MARSH

Professional and Management Liability Insurance Claims: Common Pitfalls for Unwary Policyholders

CONTENTS

FOREWORD

Insureds purchase insurance cover to transfer the financial risk of unexpected events. Insureds, therefore, must be careful not to do anything which could undermine the protection that the policy is intended to offer. Yet all too often, insureds find themselves in difficulty because they have failed to take certain steps prescribed by the policy, either at all, or in a manner compliant with the policy wording.

An insurance policy is a contract and, like any other legal agreement, it sets out rights and obligations on the part of both parties involved. To the insured, the most important obligation under the policy might be the insurer's obligation to support the insured and to pay claims in their time of need, but there are likely to be a number of requirements in the policy designed to protect the insurer as well. These are quite separate to the question of whether a particular loss is within the scope of policy coverage or subject to an exclusion.

Some of these requirements might not be the first thing that comes to mind when the insured is in the midst of dealing with the crisis that is the insured event, but failure to comply with such terms can result in a reduction of indemnity or even loss of coverage altogether. Those terms are often technical or procedural in nature, which can be a particularly frustrating reason to be denied insurance cover. Furthermore, it might not be immediately clear what the effect of breaching those terms is.

In this briefing paper we focus on professional and management liability insurance policies, and the obligations that may be found therein. We start by taking a broad look at the current claims trends in those areas and the increasing number of claims, particularly in the context of financial lines and D&O (directors and officers) insurance. The data shines a light on some of the principal causes of declined claims, leading us to consider some of the common pitfalls for unwary policyholders. Some aspects, such as obligations to co-operate with insurers, are likely to apply equally to other types of insurance. The primary focus of this paper is on UK issues, but some of the issues raised have global relevance.

At Marsh, we have the depth of specialist resources and the breadth of claims experience across all business lines to guide insureds through those difficult times when insurers argue that policy terms have been breached. However, prevention is better than cure, and this document aims to highlight those situations where insureds can avert the disagreement arising in the first place.

CLAIMS TRENDS – PAST, PRESENT, AND FUTURE

At Marsh, we have a view of the claims trends in key business lines that affect every kind of client. Below we look at some of the more striking examples we have seen, which give an indication of the volumes and types of claims affecting professional and management liability policies that might be on the horizon.

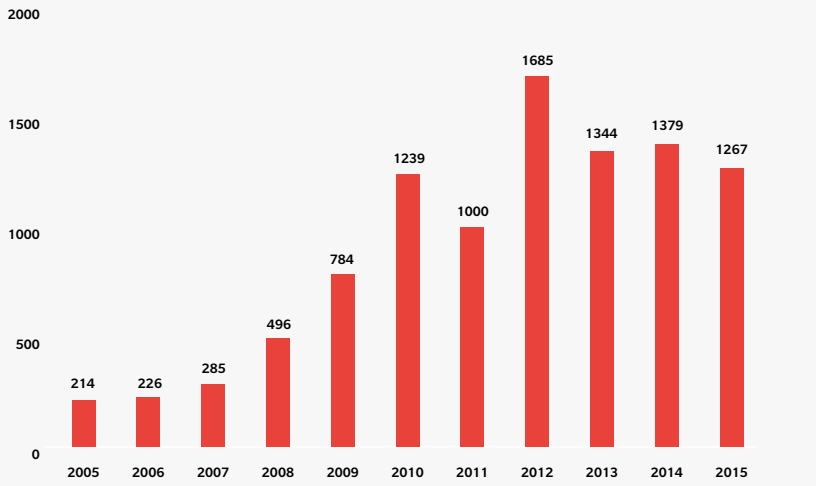
INCREASING VOLUME OF UK D&O NOTIFICATIONS

Looking at the statistics available to us in respect of Marsh's UK clients between 2005 and 2015:

- Between 2005 and 2007 we recorded between 200 - 300 D&O claim notifications annually.
- With the onset of the financial crisis, we saw a sharp increase of around 75% from 2007 to 2008.
- Claims volumes continued to rise in the following years and have not returned to pre-crisis levels.
- On average we currently record around 1,300 D&O claim notifications each year from our clients.

It must be borne in mind that over this time period there has also been a larger uptake of D&O policies, which may explain part of the increase seen. Nonetheless, regardless of the number of policies, the claims volume remains some four times higher than pre-financial crisis levels, as shown in the graph below:

FIGURE 1 **Notified D&O claims by year**
Source: Marsh's Benchmarking Survey Analysis



SPOTLIGHT

D&O liability: Conflicts of interest

Over the last few years, we have encountered increasing conflicts where both a corporate entity and its directors are insured under the same policy, but their interests may not be aligned.

This includes situations where a company's current board decides to sue former directors, and there is no applicable insured versus insured exclusion.

Such conflicts can affect the way an insured interacts with its professional advisers and indeed with insurers, and Marsh works closely with its insureds to manage such conflicts effectively, using techniques such as information barriers.

Clients are advised to ensure that they have their own procedures in place from the outset for dealing with such conflicts when they arise.

RISE IN EUROPEAN CLASS ACTIONS

There has been a general, albeit slow, shift among EU member states towards class or collective actions. Each member state's framework for class actions differs, but since the EU's consultation began in 2005, collective action procedures are being proposed throughout Europe. In 2013, the European Commission issued recommendations setting out common principles for collective redress mechanisms within the EU.

Some member states have gone further than others. Spain, Portugal, Italy, and the Netherlands, for example, all have (to varying degrees) an "opt-out" process, whereby class actions will be brought on behalf of all members of a defined class unless they positively opt-out of the action. Other countries such as Belgium and France have (at various stages of implementation) opt-in procedures, which simplify the class action process but require members to positively opt-in to the class action.

In addition, class actions are becoming more prevalent in certain areas – particularly in securities actions and competition (antitrust) actions. In England and Wales, the courts can issue Group Litigation Orders, which set out the procedure for joining claims together, but claimants must still issue their own proceedings. The Consumer Rights Act (2015) now allows a representative body to bring a claim on behalf of a class of people.

Although by no means a common feature in Europe, there is a definite move towards class actions and as the legal systems mature we expect to see more claims made on this basis, particularly by shareholders. Aside from the evolution of the legal systems, certain well-publicised issues in the financial sector have increased the sentiment among those affected (and those that represent them) that class actions are the most appropriate method of seeking redress.

INCREASED REGULATION

It is undoubtedly the case in the UK that regulators, particularly in the financial sector, have become much more active since 2008. There is also an increasing level of cross border co-operation between regulators, which is also having an impact on the volume and complexity of regulatory activity.

SPOTLIGHT

Senior Managers Regime

In the UK, the Senior Managers Regime for the banking sector and the Senior Insurance Managers Regime for the insurance sector came into force on 7 March 2016. The new regime will hold relevant individuals to appropriate standards of conduct and ensure that senior managers are held to account for misconduct that falls within their areas of responsibility.

The Senior Managers Regime, the purpose of which in the words of the Parliamentary Commission on Banking Standards is "to make individual responsibility in banking a reality," was clearly a response to the banking crisis in 2008 and what were seen, certainly in the UK, as regulatory failings.

CYBER

Cyber risk is one of the most topical issues being grappled with at board level around the world.

High-profile cyber incidents reported in the media indicate that even the largest companies in the world are at risk of hacking attacks and data breaches. A glance at the newspapers shows that cyber incidents are becoming more frequent, whether they are malicious or result from human error.

Aside from the costs of dealing with data breaches, insureds can also suffer huge business interruption losses if their networks are down for any length of time. Both of those risks will inevitably cause reputational damage as well.

Typical cyber losses have involved the hacking of customers' personal data and confidential internal information and correspondence via websites and servers. But as the world around us becomes more and more connected, everyday objects pose threats. People's homes are becoming networks due to the "Internet of Things", where everything from a TV to a heating system to a fridge is connected. On-board computer systems in cars offer Wi-Fi connectivity which, as has been shown, can be hacked so that control can be taken of the car itself. It may be possible for all of these risks to elevate the potential for third-party liability claims against companies.

Computer systems are only going to become more prevalent. Driverless cars are being tested. Unmanned drones are being developed to carry out deliveries.

These developments can only escalate the cyber risks faced by companies, in a broadening range of industries, and we foresee that the scope and frequency of cyber risks will increase greatly over the short term.

With an expansion in these risks comes an attendant requirement for companies to address them. It will then be incumbent on D&O to protect the companies they run – both in terms of protecting against the risk itself and the options available to the company for managing losses and dealing with cyber breaches. A failure to do so is likely to result in D&O claims. What's more, impending EU legislation regarding cyber breaches will put a further burden of regulation on companies and increase the risk of regulatory action. We are working closely with clients to ensure that their policies offer adequate protection in relation to these types of risk.

As these risks increase, so too will the take-up of cyber insurance policies, and ultimately claims under those policies. Much of the following discussion regarding policy pitfalls will equally apply to claims under cyber policies.

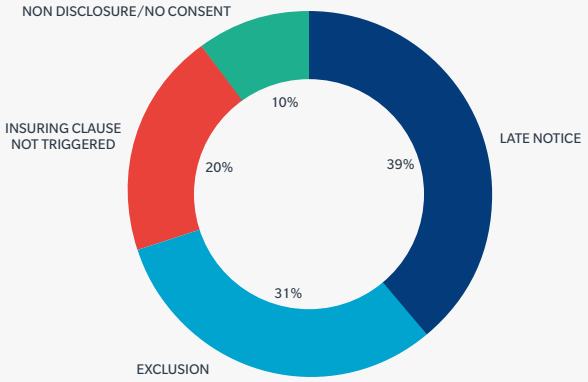
"It will be incumbent on D&O to protect the companies they run from cyber risk... A failure to do so is likely to result in D&O claims."

THE REASONS INSURERS DECLINE FINANCIAL LINES CLAIMS IN THE UK

On average, less than 1% of financial lines claims made by Marsh UK clients are declined by insurers – a positive fact that shows declinatures are thankfully rare.

However, when a claim is declined it can be catastrophic, leaving an insured to deal with the financial costs of a claim or loss entirely on its own. The chart below shows in broad terms the principal reasons that claims were declined for Marsh's UK financial lines clients between 2011 and 2015.

FIGURE 2 **Most common reasons for declined claims (UK financial lines clients)**
Source: Marsh's Benchmarking Survey Analysis



As can be seen, the largest proportion of declined claims result from a failure to notify in accordance with policy requirements or timeframes, or at all. This is a very important consideration for insurers and an obligation that they take very seriously. We explore the issues around notification of claims and circumstances later in this paper.

Policy terms relating to the triggering of cover and obtaining insurers' consent to settlements are also prevalent themes in disputes – combined with non-disclosures, those issues account for almost a third of declined claims.

While the proportion of claims that are declined is relatively small, it is clear that certain key themes recur in most declinatures. Those policy requirements are often mechanical or administrative, but nonetheless should be strictly adhered to in order to reduce the risk of a claim being declined.

This paper offers guidance on what insureds can do to protect themselves from falling foul of these terms.

"The largest proportion of declined claims results from a failure to notify in accordance with policy requirements or timeframes, or at all."

POLICY PITFALLS: POLICY TRIGGER

It is fair to say that the majority of policies in the professional and management liability fields operate on a "claims-made" basis. But what does this mean and what issues can it give rise to?

"Claims-made" means that the policy that responds, and governs the terms of cover, is the one in force at the point a third party makes a claim against an insured. This is as opposed to a "losses-occurring" basis, where the policy that responds is the one in force when the loss or damage occurs. For a claim to be covered under a "claims-made" policy, it must be "made" against the insured within the policy period.

An important point is that it is the existence of a claim (or potential claim) that is important – not whether the claim has any merit. Whether an insured will ultimately be held liable in respect of a claim and its own views of the merits of the claim are not relevant to the question of whether a claim has been made (or whether a notifiable circumstance exists), so as to trigger the insurance cover.

WHAT IS A CLAIM?

The policy will most likely define what a "claim" is, the most obvious example being the initiation of court or arbitration proceedings against an insured. Depending on the policy wording, it can be much wider, and can constitute any civil proceedings, any regulatory proceedings, a simple written demand, or at the far end of the scale, a complaint or expression of dissatisfaction. There may also be a requirement that the "claim" alleges a "wrongful act", which might also be defined in the policy.

It is likely that an insured will appreciate when formal proceedings are served on it and will notify its insurer (although, equally and understandably, the insured might feel the most pressing issue is to prepare a response to the claim). But it might not be so obvious if an informal letter of complaint makes certain allegations and seeks redress.

If the definition of claim includes written demands, for example, such a complaint might constitute a claim, triggering cover, and requiring notification. However, failure to notify the "claim" may result in loss of coverage (see following section), even though the claim has been "made" against the insured within the policy period.

Furthermore, where the issue develops into a formal claim in a subsequent policy period, that subsequent policy will most likely not respond because the claim was not first made within that policy period, it was made when the complaint was received. The claim may also be specifically excluded, as one of which the insured was (or ought to have been) aware of when the subsequent policy incepted.

If the complaint does not constitute a claim, coverage is not yet triggered. However, it may still be capable of triggering the policy if it can be considered a "circumstance".

WHAT IS A CIRCUMSTANCE?

Many liability policies also contain a "deeming provision", the effect of which is that an insured can notify an issue when it (or possibly a specified individual or group of persons within the insured) becomes aware of a circumstance that does not necessarily meet the definition of a claim in the policy, but which might give rise to a claim in the future. If that circumstance is notified to the insurer, then any subsequent "claim" that arises out of the circumstance will be treated as or "deemed" a claim made within the earlier policy period.

The policy might specify when an issue is considered a circumstance, which may be an objective or subjective determination. This is discussed in the following section on notification.

TOP TIPS

- Review and clarify the definitions of "claim" and "wrongful act" in the policy wording.
- Set up a system for reporting claims internally so that colleagues understand what to look out for and what needs to be reported internally and to insurers.
- Liaise with your broker early if it is believed there is a claim or circumstance which might give rise to a claim.
- Ensure compliance with the policy's notification provisions for both claims and circumstances (see following section for more detail).

POLICY PITFALLS: NOTIFICATION

Notification issues are a very common cause of disputes between insurers and insureds. Although the courts in England and Wales generally don't like to see insureds declined coverage because of a notification issue, they must nevertheless enforce the terms of the contract entered into. Ultimately, the insured's notification obligations will be governed by the wording of the policy, which should be closely adhered to.

The notification of claims or circumstances is intended to protect both insurers and insureds. By notifying claims or circumstances, the insured brings the issue into the cover provided by the existing policy period (see previous section) and prevents it falling foul of an exclusion in the following year's policy. Early notification also benefits the insurer, who can assess the issues and devise a strategy for minimising both its and the insured's exposure before the claim has developed beyond its control.

NOTIFYING CLAIMS

The policy wording should specify how and when to notify a claim. It might specify:

- The time period in which notification should be given ("as soon as practicable", "as soon as possible", "mmediately", "within x days", "within the policy period"). The meaning of "as soon as possible" was considered recently by the English courts in the Maccaferri case (see Spotlight). The time period may start to run from the date the claim was made or the date of awareness of a given individual (for example, the risk manager) at the insured.
- To whom notification should be given (the insurer, the agent, the broker or specific named personnel of the foregoing).
- By what method (writing, email, telephone, fax – check for the relevant address, email address or telephone number) the claim should be made.

NOTIFYING CIRCUMSTANCES

The policy wording may include a different process for notifying circumstances. As well as the mechanical issues dealt with above, the policy will dictate when a circumstance becomes notifiable. Look for wording such as "circumstances likely to give rise to a claim", or "which may give rise to a claim", or "could reasonably be expected to give rise to a claim". Each has a different threshold (also see Spotlight for the meaning of "likely"). Some policies allow a subjective determination – when does the insured (or a specified individual at the insured) think a circumstance may give rise to a claim? Others may apply an objective test – when would a reasonable insured think that a circumstance may give rise to a claim?

The policy may not use these actual words to convey this point so it is vital that insureds review their policy wording and identify how these thresholds operate – ideally before or as soon as the policy has incepted.

SPOTLIGHT

Maccaferri Limited v Zurich Insurance PLC, 2015

The insured supplied a tool which subsequently injured someone (a number of parties removed) who was using it. The policy contained a condition precedent that:

"The Insured shall give notice in writing to the Insurer as soon as possible after the occurrence of any event likely to give rise to a claim with full particulars thereof..."

The insurer argued that "as soon as possible" meant the obligation arose when the insured could, with reasonable diligence, have discovered that an event was likely to give rise to a claim. The court rejected this. On this notification wording, the insured was not required to investigate events in order to assess the likelihood of a claim:

"Likely to give rise to a claim" means there must be at least a 50% chance that a claim would eventuate. The policyholder knew there had been an accident involving one of their tools but this meant that a claim against them was a mere possibility at that stage".

In addition, some policies require notification of circumstances; others merely permit notification of circumstances, but do not make it mandatory. The ability to notify circumstances likely to give rise to claims provides a valuable benefit to insureds on claims-made policies because it allows an insured to fix cover for any subsequent claims in a particular policy period. The *quid pro quo* of that benefit is that insurers require strict compliance with time limits for such notification.

EXCESS LAYERS

It is good practice for insureds to notify excess layers as soon as they are aware of a claim or circumstance. Some excess layer policies require notification only when the insured believes the claim will impact on that policy. For example, the excess policy may require notification when the claim is likely to exceed 50% of the underlying layer of cover.

THE IMPACT OF A BREACH

A notification provision will most likely be a simple "condition" or a "condition precedent". If it is a simple (or "bare") condition, then a failure to notify a claim in accordance with the policy will give the insurer a remedy in damages for any prejudice it has suffered due to the late notification, and it would typically reduce any claim payment by that amount. Quite often, it is difficult for an insurer to prove that it has suffered prejudice.

A breach of a condition precedent is more serious. It does not require the insurer to have suffered any prejudice by virtue of the breach of the notification provisions – the insurer is simply discharged from liability for that claim.

As with all claims conditions, look for anything that is described as a condition precedent to insurers' liability under the policy. However, there does not need to be an express reference to "condition precedent", and even terms such as "Insurers will not pay unless..." or "Insurers shall have no liability unless..." can amount to a condition precedent to liability. Watch out for this type of wording, which is often found in notification provisions and other procedural terms. Some policies may also include a provision attempting to convert all terms to conditions precedent.

TOP TIPS

- Check the notification wording as soon as the wording is received.
- Understand the timing of the notification, how and when the notification must be made, the distinction between a claim and circumstance, and the point at which a circumstance becomes notifiable.
- Set up internal processes accordingly.
- Be particularly wary when the notification obligation is expressed to be, or could be construed as, a condition precedent.

"A breach of a condition precedent does not require the insurer to have suffered any prejudice by virtue of the breach of the notification provisions – the insurer is simply discharged from liability for that claim."

POLICY PITFALLS: SELECTING AND INSTRUCTING EXTERNAL COUNSEL, AND INCURRING DEFENCE COSTS

Third-party claims against an insured can move quickly. The natural reaction to receiving a claim is to appoint lawyers and other professional advisers to defend and reduce the potential exposure, particularly when the claim could become public and a company's reputation is at stake.

The majority of liability policies will provide defence costs cover, intended to reimburse the legal costs and other expenses (such as experts' fees) incurred in defending a claim, which is readily understandable given that this will likely also reduce insurers' exposure.

The policy may require insureds to seek their insurers' consent before taking any steps to defend claims or incurring related costs and expenses. Some policies will provide that consent should not be unreasonably withheld by the insurer. Nonetheless, acting without consent can lead to a refusal by insurers to indemnify those costs (or even to the entire claim being declined, if the requirement for prior consent is a condition precedent to any liability for the claim).

In addition, the policy may require the insured to appoint counsel selected by insurers. Insurers may have negotiated preferential rates with a panel of law firms, or they may seek comfort in using trusted advisers to represent the insured's (and their own) interests. That is not to say that insurers cannot be persuaded to use other counsel, but they may only agree to indemnify an hourly rate equivalent to that agreed with their preferred counsel.

Early engagement on the selection and instruction of counsel can avoid such issues leading to coverage disputes.

MITIGATION COSTS

Caution needs to be exercised where mitigation costs are not covered by the policy. In those circumstances the insured bears the costs of mitigation but may still be required to refrain from taking mitigating steps without the insurers' consent (again, this would generally be specified to be not unreasonably withheld).

Some policies may positively require the insured to take steps to mitigate the loss, even though the costs of doing so are not covered.

In cases where mitigation costs are not covered but where mitigation may reduce or remove the likelihood of a claim, it is nonetheless worth working closely with insurers and looking into the possibility of an *ex gratia* contribution to costs for doing so, particularly as the insurers stand to benefit from those mitigating steps in the long run. This would only be at the insurers' discretion, however.

TOP TIPS

- Check with insurers before instructing counsel.
- If it is imperative to instruct counsel (for example, to obtain an injunction) before you can obtain insurers' consent, liaise with your insurers as soon as possible after the instruction and seek retrospective consent.
- Seek the early involvement of insurers if you are trying to mitigate a claim or potential claim.

SPOTLIGHT

Crime policies

It is an obvious reaction to a crime or fraud for an insured to appoint their lawyers and/or their auditors to investigate. However, insureds should be careful about doing so. Firstly, crime sections of liability policies frequently sub-limit (restrict) the maximum indemnity payable in respect of investigation costs. These limits may be low, and insureds are advised to obtain cost estimates and obtain insurers' consent in advance of appointing investigators. In the case of a fraud, a secondary consideration could be whether the insured's regular auditor ought to have spotted the fraud. By instructing its regular auditor to investigate, the insured may adversely affect the opportunity to claim against those auditors, which could also have ramifications for policy response.

Crime policies usually have a notification requirement based on "discovery" of a loss. As with third-party claims under liability policies, ensure you comply with the precise mechanics and deadlines in the notification clause.

A crime policy may also include a requirement to provide a proof of loss within a certain timeframe, typically within six months of notification. In complex frauds in particular, this timeframe may be challenging and extensions may be requested and are often granted within reason. It is important, however, that this period is noted and monitored. Crime claims require the insured and insurer to work closely together; once a claim is paid by insurers, they have the right to make recoveries from the person or persons who committed the fraud or crime and are entitled to assistance from the insured to do so.

POLICY PITFALLS: CLAIMS CO-OPERATION AND SETTLEMENTS

Insurers have a direct interest in the handling and settlement of a claim – the insured will be asking them to indemnify all losses incurred in getting to that point. Most liability policies, therefore, incorporate mechanisms to ensure that insurers are kept up to speed with, and have a say in, the defence of the claim.

CO-OPERATING WITH INSURERS

Insurers will require regular updates on claims so that they can monitor the position, set reserves, and protect their interests. It is important that the insured responds to any reasonable requests from insurers and keeps them updated. Some policies will state that no claim will be payable without certain information being provided to the insurers. In addition, look out for specific policy time limits governing the provision of documentation to insurers.

Failure to comply with these requirements could prejudice the right to receive an indemnity or full payment of loss from insurers. Even where the policy requirements are not conditions precedent, a failure to keep insurers updated could give rise to arguments that they have been prejudiced as a result and are entitled to reduce or even extinguish the indemnity otherwise due to the insured.

Aside from the provision of documents and information relating to the facts of the claim, it is prudent to provide regular updates to insurers on the development of the claim and intended future steps. It may not be a policy requirement that insurers must provide their formal consent to every step taken, but giving them the opportunity to object can be important as it may be difficult for them to ultimately disagree with that course if they did not object at the time.

Ultimately, it is far easier for an insured to persuade insurers to agree to a certain course of action and to indemnify them, whether for defence costs or otherwise, if they have been brought along on the journey. It is far harder when trying to justify certain actions taken after the fact, or that it was reasonable and necessary to incur costs, or instruct the particular external counsel concerned, in circumstances where insurers have been effectively kept out of the information loop.

SETTLEMENT

On receipt of a third-party claim, an insured should not admit liability without insurers' formal written consent, even if they consider that liability to be certain, as this could prejudice the ability to obtain an indemnity under the policy. Equally, an insured should not make any payment to a third party or agree to any set-off, even for commercial reasons, without having involved its insurer beforehand.

When responding to a third-party claim, it should be explained that the matter is being investigated before reverting. It is best not to mention insurers' involvement if it can be avoided, as the claimant might be tempted to increase the claim if there is a prospect of insurance cover being available. The policy may also specify that the existence of insurance ought not to be disclosed.

SPOTLIGHT

Ted Baker v Axa Insurance

Insurers may make numerous requests for information regarding a claim or circumstances. This can impose a heavy burden on an insured and an insured may be particularly reluctant to provide information where insurers have not confirmed coverage.

The recent judgment in *Ted Baker v Axa, 2012,* provides a cautionary tale in this regard.

An employee of the clothing company Ted Baker had been stealing from their employer. The insurance policy required the insured to deliver "such books of account...and other documents proofs information explanation and other evidence as may be reasonably required by [insurers] for the purpose of investigating or verifying the claim."

The insurer had refused to confirm cover but required a significant amount of information, which the insured failed to provide. The judge held that the majority of the insurer's requests were unreasonable (the fact that the insurer had refused to confirm coverage may have been a factor).

However, the judge did hold that one category of requests was reasonable. In failing to respond to that category, the insured had failed to comply with the policy provision and as such was not entitled to any indemnity.

Clearly, there is scope for arguing that certain requests might be unreasonable, but the issue should be discussed with insurers to explain the position and to try to reach an agreement on the scope of "co-operation".

Settlement should always be discussed with insurers first. If there is a dispute as to coverage at that time, seek a waiver of the requirement to obtain insurers' consent. This prevents the insured, on the one hand, from losing the opportunity to settle the third-party claim and extinguish its liability and future exposure, and, on the other hand, from breaching its policy obligations and prejudicing its insurance cover.

Clients often have concerns about losing legal privilege in documents when they share information with insurers. In England and Wales at least, such information may be protected by common interest privilege where insurers are covering the claim. However, it is sensible to consult your legal adviser if court proceedings are expected, before providing documents or information to insurers.

Complying with co-operation requirements in the context of litigation can sometimes be a balancing act.

TOP TIPS

- Keep insurers updated on developments in claims.
- Comply with insurers' requests for information where possible; if that is difficult, enter into a dialogue with insurers to try to reach agreement about the scope of the requests.
- Don't admit liability or pay money to third parties without insurers' consent. Ask for insurers' prior support and agreement at each and every step of any negotiation.
- Consider seeking a waiver from insurers if there are coverage issues.

"Settlement should always be discussed with insurers first. If there is a dispute as to coverage at that time, seek a waiver of the requirement to obtain insurers' consent."

CONCLUSION

There are several trends that indicate professional and management liability claims are increasing both in number and complexity. In light of these, insurers will continue to demand strict compliance with policy terms to protect their own (and policyholders') interests.

Many of the disputed claims with which we assist arise from the pitfalls addressed in this paper. You should familiarise yourself with these types of terms and conditions as soon as you receive your policy wording, and not simply when the claim is first made against you (or worse, once it has developed or been settled). This will enable you to put systems in place for dealing with insured losses in a way that complies with the policy requirements. A written set of procedures detailing how liability claims should be dealt with in accordance with your insurance policy, shared at the outset of the policy period with the relevant members of staff (which may be the risk management and insurance teams, but also complaints and customer service departments), can avoid creating problems which can compromise policy coverage.

In order to assist with adopting your procedures and dealing with third-party you should:

- Examine your wording to identify what might trigger the policy.
- Notify your insurers of any claim or circumstance within the correct time period and in the correct manner.
- Seek insurers' consent before instructing counsel, incurring defence or mitigation costs, admitting liability, or settling any third-party claims made against you.
- Co-operate with reasonable requests from your insurers for information regarding the claim.
- Pay particular attention to conditions precedent.

If in doubt, seek advice from your broker.

Aside from avoiding coverage issues, bringing your insurers on board early on in the claim can provide valuable assistance in minimising the financial loss, as well as the reputational damage, that liability claims can bring.

We hope you have found this report useful. Please contact your client executive or refer to the contacts section in this paper if you should require further information.

About Marsh

Marsh is a global leader in insurance broking and risk management. Marsh helps clients succeed by defining, designing, and delivering innovative industry-specific solutions that help them effectively manage risk. Marsh's approximately 30,000 colleagues work together to serve clients in more than 130 countries. Marsh is a wholly owned subsidiary of Marsh & McLennan Companies (NYSE: MMC), a global professional services firm offering clients advice and solutions in the areas of risk, strategy, and people. With annual revenue of US$13 billion and approximately 60,000 colleagues worldwide, Marsh & McLennan Companies is also the parent company of Guy Carpenter, a leader in providing risk and reinsurance intermediary services; Mercer, a leader in talent, health, retirement, and investment consulting; and Oliver Wyman, a leader in management consulting. Follow Marsh on Twitter, @MarshGlobal; LinkedIn; Facebook; and YouTube.

About the Complex Claims and Disputes Team

The Complex Claims and Disputes Team is a division of Marsh's Global Claims Practice and focuses on the presentation and negotiation of clients' significant claims. Members of our team are all English qualified lawyers and have backgrounds in private practice in city law firms where we have specialised in insurance and reinsurance litigation (representing both policyholders and insurers).* Our team has have significant experience of the pitfalls identified in this report, having successfully negotiated many insurance claims across a range of insurance lines where these issues were present. If you would like to engage our team to assist with a complex or declined claim please refer to the contacts at the end of this paper.

* Although members of the Complex Claims and Disputes Team are legally qualified, they do not provide legal advice.

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For more information, contact the colleagues below or visit our website at: www.marsh.com

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