



Legal Developments in Insurance

2026



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Welcome to our 2026 Insurance Publication, covering the legal developments and emerging risks shaping New Zealand’s insurance sector.

This edition explores the impact of AI, cyber and data risks on insurance liability, the GST implications of insurance proceeds following *Mainzeal v CIR*, and preparations for the Contracts of Insurance Act. We also examine the latest trends in IFSO Scheme disputes, including rising health claims and AI-assisted complaints, and the implications of building reform and proportionate liability for insurers.



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Disclaimer: The content of this publication is general in nature and not intended as a substitute for specific professional advice on any matter and should not be relied upon for that purpose.

AI, cyber and data risk: where insurance liability is heading next

As artificial intelligence is becoming more integrated into ordinary business processes, it exposes businesses to new areas of risk.

The development and implementation of agentic AI tools has created new potential risks for organisations, even as it helps improve business processes. Unlike earlier tools, agentic systems can plan and carry out tasks with limited human involvement, including accessing data, communicating with customers, generating work product, and interacting with other systems. Joint guidance issued by the New Zealand National Cyber Security Centre and its international counterparts identifies risks arising from agent behaviour, system integration and downstream use¹.

Cyber, D&O and professional liability exposure

For professional indemnity insurers, autonomous agents create a risk that incorrect advice, analysis or other work product may be produced and relied on before it is properly reviewed. The relevant liability is still likely to rest with the organisation or professional using the system. However, questions may arise about the adequacy of human oversight, whether AI use formed part of the insured professional service, and whether responsibility can be passed to the technology provider. Copyright, confidentiality and privacy claims may also arise from material used or produced by the system.

For D&O insurers, the exposure is more likely to concern governance and disclosure. Boards may face claims concerning the controls adopted before autonomous systems were deployed, the monitoring

¹ [Careful adoption of agentic AI services](#)

of those systems, responses to known deficiencies, or statements about the organisation's AI capability. In addition, as organisations increase their reliance on AI generated content, boards may find themselves relying on summaries prepared without human intervention, leading to questions about the degree to which directors relied on the advice of others. These are not necessarily new legal duties, but AI may create new circumstances in which established duties and policy provisions are tested.

Cyber risk extends beyond an organisation's own use of AI. The NCSC's 2026 Cyber Threat Report records that malicious actors are already using AI to increase the speed and scale of attacks, produce deepfakes, undertake reconnaissance and deliver targeted phishing. More advanced agents may also identify vulnerabilities and combine them into more complex attacks. This allows threat actors to conduct broader and more tailored campaigns with fewer resources.

Emerging exclusions

Overseas insurers are beginning to address AI exposure expressly. Developments are most advanced in the United States. One publicised endorsement excludes claims arising from AI-generated content, services incorporating AI, inadequate AI governance, chatbot representations and statements about an organisation's AI use or capability. Recent discussion in the London insurance market has also considered absolute exclusions, proposal-form questions and other changes to policy wording.

These clauses may extend beyond liability for defective AI-generated work product. Depending on their wording, they may also affect claims arising from a failure to identify third-party AI content or from the processes



Overseas insurers are beginning to address AI exposure expressly. Developments are most advanced in the United States.

adopted to supervise AI use. At the same time, affirmative products are emerging overseas. In March 2026, HSB announced cover for certain bodily injury, property damage and advertising injury claims arising from AI use².

At this stage broad AI exclusions have not become standard in New Zealand. The immediate issue for insurers and brokers is therefore likely to be identifying existing exposure, reviewing how current exclusions apply, and considering whether AI should be addressed expressly at renewal. This is of particular importance for organisations which are early adopters of agentic AI systems.

² [HSB Introduces AI Liability Insurance for Small Businesses](#)

When insurance proceeds attract GST: key implications of Mainzeal v CIR

The High Court's latest decision in the Mainzeal saga (*Mainzeal Property and Construction Ltd (in liq) v McKay and The Commissioner of Inland Revenue* [2026] NZHC 2715) confirms that the actual (GST-registered) recipient of a payment made under a contract of insurance must account for GST on that payment, regardless of the circumstances.

The decision clarifies the operation of section 5(13) of the Goods and Services Tax Act 1985, and confirms the position for insurers and any GST-registered business involved in commercial litigation where damages may be funded by insurance.

Key points

Any GST-registered plaintiff should:

- ensure that they are aware of the defendant's insurance arrangements, to assess net recovery; and
- plead the claim, and structure any settlement, to account for the GST exposure from the outset.

Insurers should obtain early clarification of whether a plaintiff is GST registered. If they are, this should be factored into reserves and settlement strategy, as the plaintiff can be expected to seek a GST gross-up in settlement negotiations, increasing the effective cost of claims.

Although the existence and extent of a defendant's insurance have long been considered irrelevant in court proceedings (because it goes to ability to pay, not liability), the existence of insurance will now always be relevant in assessing the quantum of the claim, at least where the plaintiff is GST registered.

The decision

Mainzeal Property and Construction Limited, once one of New Zealand's largest construction companies, was placed into liquidation in 2013. Following litigation that reached the Supreme Court, four of Mainzeal's former directors were found to have breached their duties to the company. Mainzeal's liquidators recovered approximately \$20 million from QBE Australia, paid on behalf of the directors under a Directors and Officers Liability and Company Reimbursement Insurance Policy.

The central question was whether the payment attracted GST under section 5(13) of the Goods and Services Tax Act 1985, which deems a payment received "under a contract of insurance" to be consideration for a supply of services where it relates to a loss incurred in the course of the recipient's taxable activity. The liquidators argued that a person only "receives a payment under a contract of insurance" if they suffered the insured loss – here, the directors were the insureds, not Mainzeal. The Commissioner's argument was that it was sufficient for the payment to be sourced from insurance, and that the "loss" need not be the insured's loss.

Tracey Walker J found for the Commissioner. Her Honour held that the 2000 amendment to section 5(13) was specifically designed to ensure that GST was payable by registered third parties when they received insurance-funded payments.

The Court concluded that the "loss" includes the third party's loss, and that the words "whether or not the person is a party to the contract" were added to catch precisely this situation. The Court described the

section's language as "internally inconsistent" but was guided by the legislative history, finding that Parliament intended the actual recipient of the insurance-funded payment to bear the GST liability.

Unfortunately for Mainzeal, in the concurrently-issued *Mainzeal Property and Construction Ltd (in liq) v QBE Insurance (International) Pty Ltd* [2026] NZHC 2716, the Court also decided that the requirement in the policy for QBE to indemnify "the Insured" if it is liable for GST under s 5(13) does not extend to a payment to a third-party. This means that the GST owed is Mainzeal's concern, not the insurers.

Practical implications

The decision acknowledges that section 5(13) creates a notable inconsistency for litigation: GST incidence turns on who makes the payment. A GST-registered plaintiff awarded \$1 million in damages for a business loss keeps the full \$1 million if the defendant pays directly. But if the defendant's insurer funds the payment, the plaintiff retains only approximately \$869,565 after accounting for GST at 15%. The Court itself recognised this under-compensation risk, observing that it is "not clear why GST obligations ought to be dependent on who makes the payment." This asymmetry will inevitably feature in settlement negotiations, with plaintiffs seeking to gross up claims to neutralise the GST impact.

In practice, claims should be pleaded and settlements structured to account for section 5(13) from the outset. Plaintiffs should make early inquiries about a defendant's insurance arrangements, as the source of funds materially affects the net recovery.

What should you do now?

- Insurers should review claims-handling protocols to incorporate early identification of third-party claimants' GST registration status.
- Lawyers should plead claims to account for section 5(13) GST exposure – consider including an express head of claim or prayer for relief addressing GST gross-up where the defendant is insured.
- GST should be addressed expressly in settlement agreements, including whether the proposed sum is GST-inclusive or exclusive and providing appropriate warranties regarding the source of funds.

Looking ahead

The Mainzeal decision provides important clarity on the scope of section 5(13), but it is unlikely to be the last word. The Court acknowledged the section's "internal inconsistency," and the policy consequences – particularly the under-compensation of claimants whose damages are funded by insurance – are significant.

In February 2020 Inland Revenue issued an issues paper canvassing the difficulties arising from section 5(13) and setting out options for reform, although nothing has eventuated. We will continue to monitor developments and report on any legislative changes or further judicial consideration of this issue.

Insurers should obtain early clarification of whether a plaintiff is GST registered.

Getting ready for the Contracts of Insurance Act

The countdown to the Contracts of Insurance Act has already started. The question is not whether insurers need to prepare, but whether they have started preparing soon enough.

The Christchurch Earthquakes of 2010 and 2011 served as a catalyst for reform of New Zealand's insurance law, with industry consultation initiated in 2018. The Contracts of Insurance Act 2024 (COIA) was finally passed on 14 November 2024. The commencement date remains subject to confirmation by an Order in Council, with implementation required no later than 15 November 2027.

The Act will revolutionise the statutory basis for insurance law and consolidate all relevant rules and principles into one statute. COIA will cover all insurance contracts (although some provisions are consumer insurance-specific and others non-consumer insurance-specific), including life insurance policies and marine insurance.

While commencement may still seem some way off, the scale of the reforms means insurers, brokers and other market participants should already be considering the practical implications for their businesses.

Key features of the COIA

Contracting out

Under s 166, the provisions of COIA may not be contracted out of. Unlike in the UK, this applies in all cases, consumer or otherwise.

Reinsurance

The Act does not cover reinsurance (s 6(3)). This creates significant differences between insurers' and reinsurers' obligations, for example liability for late payment and reliance upon late notifications of losses.

Duty of utmost good faith

The common law principle of 'duty of utmost good faith' is codified by the COIA (both for the insurer and insured). Section 59 follows the Insurance Act 2015 (UK) in divorcing utmost good faith from pre-contract disclosure and from the remedy of avoidance.

Insureds' duty of disclosure

The existing requirement is that all insureds (both consumers and businesses) must, before entering into an insurance contract, disclose to the insurer all material information. COIA now flips the responsibility onto the insurer to ask questions of the insured to obtain the required information.

Consumers are required to "take reasonable care not to make a misrepresentation" when answering these questions and COIA sets out matters to be taken into account when determining whether reasonable care has been taken.

Business (or non-consumers) are required to make a "fair representation of risk" to the insurer. This means disclosing every material circumstance that the insured knows or ought to know, or that would give the insurer sufficient information to put it on notice that it needs to make further inquiries, and doing so reasonably clearly and accessibly, that is substantially correct in fact or believed in good faith.

The principle that the knowledge of brokers is to be treated as knowledge of the insurer has been carried over into the COIA for consumer and non-consumer presentation of risk. As a result, the Act imposes duties on intermediaries and remedies for insurers.

Timing of payments

The Act introduces an implied term into every contract of insurance that the insurer must pay any sums due in respect of a claim made under the policy within a 'reasonable time'. What constitutes a reasonable time will turn upon what is required to investigate and assess the claim.

Timing of claims

Carried over from section 9 of the Insurance Law Reform Act 1977, an insurer cannot decline a claim on the basis it was not notified within the time set out in the policy. However, "claims-made" policies may be declined in certain circumstances.

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Genetic testing

The Act includes provisions allowing for regulations to be made either to prohibit or control the conduct of insurers in connection with genetic testing. This could cover insurers requiring someone to undergo genetic testing, to disclose any results of genetic testing, or to confirm whether they have already undergone genetic testing.

Before recommending any regulations, it is expected that the Minister will conduct a full policy development and consultation process.

Third party claims against insurers

The Act updates the provisions (from section 9 of the Law Reform Act 1936) relating to circumstances where a third party can make a claim directly against an insurer, bypassing the policyholder. A third party will be permitted, with leave of the court, to claim directly from the insurer if the insured party is insolvent or dead.

Increased risk exclusions

Section 11 of the Insurance Law Reform Act 1977 is also carried over into COIA, providing that an insurer cannot decline a claim because of an exclusion where that exclusion did not cause or contribute to the loss. The insured will not be bound by an increased risk exclusion if the insured proves that the loss “was not caused, or contributed to, by the happening of the event or the existence of the circumstance referred to in the increased risk exclusion.”

Contracts of Insurance (Repeals and Amendments) Act 2024

The Contracts of Insurance (Repeals and Amendments) Act 2024 was passed alongside the COIA. This Act was passed to repeal or reform a number of statutes. Key areas of reform include changes to the unfair contracts regime in the Fair Trading Act and amendments to the Financial Markets Conduct Act 2013.

The next steps

Insurers and brokers will need to prepare for COIA before it comes into effect. This will include:

- Reviewing and updating disclosure processes, including implementing separate processes for consumer and non-consumer insurance;
- Updating documentation to explain the new disclosure duties and the consequences for non-compliance;
- Ensuring that proposal forms for consumer insurance cover all material points, and are sufficiently specific and clear to ensure that all required information is obtained;
- Ensuring that there are suitable systems between insurers and brokers to make sure that all required information is passed between them; and
- Checking that policy terms are consistent with COIA, and do not contain avoidance rights that are wider than or inconsistent with the Act.

The scale of the changes required should not be underestimated. In May this year, the Financial Markets Authority (FMA) wrote to insurers setting out its expectations regarding implementation of the COIA, stating that insurers should already be actively preparing for the reforms and should not delay implementation planning pending final regulations. The FMA specifically identified the need for insurers to undertake gap and impact assessments, identify areas requiring redesign, and embed COIA considerations into governance, risk management and assurance frameworks.

The FMA's message reflects a broader lesson from major regulatory and operational change programmes. Experience shows that the greatest implementation risks often arise not from uncertainty about the final form of regulation, but from underestimating the time required to review systems, update documentation, design new processes, train staff and embed change across an organisation.

Conclusion

This comprehensive reform of New Zealand insurance law will require significant action by insurers to ensure their policies and procedures align with the new regime. Although the latest possible commencement date remains more than a year away, insurers and brokers would be well advised to start assessing the practical implications of COIA immediately, if they have not already done so. The organisations best placed to navigate the reforms are likely to be those that treat commencement as the culmination of the implementation process, rather than the starting point.



IFSO Scheme 2025/26: record disputes, surging health claims and AI Assisted complaints

In brief

- The IFSO Scheme completed a record 833 dispute investigations in the year ended 30 June 2026 – up 46% on the prior year and close to 190% over five years, without a major natural disaster.
- Health insurance is now the single largest dispute source (up 91% year-on-year), driven by scope of cover, policy exclusions, benefit limits and changes to policy terms.
- AI tools are lowering the barrier to complaints, with consumers using AI-generated submissions to escalate declined claims.
- The FMA has named complaints handling as an insurer-specific priority for 2026/27, expecting complaints data to inform product design and service improvement.

Background

The Insurance & Financial Services Ombudsman (IFSO) Scheme has released its annual figures for the year ended 30 June 2026¹. The Scheme received 3,977 total cases including 2,602 complaints, completed 833 dispute investigations and recorded consumer payments totalling more than \$1.39 million, with an average investigation time of 46 days. More than 92% of accepted disputes were insurance-related. The figures reveal a significant shift in both the volume and composition of insurance disputes in New Zealand.

Key developments

Record volumes

The Scheme completed 833 dispute investigations – up 46% on the prior year and nearly triple the 285 recorded in 2022

¹ Insurance & Financial Services Ombudsman Scheme Annual Report 2026

(close to 190% over five years). This surge occurred without a major natural disaster. As Ombudsman Karen Stevens observed: “While there have been no recent major natural disasters driving complaint volumes, we continue to see record levels of disputes coming to the IFSO Scheme.”

Health insurance overtakes all other categories

Health insurance has displaced house and motor vehicle cover as the single largest source of disputes, with investigations up 91% year-on-year. The most common issues are scope of cover, policy exclusions, benefit eligibility, limits and changes to policy terms. Stevens attributed the trend to systemic pressures: “Rising healthcare costs and increasing pressure on the health system are probably contributing to the high number of health insurance disputes. ... Consumers generally do not realise how those factors affect their cover until they need to make a claim.”

The backdrop is challenging: only 64.9% of patients received elective treatment within four months in Q3 2025/26 (against a 95% target), with 196,006 people on the first specialist assessment waitlist and more than 76,000 past the four-month mark. Aon projects New Zealand medical plan costs rising 18% in 2026 – nearly double the Asia-Pacific average of 11.3% and above the global average of 9.8%. Product changes are also feeding disputes: nib NZ’s November 2025 changes included a 20% co-payment on specialist consultations and diagnostics not on its schedule, and the removal of several benefits from selected policies.

AI-assisted complaints

Stevens highlighted the growing use of AI tools by consumers: “We are also seeing growing use of AI tools to make complaints,

which have had an impact on the volumes we’re receiving.” Policyholders who may previously have accepted a declined claim can now escalate more readily with structured, AI-generated submissions. For advisers, this raises the stakes around documentation and upfront disclosure of policy limitations.

Travel insurance and the war exclusion

Travel insurance disputes rose 32%, with some linked to Middle East conflict-related disruption. In one case, a traveller in India was unable to proceed to Dubai after regional airspace closures; the insurer declined citing an exclusion for losses arising from acts of war, and the IFSO Scheme found the exclusion was correctly applied. Stevens noted: “This dispute highlights the importance of understanding policy exclusions and checking what events may not be covered before travelling.”

FMA regulatory focus

The FMA’s Financial Conduct Report 2026/27 names complaints handling as one of three insurer-specific priorities (alongside product design and fraud detection). The regulator found that only some insurers maintain comprehensive complaints policies and that use of complaints data to drive product improvements is inconsistent. The FMA’s position: complaints trends should be a material input into product and service decisions, not a standalone compliance task.

Limits of the Ombudsman’s role

Stevens was candid about the Scheme’s boundaries: “Because we can’t change the law or rewrite their contracts, we often cannot give consumers the outcome they’re hoping for. If no cover exists under the policy they took out, we can’t change that.” This underscores the critical importance of advice at the point of sale and renewal.

What this means for you

The 2025/26 IFSO figures confirm that dispute volumes are structural, not event-driven, and show no sign of plateauing. For insurers, the FMA’s regulatory focus means complaints handling must be treated as a governance and product-design issue, not only an operational one. For advisers and brokers, the combination of rising health disputes, AI-empowered consumers and an Ombudsman who cannot extend cover beyond the policy terms makes the quality of advice at placement and renewal more important – and more scrutinised – than ever.

Recommended next steps

- **Prioritise clear communication at renewal.** Ensure policyholders understand exclusions, benefit limits and any changes to terms before they need to claim, particularly in health insurance.
- **Document advice thoroughly.** AI-assisted complaints mean consumers are better-equipped to challenge declined claims. Robust file notes and upfront disclosure of policy limitations are the best defence.
- **Treat complaints data as a strategic input.** The FMA expects complaints trends to inform product design and service improvement. Review whether your complaints handling framework meets this expectation.
- **Review war and conflict exclusions in travel portfolios.** Proactively discuss exclusions for acts of war and related disruption, particularly for itineraries involving transit through or near conflict-affected regions.
- **Engage with systemic drivers.** The intersection of public health system pressure, rising medical costs and private insurance limitations will continue to generate disputes. Ensure product suitability and manage client expectations.

The figures reveal a significant shift in both the volume and composition of insurance disputes in New Zealand.

Building reform and proportionate liability: implications for insurers

The Building Amendment Bill (the Bill) was introduced to Parliament in June this year, passing its first reading on 2 July 2026. The Bill would amend the Building Act 2004 (alongside other legislation) and seeks to address inefficiencies in the building system that increase costs, delay project delivery and contribute to “risk-averse” behaviour across the sector. The Bill also represents some of the most significant reforms to New Zealand's building and construction liability framework in decades, described as a “fundamental, if not tectonic shift in how responsibility for building defects will be allocated.”

Some of the key reforms proposed by the Bill include:

- replacing the current joint and several liability regime with proportionate liability for defective building project work;
- introducing mandatory residential home warranties for qualifying residential building work;
- mandatory professional indemnity insurance for design professionals who contribute to building work over \$100,000 (including architects, designers, engineers and surveyors);
- introducing a fast-track consenting pathway for certain residential developments incorporating solar generation or sustainable attributes;
- modernising the framework for funding building research and allocating resources across the building sector; and
- expanding the existing exemption for small stand-alone dwellings (‘granny flats’) by allowing qualifying homes to be constructed off-site before a Project Information Memorandum (PIM) is obtained, provided a PIM is secured before any on-site building work begins.



Joint and several v proportionate liability

New Zealand's building and construction sector currently operates under a joint and several liability regime. Under this regime, all defendants to a claim (regardless of their relative contribution) are jointly liable for the entire cost of repairs incurred by a plaintiff (usually the building owner). Claimants can recover the full cost of loss arising from defective building work from any liable defendant. As such, if one or more responsible parties becomes insolvent, the financial consequences are borne by the remaining defendants. In the context of building defect litigation, these defendants often include councils, architects, engineers and other insured professionals. The Government's view is that this approach has placed a disproportionate burden on parties with the financial capacity to respond to claims, especially councils, even where contributions to any defects were minor. This burden has also been identified as a contributing factor to defensive practices that increase the cost and complexity of the building process, with parties seeking to avoid litigation risks.

The Government's view is that this approach has placed a disproportionate burden on parties...



The Bill proposes to replace joint and several liability with a proportionate liability framework. Under the proposed framework, if multiple parties contribute to defective building work and a claim is pursued, each defendant would only be responsible for the share of the loss attributable to their contribution. Insolvency risk would therefore move away from the remaining defendants and fall upon the claimant. A proportionate liability regime would have huge implications for those involved in the construction litigation sector, including insurers, brokers, claimants and insured professionals, as insured parties would be exposed to significantly less risk, and not be joined into claims where there is limited basis. Liability would rest in accordance with the size of the party's relative contribution.

Home warranties, indemnity insurance and claims complexity

To address the impacts of proportionate liability on claimants who are unable to seek full recovery where a party is absent or insolvent, the Bill also introduces measures to reduce the risk of uncompensated loss by introducing mandatory home warranties, alongside mandatory professional indemnity insurance for design professionals. The mandatory home warranties would be introduced for new houses, multi-unit residential buildings up to ten metres in height and renovations valued at \$100,000 or more, where the work includes restricted building work and requires a building consent. The warranties must provide a minimum one-year defects period and ten years' coverage for structural defects. The Bill also proposes fines for non-compliance with the new warranty rules of up to \$50,000 for individuals and \$150,000 for body corporates. The Bill would also make professional indemnity insurance mandatory for design consultants who contribute to the design or compliance of building work (including architects, designers, engineers and building surveyors) where the total price of the building work is more than \$100,000 (including GST). Although many parties involved in commercial building projects already have comprehensive professional indemnity insurance, making this mandatory ensures universal coverage.

Historically, councils and professional indemnity insurers have often been viewed as the ultimate source of recovery in defective building claims. Under the proposed framework, warranty providers may increasingly assume that role. The reforms therefore have the potential to reshape not only liability allocation, but also the mechanics of recovery within construction disputes. This will mean that insurers will become even more central to the construction industry, with new demand for professional indemnity cover and warranty capacity. Notably, the Bill also includes a mechanism allowing the Governor-General to temporarily disapply some, or all, of the warranty and professional indemnity insurance requirements if market conditions materially affect the availability or affordability of those products. This reflects an acknowledgement that the success of the reforms is closely linked to the capacity of the insurance market to support them. The interaction between warranty products, professional indemnity policies and recovery actions against builders and consultants is likely to become an important area of focus as the new regime develops.

Looking ahead

For insurers, brokers and insured professionals, the proposed reforms suggest a significant shift not only regarding the allocation of liability, but also potentially for the number and nature of defective building work claims moving forward. Professional indemnity insurers may see reduced exposure to insolvency-driven claims and fewer matters where insured professionals are joined primarily because they represent a reliable source of recovery. However, that benefit must be viewed against higher complexity and more expensive claims together with greater liability for defendants, as parties seek to determine their precise share of responsibility for a loss. Whether the proposed reforms ultimately reduce the overall cost of construction disputes remains to be seen. What appears more certain is that the proposed regime will materially reshape the way risk is allocated within the construction sector and how insurers, brokers and insured parties respond when defects arise.



The question is not whether insurers need to prepare, but whether they have started preparing soon enough.



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