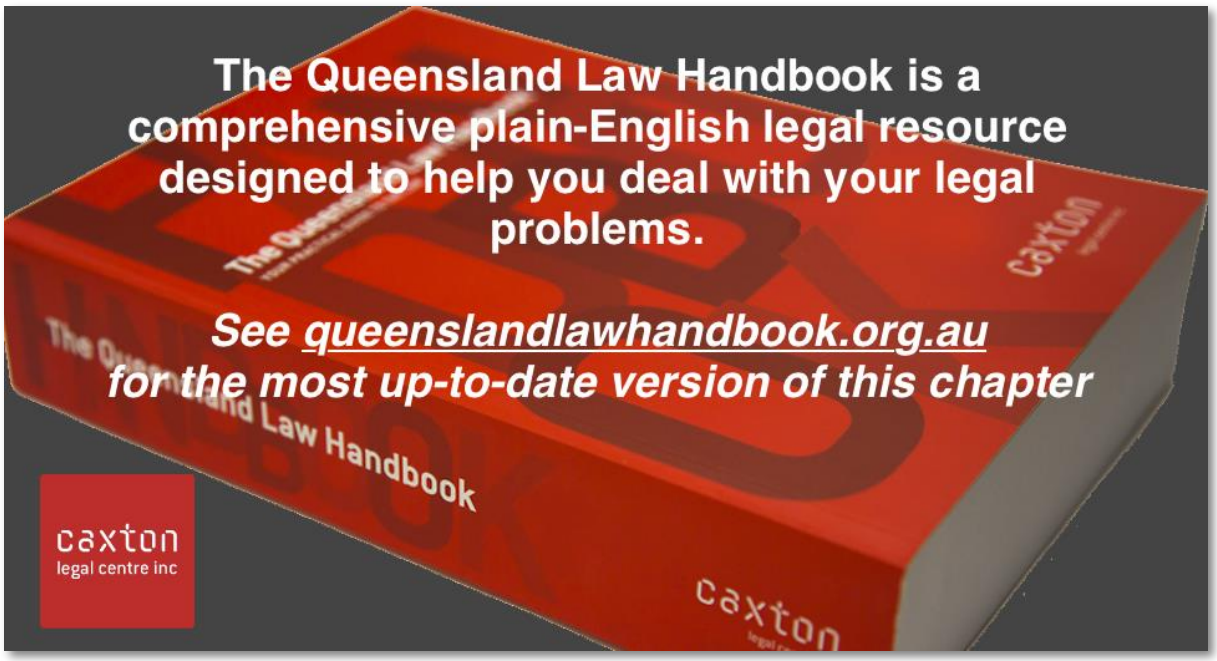

Insurance

CHAPTER CONTENTS

Introduction

Insurance is a contract between an insurer and the insured by which, in exchange for money (the premium), the insurer agrees to cover (indemnify) the insured to the extent of the agreement.

Insurance should be considered as risk management for any peril that may threaten the financial wellbeing of the insured. Insuring against fire damage or motor vehicle third party property liability for example may give relatively inexpensive peace of mind. One benefit of taking out appropriate liability insurance, professional indemnity insurance, or directors and officers insurance, may be to cover all or some of the cost of legal representation, should the insured be sued for damages and have to defend a claim after an insured risk occurs.

There may be an obligation to insure provided in legislation (e.g. for employers and registered health practitioners) or by contract (e.g. for tenants, a person obtaining finance to purchase a motor vehicle or a mortgagor).

Types of Insurance

It is important for people to inform themselves and think carefully about what risks they are exposed to in business and in their personal lives, the likelihood of each risk occurring, the range of potential consequences should the risk occur, their capacity to bear an uninsured loss or liability, and the adequacy and cost of insurance products available to them on the market. One option for a person who wants to seek new insurance or renew their insurance is to consult a broker (or licensee), who may have experience and knowledge about a particular class of risk (e.g. agricultural, construction, marine, professional liability, director's and officer's liability, cyber risks). An experienced broker should be aware of different insurance products available domestically or overseas, the relative benefits and cost of different policies, and the claims management practices of different insurers.

Personal insurance

Personal insurance may cover property (and/or related liability) of:

- motor vehicle
- home building or contents
- pleasure craft (e.g. boats)
- travel
- accident and sickness.

Liability for personal injuries caused by car accidents in Queensland is insured and paid for at the same time as vehicle registration. It is known as Compulsory Third Party (CTP) insurance (see chapter on *Accidents and Injury*).

Home building and/or contents insurance policies will usually include cover for liability as homeowner or occupant (e.g. covering a visitor who falls down the stairs). For convenience, many homeowners insure both building and contents together. Accidental damage to valuables is often available for an extra premium.

Personal accident or sickness insurance can be purchased to protect a person's income stream should they be injured, irrespective of any fault of another person, or should they become unable to work for an extended period due to illness.

Life insurance, which is not within the scope of this chapter, encompasses several types of risk insurances for example term life, trauma (critical accident or illness) and income protection (salary continuance). A total and permanent disability insurance policy is sometimes packaged with and funded through a superannuation account.

If a householder employs workers in and around the home and garden, or for child care, it is compulsory to take out workers compensation insurance. It can sometimes be ambiguous whether a worker is an employee or a subcontractor. Household worker insurance is available through WorkCover Queensland at a low cost and in conjunction with the public liability cover provided in most home and contents insurance policies, provides broad liability insurance protection to householders.

Small business insurance

Small business insurance may cover:

- industrial special risk comprehensive cover
- business package components, including fire and allied perils, business interruption, theft, money, plate glass, engineering, accidental damage for valuables, goods in transit and/or fidelity guarantee
- construction and erection
- business motor vehicle or fleet
- various liabilities, including public, product, professional indemnity, company director or officer, statutory liability and/or management liability
- personal accident or illness.

It is often better for a business to obtain independent financial advice from a broker before arranging insurance. Legal advice regarding obligations to insure and/or risk transfer provisions in contracts with associates may also be prudent.

Employers of workers in Queensland are required to take out accident insurance to cover the employer's potential liability to pay compensation or damages to any employed worker who suffers injury in the course of their employment. Legal advice should be obtained about what insurance should be taken out if the business employs workers who usually work in more than one state or territory of Australia. The insurance premium paid to the workers compensation insurer in Queensland represents a proportion of the employer's payroll and is affected by industry and claims experience.

For professionals requiring professional indemnity insurance, information about suitable insurers can sometimes be obtained through professional or industry associations. Recently retired professionals

may need to arrange 'run off' professional indemnity insurance for some years after they ceased providing professional services to clients.

The Insurance Agreement

What risks are insured and the amount that an insurer will pay if a risk eventuates and an insured suffers loss or faces a potential liability and requires legal representation, will be determined by the insurance contract.

For some classes of commercial insurance, the insurer and insured may nominate in the insurance contract the law that will govern the interpretation of the contract (e.g. England, Singapore, New South Wales) and the court or forum in which disputes about the insurance contract will be heard. However, in the case of many types of general insurance marketed to consumers in Australia, s 8 of the *Insurance Contracts Act 1984* (Cth) (Insurance Contracts Act) restricts the parties from specifying that the law of another jurisdiction governs the insurance contract, where the nominated law is different to what would normally be regarded as the proper law of the contract. This is to prevent insurers from contracting out of consumer protection provisions of the Insurance Contracts Act. An insurance contract may also nominate a particular resolution process before parties can proceed to litigation.

Each element of an insurance contract is important. The contract is often referred to as a policy but will be governed by proposal, schedule, policy wording (now contained in a Product Disclosure Statement (PDS)), Statement of Advice (containing any specific advice), statutes and the common law.

Proposal

The insured may receive guidance from a range of people in completing the proposal form. These may include the insurer's staff, a licensee (broker) or authorised representative (agent). It is often done over the telephone for mutual convenience.

The person seeking insurance has a very important duty to disclose all information that a reasonable person would consider relevant to an insurance company when deciding whether to provide insurance cover and on what terms. Even if using the services of a licensee, the person seeking insurance should be careful to ensure that all relevant information is provided to the insurer.

Policy schedule

The policy schedule will include particulars on any individual policy taken from both the insurer and the insured (usually from the proposal form). When considering an insurance proposal, when renewing an insurance policy and before making a claim, the insured should check that all particulars are correct such as:

- those named as insured (for companies, the correct company name and Australian company number should be noted)
- those noted as having an interest in the policy (and exactly the nature of the interest)
- the thing(s) insured

- the time period insured (including whether the policy is a 'claims made' or an 'occurrence-based' policy)
- the basis of insurance (i.e. agreed or market value)
- the excess/deductible (including whether the deductible is defence legal 'costs inclusive' or 'costs exclusive')
- any sub-limits, special endorsements or conditions.

Policy wording

The policy wording is contained in the PDS. It is important to keep this document and carefully note:

- that the wording version in the PDS is the same as described in the schedule
- any notices highlighting the insured's duty of utmost good faith and disclosure
- the definitions (e.g. contents may not include all that a person wants to have covered such as cover for electrical appliances but not home office equipment)
- sub-limits (e.g. those applied to valuable items and collections or a lower level of cover for 'investigation costs' in a professional indemnity policy (e.g. when meeting the professional costs of responding to tax office audits or workplace health and safety investigations))
- exclusions (e.g. criminal fines, acts of terrorism and fences may not be covered for storm damage)
- average or co-insurance clauses (e.g. if the insured item is underinsured (the value that the item is insured for is less than the actual value of the item), the insurance company may wish to reduce all claims in proportion to what the true sum insured should have been. This may be regardless of the value of the actual claim)
- conditions of cover (e.g. the responsibility to take all reasonable precautions to prevent loss)
- the claims process, particularly in relation to the time limits and process for claims notification.

Duties and rights

Federal and state statutes and the common law contain established duties and rights concerning insurance law. The industry itself has also introduced a number of self-regulatory measures. Relevant legislation includes:

- *Insurance Contracts Act 1984* (Cth) (Insurance Contracts Act) as amended
- *Financial Services Reform Act 2001* (Cth) (FSR Act).

The FSR Act statutes have reformed the entire financial services industry, including insurance, particularly in respect of industry regulation and consumer information required in the PDS and any statement of advice.

The Australian Securities and Investments Commission (ASIC) and the Australian Prudential Regulation Agency (APRA) oversee the general insurance industry.

The industry itself has also introduced a number of self-regulatory measures.

Duty of utmost good faith

Insurance policies are special contracts because an insured is usually in a better position to know what risk is to be transferred to the insurer, and an insurer usually has far more negotiating power and insurance law knowledge than the typical insured. The Insurance Contracts Act provides that a contract for insurance is based on utmost good faith (s 13).

Accordingly, both insurer and insured (now including those covered in the policy wording but not named in the schedule) have the duty to act in the utmost good faith toward the other. The duty is not one of usual good faith but utmost good faith when contracting, and it is not to be diminished by any other obligation or right. There are important consequences for breach of this duty for example the policy (along with claims falling under it) may be avoided for such breaches. Both insured and insurer should be mindful of this serious duty at all times.

Duty of disclosure

It follows from the duty of utmost good faith that the insured, usually knowing far more relevant information about the subject matter to be insured, should disclose all that a reasonable insured person would know to be relevant to the insurer. This is a statutory requirement (s 21 Insurance Contracts Act). However, s 21(1)(a) of the Insurance Contracts Act has modified the disclosure required at the time a contract of insurance is first entered into. It requires the insurer to ask specific questions about what is considered relevant, rather than relying on a general question to the intending insured to reveal everything they think relevant. If there is no specific question asked and the matter is not exceptional (as defined by the Insurance Contracts Act), the insurer may no longer be able to rely on a non-disclosure to deny a claim or avoid a policy. The insured must remember, however, that it is a new insurance contract every year, so they must make proper disclosure on each and every renewal.

According to s 22 of the Insurance Contracts Act, the insurance company must, in writing and before the insurance agreement is entered into, advise a person seeking insurance that that person has a duty of disclosure.

Insurance Fraud

Insurers take fraud seriously and may well prosecute even a low-value fraudulent matter as a policy measure to discourage fraud throughout the insurance market.

Generally, where insurance has been obtained and there has been fraud, misrepresentation or non-disclosure, the insurance company has several options. It can:

- avoid the contract if the non-disclosure or misrepresentation was fraudulent (s 28(2) Insurance Contracts Act)
- reduce its liability in respect of any claim under the policy to the extent of the non-disclosure or misrepresentation (s 28(3) Insurance Contracts Act).

Under the Insurance Contracts Act, an insurer is generally entitled to reduce the claim to the extent that its rights were prejudiced (s 54). For example, had the insurer known a vehicle was the turbo model, they may still have underwritten the policy but with a higher excess and premium.

Outright fraud may be difficult to prove but, when proved, the insurer will be entitled to deny the portion of the claim that is affected. However, if the fraud on the claim is indivisible (e.g. saying that a burnt-down house was in good condition when in fact it was condemned by the local council), the entire claim may be refused.

Special rules apply in relation to fraud, misrepresentation and non-disclosure in relation to life insurance contracts, which allow a life insurance provider to avoid the contract or vary the policy terms (s 29 Insurance Contracts Act).

An insured accused of any dishonesty should seek legal advice immediately.

General Insurance Code of Practice

The General Insurance Code of Practice (Insurance Code) is an industry agreement adopted by most leading insurers. It is administered by the Australian Financial Complaints Authority (AFCA), and a failure by the insurer to comply with the Insurance Code may be addressed by the General Insurance Code Governance Committee.

Some relevant claims procedure deadlines include:

- advise the insured of required information, appoint loss adjuster and/or provide initial time estimate of claims decision on initial claims receipt (10 business days)
- advise insured about the progress of the claim (at least every 20 business days)
- respond to the insured's information requests (10 business days)
- accept or reject the claim once all relevant information in hand (10 business days)
- make decision about the claim except in specific circumstances such as fraud or extraordinary catastrophe (within 4 months)
- make decision about complaint (30 calendar days).

For claims rejections, it is required for the insurer to provide:

- written decision reasons
- information on complaints handling procedures
- copies of service provider reports upon which the rejection was made upon request.

A copy of the Insurance Code is available from the Insurance Council of Australia.

Financial Ombudsman Service Ltd

Most leading insurers are members of AFCA, which is not a government ombudsman but a company limited by guarantee that administers an industry dispute resolution scheme controlled by its *Australian Financial Complaints Authority Operational Guidelines to the Rules*. For more information visit the AFCA website.

Elements of an Insurance Claim

A claim can be broken down into a number of elements: event, proximate cause, insured property and proof of ownership and value.

Event

The event that gives rise to the claim is usually thought of as a single sudden one. While this is often the case, it need not always be so. For example, an event may be a steady drip from a shower pipe behind a bathroom wall, the damage of which occurred and remained hidden for some years.

Proximate cause

The loss or damage must be proximately caused by an insured event. For example, a piece of jewellery may have gone missing, but it is for the insured to prove that it was in fact stolen. Similarly, where a house has been damaged, it is the responsibility of the owner to prove that the damage was caused by an event that is covered by the insurance policy (e.g. a fire or storm).

Insured property

The property of the claim, which has been lost or damaged, may not be covered, either because it falls outside of what is defined (e.g. the home building when only contents are insured) or it is excluded (e.g. a motor vehicle in a claim under a home contents policy, even though it was stored in the home building).

Insurable interest and third-party beneficiaries

Traditionally an insured needed to show that they had an 'insurable interest' in respect of insured property at the time they entered into an insurance contract and at the time they made a claim. For contracts of general insurance governed by the Insurance Contracts Act, an insurable interest is no longer required. What the insured will normally need to show is that they have suffered economic loss.

It is common to name third-party beneficiaries in an insurance contract. For example, a mortgagee may be named in a home insurance policy or a principal may be named by a subcontractor in a public liability policy. Third-party beneficiaries are entitled to claim under the insurance contract and, like the primary insured, owe the insurer a duty of utmost good faith when making that claim.

Proof of ownership and value

It can be distressing when the subject of an insurance claim is either gone or destroyed, and proof of the insured ever owning it and its value are questioned by the insurer. Keeping purchase invoices, ownership manuals and other documentation is advisable. However, making statutory declarations under the *Oaths Act 1867* (Qld) or providing photographic evidence of ownership may be sufficient.

Insurance Claims Procedure

It is important that the proper procedure in making a claim is followed, as breakdowns in procedure may well translate to delays and less than full entitlement being received by the insured. Insurers are now allowed to give notices and information electronically and may often wish to do so.

Read the policy

After immediate matters are dealt with (e.g. putting out fires), the next thing an intending claimant should do is read the policy as the case may be including all of the following:

- proposal
- schedule
- Product Disclosure Statement (PDS), including policy wording
- relevant communications and file notes.

It is always better to deal with the insurer from a position of some knowledge.

Lodging a claim

The insured should take note of whether the insurance policy provides cover on an 'occurrence-based' or on a 'claims-made' basis, and must be careful to strictly and promptly comply with all obligations to notify the insurer should they become aware of a claim or circumstance that may give rise to a claim.

Claims service, including claims handling procedures, will vary from insurer to insurer. A good first step for a person making a claim is to telephone the company and find out if there will be one or a series of claims staff appointed to deal with the claim. If there is only one person, it is advisable to note their direct contact information.

Once the insurer has been contacted, there is a good chance the claims officer will have a standard procedure to follow in handling the matter. This may include:

- taking the insured's name and policy details
- asking for a brief description of the loss and its cause
- taking the basic claim details over the telephone or sending out a claim form
- asking the insured person to obtain quotations to repair the damage
- advising that a loss adjuster/assessor will be in contact to go through the claim on site.

Loss adjusters

Loss adjusters (or assessors) are either employees of the insurer or contractors to it. Their role is to assess liability and recommend what amount (or quantum) should be paid by the insurance company. Loss adjusters may either come from the ranks of the related trade (which is particularly common in motor vehicle claims), the insurance company, or from a legal or other background.

In motor vehicle claims, assessing centres are now quite common for damaged but drivable cars, and some insurers will ask its nominated repairer to also assess the claim.

Investigators

Investigators are usually appointed where a loss adjuster is not able to gather all the information desired by the insurance company. This could be for a number of reasons including:

- witness statements need to be taken
- large claims need to be investigated according to company procedure
- a certain type of claim (e.g. loss of all luggage) needs to be investigated
- further investigation is necessary before accepting liability due to unusual or suspicious circumstances.

Investigators are sometimes retired police officers, and covert surveillance of an insured does take place from time to time. Unless the insured is concerned that something is wrong, assisting the investigator may be quite fair and reasonable. However, if there are any concerns, the insured should say nothing and obtain legal advice immediately.

Repairers

Various tradespeople and other professionals (e.g. engineers) may be involved in the claim process. As with adjusters and investigators, the insured should know what repairers are involved and what work they are doing. A copy of all relevant documents (including their reports) should be given to the insured person.

The work of repairers should be checked regularly and without delay. Quality issues with the work should generally be directed first to the adjuster or directly to the insurer if no adjuster is appointed.

Service providers for the insured

Preparation of the claim may be an expense covered by the policy. The insured should review the policy and obtain insurer agreement in advance, but if in doubt take independent legal advice.

Public insurance adjusters, investigators, repairers and other professionals may be hired by the insured themselves to deal with insurance claim matters. It may be for the insurer to decide if they will pay for such representatives and indeed what weight, if any, is placed on their opinions. This will be a matter of negotiation and may be better placed in the hands of the insured's solicitor.

Claiming on another's insurance

Those claiming on the insurance of the at-fault party (e.g. a negligent truck driver) are often described by an insurer's staff as third parties. They are a third party to the policy of insurance between the insurer and the insured. These third parties may wish to claim on another's insurance, as they either have no insurance or do not wish to claim on their own policy for some reason.

Unless there is an unusual circumstance, such as a contractual arrangement between the third party and the insured, the insured has died or gone missing and cannot reasonably be found, there may be no legal entitlement for the third party to claim on a policy direct.

It is usually the case that cover is dependent on the insured:

- making a claim themselves
- passing on the third party's claim and requesting cover for that also
- meeting other contractual requirements, such as payment of an excess.

The third party should send a letter of demand with a time limit for compliance to the insured. Personal delivery of the letter is preferable. However, litigation is sometimes necessary before an insured will complete all required steps.

Insurance Policy Benefits and Limitations

Some will purchase insurance just on price, and while most policies have a similar theme, each personal and small business policy is a contract worded differently.

Once a claim is established (as described in Elements of an Insurance Claim), one must then look at limiting factors.

Prescribed minimum cover

For some personal insurances, the Commonwealth Government has prescribed a statutory minimum policy cover (and exclusions) in the *Insurance Contracts Regulations 2017* (Cth) (Insurance Contracts Regulations) as a 'safety net'. These policy types are:

- personal motor vehicle
- home building
- home contents
- sickness and accident
- consumer credit.

If the insured has less cover than that prescribed by government because, for example, the insurance contract places sub-limits on payments for certain types of claims, then pursuant to the Insurance Contracts Act, the insurer must still pay an amount equal to the minimum prescribed cover in the Insurance Contracts Regulations unless the insured:

- knew or could reasonably be expected to know that the cover was less than the minimum statutory prescribed cover
- was clearly informed in writing prior to taking out the insurance, that the contracted cover was less than the minimum statutory prescribed cover.

This information notice is often in the Product Disclosure Statement (PDS) supplied by an insurer with the blank proposal form. However, if the insurer representative did not actually supply the PDS, the insured may be entitled to government minimum cover.

Sub-limits

Insurers often apply policy sub-limits to certain risks for example to:

- jewellery and watches
- any item containing a precious metal or gemstone
- antiques, manuscripts and curios
- collections of stamps, coins, medals

- art works, tapestries and handmade rugs
- cash, bullion and bonds
- computers and computer equipment
- mobile phones
- items used in business or trade
- contents in the open air.

Such sub-limits are usually less than the government-prescribed minimum cover and therefore must be explained to the insured prior to taking out the policy. If this has not been done, the insured is entitled to the minimum cover determined by government.

Co-insurance and average clauses

Underinsurance is seen by the industry as a big problem. That is, the insured are often taking out policies where the sums insured are significantly less than the proper value.

Where an insured has insured an item for less than its actual value, some insurers will reduce any claim in proportion to what the correct sum insured should have been. For example, if the insured owned a car valued at $50 000 but only had it insured for $25 000, the insurance company might then say it is only responsible for half of any claim. If the car owner then claimed $10 000 in repairs for a car accident, the insurance company could average out its liability and say it was only responsible for half of the insurance value and need only pay half of the claim, in this case $5000.

Under s 44 of the Insurance Contracts Act, an insurance company can only rely upon averaging where there is an averaging clause in the contract, and it has clearly notified the insured person of the effect of that clause.

Moreover, s 44 of the Insurance Contracts Act provides:

- for an underinsured buffer of 20%. This means that an insurer cannot rely upon an averaging clause where the value insured is 80% or more of the actual value. In the above example, if the car owner had insured the car for $45 000 (or 90% of its real value), the insurance company could not limit its liability to 90% of the total claim but would have to pay the whole claim
- that where an item is more than 20% underinsured, the insurance company cannot average out to more than 80% of the insured value. In the above example, if the car owner insured the $50 000 car for $25 000 and then claims $10 000 in repairs, the insurance company would have to pay $6250.

Exclusions

In contrast to the subject matter simply not being insured or underinsured, a number of exclusions are typically applied to any one insurance policy. These may come in many forms, but some examples include:

- flood

- wear and tear, rust or corrosion
- depreciation
- storm or tempest loss, damage to fences, gates or retaining walls
- theft by a person ordinarily residing with the insured person(s)
- intentional damage
- damage in connection with an unlawful purpose
- government seizure
- insects or vermin damage
- racing, pace-making, reliability trial, speed or hill-climbing test
- some types of loss or damage where the building remains unoccupied for more than 60 continuous days, even when on holiday.

The insurers are obliged to clearly inform the insured in writing whether the policy covers flood, which now carries a standard definition. Depending on the circumstances, the issue may be a matter of fact, expert opinion or a matter of law. If it is a matter of policy interpretation on whether the loss or damage was, for example, caused by flood as defined in the PDS, compared with rainwater runoff, then the insured should seek legal advice.

Insurance Dispute Resolution

An insured may believe their insurer's claims procedure is not fair or that a claims decision is wrong or unreasonable.

Generally, procedural matters should first be raised with the claims officer. If no acceptable result is forthcoming, the insured should discuss the matter with the relevant claims manager. This may resolve the problem but if not, a formal letter of complaint should be written to the Internal Dispute Resolution (IDR) officer as soon as practicable after the claims decision for insurer response within 45 days.

Serious procedural and claims decision disputes should be discussed with a solicitor immediately. A solicitor will be able to advise policy interpretation and options within a reasonable timeframe. Hopefully, a solicitor's letter and negotiation by telephone will be all that is required.

Financial Ombudsman Service complaints scheme

Most leading Australian insurers and brokers are members of the Australian Financial Complaints Authority (AFCA). The authority fields general enquiries and runs a complaints scheme, including a panel that makes decisions. AFCA is currently able to make binding decisions on personal and small business insurance claims of up to $500 000 in value.

Complaints to AFCA against any insurance service provider should be made as soon as practicable but within six years of the cause of action accruing and within two years of any IDR decision. The complaint may be lodged online or in hard copy. The authority allows respondents 35 days to resolve

the dispute by IDR; when no agreement is reached within that time, the AFCA complaint then proceeds.

Once the complaint is accepted by AFCA, there is an exchange of documents from both sides; an AFCA dispute officer prepares the case and presents it to the decision-making body (e.g. a dispute analyst or panel). AFCA also has power to negotiate or conciliate a resolution. Once the authority has made an arbitration decision, both the insured and respondent are notified. A decision must be accepted or rejected within 30 days.

There are some limits to the *Australian Financial Complaints Authority Operational Guidelines to the Rules* for example in matters of alleged fraud. It is usually best to consult a solicitor before lodging a complaint. Although strict rules of evidence law do not apply, thorough case preparation, including expert examination and reporting, is important. Upon notice of an AFCA complaint, the respondent may well instruct their own specialist staff and defence lawyers. Complaint applications have no filing fee, and each party generally bears its own legal costs, although up to $5000 for the insured's costs may be awarded.

The AFCA dispute resolution procedure may be a suitable arbitration process to the insured, if not as speedy as sometimes hoped. If the insured accepts the decision, the respondent must pay the decided amount (subject to a reasonable release document); but if not, the insured is still free to pursue their rights to sue in a court of law.

Litigation

Where a significant claims dispute arrives at an impasse, legal action may be unavoidable. Legal representation is recommended for any litigation action, as the respondent will likely instruct specialist lawyers to defend the claim. There are a number of procedural steps before a matter reaches court, and these ordinarily require the attention of a solicitor experienced in insurance disputes. Most of the relevant procedural rules and forms are found in the *Uniform Civil Procedure Rules 1999* (Qld), and further information can be found on the Queensland Courts website. Contact details of solicitors experienced in insurance law are available from the Queensland Law Society referral service.

When a liability insurer agrees to indemnify an insured under a contract of insurance, the insurer is usually entitled both under the common law and under an express term of the insurance contract to be 'subrogated' to the rights of the insured. This means that if a third party has contributed to the loss and damage through negligence or breach of contract, the insurer can advance a civil cross-claim against that party in the name of the insured. This can sometimes run counter to an insured's commercial interests. Where a single firm of solicitors is appointed to act for insurer and insured, potential conflict-of-interest issues arising out of any cross-claims need to be carefully managed.

Legal Notices

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