 - Extended orders: Relating to a particular matter or a related matter
 - General orders: Preventing any civil proceedings.

Should you engage external counsel?

External lawyers will not necessarily have any more success in persuading an obsessive claimant to go away, and they can become a target themselves. They can, however, assist in the following ways:

- Relieving pressure on your organisation so you are not distracted.
- Providing independent and dispassionate strategic advice for dealing with the claimant.
- Managing responses to external bodies such as the IFSO or the Privacy Commissioner.
- Protecting documents with legal privilege.
- Taking proactive steps to seek restraining orders where necessary.
- Defending any Court proceedings.



Conclusion

Obsessive and vexatious claimants are a growing problem for insurers, causing stress, disruption and cost that is often disproportionate to the importance of the issues they raise. This trend is likely to continue due to the availability of AI tools. It is important that insurers are aware of the risks they pose and identify them early to respond effectively.

Faulty workmanship exclusions:

Clarity in drafting and the Court's role after IFSO*IAG New Zealand Ltd v Aubrey* – High Court of New Zealand

A recent High Court decision, *IAG New Zealand Ltd v Aubrey*, delivers a pointed reminder to insurers: ambiguous exclusion clauses will be construed against the party that drafted them – and standard form wording that has served an insurer well in one policy may not carry the same meaning in another.



The Court's application of that principle to a clause excluding the cost of "fixing faulty workmanship" shows just how carefully insurers must approach exclusion drafting. Language that appears straightforward on its face may, when read in the context of a particular policy type, yield a meaning that is considerably narrower – and more favourable to the insured – than the insurer intended.

The decision is also a timely reminder that an insured's decision to refer a dispute to the Insurance and Financial Services Ombudsman (IFSO) does not foreclose the insurer's access to the courts. IFSO's own Terms of Reference expressly contemplate that a participant may institute High Court proceedings to resolve a disputed interpretation issue by way of declaratory judgment – a pathway that this Court confirmed, in an earlier case, is consistent with the Scheme's rules.

Background

As part of the construction of a new home in Twizel, the Aubreys engaged Infinite Energy Ltd (IEL) to supply and install a solar PV system on their roof. In the course of the installation, IEL's workers dented several roof sheets, causing damage of NZD96,651.98. The Aubreys held an NZI Contract Works – Single Project policy with IAG, covering the period of the building works.

IAG declined the claim, relying on a faulty workmanship exclusion (FWE) in the policy, which provided that the policy did not insure the cost of "fixing faulty workmanship." This was subject to a proviso, stating that the exclusion did not apply to "any resultant sudden and accidental loss to separate insured property or to other parts of the same insured property arising from [the faulty workmanship]."

The Aubreys challenged IAG's declination before IFSO. IFSO found in the Aubreys' favour, concluding that the claim fell within the exception to the FWE and that IAG was required to meet it.

IAG seeks declaratory relief from the High Court

Rather than accepting IFSO's determination, IAG commenced High Court proceedings seeking a declaratory judgment on the correct interpretation of the FWE and its proviso. IAG gave the undertakings prescribed by IFSO's terms of reference (i.e. IAG agreed to pay the Aubreys' claim in full on a without prejudice basis and agreed to meet their costs on a solicitor and client basis) and pursued declaratory relief. Both the FWE and its proviso were standard language used across a number of IAG policies.

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Case Study: Faulty workmanship exclusions: Clarity in drafting and the Court's role after IFSO

IAG New Zealand Ltd v Aubrey – High Court of New Zealand

However, ultimately, the Court preferred the position advanced on behalf of the Aubreys, finding that the “cost of fixing faulty workmanship” is limited to the cost of redoing that primary task – not the cost of repairing consequential physical damage caused to other parts of the property in the course of the works. In reaching this decision, the Court noted the difficulties in drawing a distinction between work integral to the performance of the contract and extraneous activities, and referred to other exclusion wordings which could have been used to clearly exclude claims of this nature. The Court also commented that, while the Court of Appeal had adopted a broad interpretation of the word “workmanship” in *Timtech*, that case concerned the interpretation of a general liability policy – and the same definition did not apply to the contract works policy at issue.

The High Court's decision

IAG argued for a broad interpretation of “workmanship”, drawing on the Court of Appeal's definition in *TimTech Chemicals Ltd v QBE Insurance (International) Ltd*, which had described workmanship as “the combination of skills directed at completing the relevant contractual

obligation,” covering “the whole physical responsibility of performing the contract.” On that basis, IAG contended that “workmanship” extended to integral protective or preventive measures undertaken in the course of performing the primary contractual task – such as the obligation to protect the roof sheets while carrying equipment across them – but drew a distinction between those integral responsibilities and genuinely extraneous activities giving rise only to a general duty of care.

The Court declined to make a declaration on the meaning of the proviso, noting that there was not enough material before the Court for it to be comfortable that unintended consequences would not flow from a declaration.

This aspect of the case carries an important practical reminder for insurers: an IFSO determination does not foreclose the option of seeking clarification from the courts. Where a policy interpretation question has wider ramifications for an insurer's book of business, declaratory relief remains available under IFSO's terms of reference.



What this means for insurers

1. Clarity in drafting is essential

The Court's decision is a reminder that ambiguity in exclusion clauses will be resolved against the insurer. Where the text of an exclusion is unclear, New Zealand courts will apply the *contra proferentem* principle – construing the ambiguity narrowly, against the party that drafted the relevant clause.

The practical consequence is clear: if insurers do not intend to cover consequential damage caused incidentally in the course of faulty workmanship, that intention must be expressed in clear and unambiguous terms. It cannot be assumed that a word used in one policy type will have the same meaning across other policy types.

2. IFSO determinations are not the final word

This case is also a timely reminder that the IFSO complaints process is not the end of the road for insurers who disagree with a determination. Where a policy interpretation question has material implications for an insurer's wider business, seeking declaratory relief from the High Court remains available.

Insurers facing adverse IFSO outcomes should consider carefully whether the issues at stake warrant further engagement with the courts, particularly where the policy language in question appears across multiple products of the same type.

Speak to our insurance experts



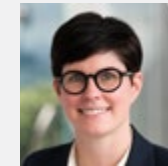
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