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The US Representations and Warranties Insurance Market: Structure and Sustainability

By the IUA Transactional Liability Committee

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About this Paper

This paper has been prepared by the International Underwriting Association's Transactional Liability Committee. It examines the evolution of the US Representations and Warranties Insurance (RWI) market and considers how current product structures, underwriting practices and claims experience interact with risks being assumed. Drawing on publicly available claims studies, market data and legal developments, the paper explores trends in claim severity, product design, retention levels, valuation-based loss, notification practices, fraud recourse and the allocation of transactional risk between buyers, sellers and insurers.

The paper is intended to provide underwriters and insurance professionals with a practical analysis of the structural and economic developments shaping the RWI market. It highlights areas that will remain pertinent to all market participants, including underwriting approaches, product design, claims management and policy wordings. The objective is not to prescribe market standards or promote any particular commercial approach, but to contribute to informed discussion regarding the sustainability and future development of the product.

The International Underwriting Association's Transactional Liability Committee was founded in 2024. It brings together underwriting experts to consider challenges facing the market, promote knowledge sharing and support education and understanding of Transactional Liability insurance and associated risks. The views expressed in this paper are intended to support professional discussion and analysis. All underwriting, pricing, coverage and claims decisions remain matters for individual insurers to determine independently.

Nothing in this paper is intended to recommend or facilitate coordination between market participants concerning pricing, retentions, coverage, exclusions, underwriting criteria, claims handling, capacity, customers or other competitively sensitive matters. All such decisions must be made independently by each market participant. The paper relies on public, historical and aggregated information and does not invite the exchange of non-public, competitively sensitive information.

Executive Summary

This paper argues that US Representations and Warranties insurance (RWI) has moved from a product that largely supplemented seller recourse to one that often operates as the principal source of recovery for post-closing loss. That shift has supported cleaner exits and reduced execution friction. It has also changed the economics of the product: where seller exposure is limited, retentions are lower and coverage is broader, more of the transaction risk sits with the insurance policy.

The key evidence points to severity rather than frequency as the central sustainability issue. Published claims studies show large paid losses, valuation-based damages, financial statements and material contracts claims, long-tail notifications, third-party and regulatory claims, and more active post-closing policy review by insureds and advisers. Frequency remains relevant and may be under pressure in some recent underwriting years, but it becomes materially more damaging where average paid severity is high, and distribution cost reduces the premium available to absorb loss.

Several connected features drive that severity: nil seller recourse, lower and dropping retentions, broader coverage, materiality scrapes, valuation-based damages, late notification, thin particularisation, third-party and regulatory claims, and more active post-closing policy review by insureds and advisers. The issue is not any one of those features in isolation. It is the cumulative effect of a product that now carries more of the economic risk of the transaction than some participants may have anticipated when assessing the exposure assumed.

The illustrative portfolio sensitivity shows why this matters. On the assumptions used in the paper, the model is close to break-even after brokerage and before claims handling and other expenses when median paid severity is used at an 18% notification frequency. Higher notification frequency or average paid severity produces materially worse underwriting outcomes. Retentions, coverage breadth, valuation-based loss, notification discipline and claims-control terms operate together.

RWI should now be assessed more clearly as a severity-driven, claims-paying product. This paper considers that proposition through diligence and coverage, materiality scrapes, multiplied damages, fraud subrogation, proportional allocation of fraud recoveries, notification and particularisation, prosecution costs, dispute resolution, and the possible analytical separation of Legal Expenses Coverage, Third-Party Claims Coverage, First-Party Loss Coverage, Regulatory Claims Coverage and Multiplied Damages Coverage. These are matters for underwriting, pricing, wording and claims assessment by each market participant, not proposed market standards.

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Introduction

Transactional Liability insurance is now an established feature of private M&A. In the United States, representations and warranties insurance (RWI) has moved from a specialist product into a standard feature of private M&A transactions, used to facilitate execution, reduce seller recourse and support clean exits. This paper uses "Transactional Liability" to refer to the broader class of Transactional Liability insurance and "RWI" to refer to the US representations and warranties insurance product considered in this paper. Published commentary on the 2025 ABA Private Target M&A Deal Points Study reports that references to RWI appear in 63% of surveyed transactions and that, among agreements referring to RWI, 46% treated the policy as the sole source of recovery for breaches of representations and warranties[1].

That development has changed the product's economic role. Buyer protection is now shaped not only by the Share Purchase Agreement (SPA), but by the cover each insurer is prepared to offer. Each participant may decide independently whether its underwriting approaches and claims frameworks remain aligned with the severity it elects to assume.

The market has also moved from deal facilitation, through established risk transfer, to a phase in which recovery is a more visible reason for purchasing RWI. Insureds and advisers increasingly understand the policy as a recoverable asset to be reviewed and managed after closing. That does not make claims improper; it means claims behaviour, notification, dispute resolution and policy wording now matter to the product's economics at placement as well as after loss.

RWI remains valuable, and claims are an expected feature of a mature insurance class. The sustainability question is whether the current structure remains appropriate in a market where severity has become the defining economic feature: valuation-based loss, large claims, long-tail notifications, broader third-party and regulatory exposures, and increasingly sophisticated post-closing claim review.

Retentions are an important part of that analysis, but not the only part. Lower retentions, particularly where combined with nil seller recourse and drop-down mechanics, reduce the economic threshold for claims. They sit alongside other issues considered in this paper, including valuation-based loss, broader coverage, diligence quality, long-tail claims, third-party and regulatory exposures, claims behaviour, dispute resolution and legal-expense exposure. The illustrative portfolio sensitivity later in the paper shows the same point numerically: retention movement matters, but portfolio economics are most strained when frequency and paid severity move together.

Although this paper focuses on US RWI, certain observations may also be relevant to US-style W&I policies written in international markets. While such policies may relate to acquisitions in a range of jurisdictions, they are designed to provide a coverage structure, underwriting process and claims experience familiar to US insureds. These policies may contain features such as modified disclosure regimes, including reduced reliance on general disclosure of the virtual data room, and in some cases the application of US law and court-based dispute resolution rather than arbitration, which remains more common in many international W&I markets. To the extent that these policies adopt elements of the US RWI model, some of the issues discussed in this paper may also be relevant to their underwriting and claims experience.

[1] Daniel R. Avery, Thuy-Dien Bui and Allison J. Sherrier, 2025 ABA Private Target M&A Deal Points Study: What's Market? (Goulston & Storrs, 6 May 2026).

Market Evolution and Loss Profile

Market Structure

A distinctive feature of the US RWI market is the number of specialist MGAs and MGUs deploying carrier capacity alongside direct-writing insurers. That model has helped the market scale by allowing carrier capital to access experienced underwriting teams, broker relationships and transaction infrastructure without building a complete internal function. Its relevance to sustainability is that a material part of the market is written through platforms whose economics depend on originating and binding new risks in a class where the policy is transaction-specific and does not renew annually.

In a non-renewing class of insurance, the ordinary discipline of annual renewal is weaker: underwriters do not return to the same insured relationship each year to re-price or decline the risk in light of developing loss experience. Where platform income is driven principally by deal flow, competition for mandates, broker dynamics and the need to maintain premium volume may therefore place pressure on price, coverage and risk selection, particularly where claims experience would otherwise justify greater caution.

That does not make delegated underwriting inherently less disciplined than balance-sheet underwriting. Direct writers also face growth, broker and competitive pressures. The point is narrower: where business models depend significantly on maintaining deal flow, commercial growth incentives may create additional pressure on underwriting discipline and risk selection. Recent Marsh data, discussed below, identifies higher primary rates and greater selectivity on larger towers, reflecting a more selective underwriting response to the developing claims environment.[2]

Current Market Trends and Loss Environment

Although no single published market-wide loss ratio isolates US RWI business, the available claims studies give a consistent picture. Frequency remains material, but the more important economic development is severity: large losses, valuation-based loss, long-tail notifications and a broader range of severe claim categories. The sensitivity analysis below is included to show how those variables interact at portfolio level. It is illustrative only and not an estimate of any individual book.

Marsh's 2025 North America data supports that perspective: it reported record North American loss payments despite a modest reduction in notifications, together with a 16% year-on-year increase in North American primary RWI premium rates and more selective management of aggregate exposure, particularly on larger transactions and structured towers. The data points to a more mature US claims environment in which utilisation, payments and claims confidence are all more visible.

Valuation-based loss is central to that severity. Aon's 2026 study[3] reports that 20.6% of claims on policies placed between 2021 and 2025 alleged more-than-dollar-for-dollar loss, and that 68% of total amounts paid in 2025 were attributable to loss calculated on a multiple basis, largely driven by financial statements and material contracts claims. The issue is no longer peripheral: multiplied damages are now a primary severity mechanism.

[2] Marsh Risk, *Transactional Risk Insurance 2025: Year in Review* (2026).

[3] Aon plc, *Transaction Solutions Global Claims Study* (2026).

Large losses are becoming more visible and economically significant, with published data indicating that paid loss is concentrated in a comparatively small number of severe claims. Marsh reports that claims exceeding USD 20 million represented less than 8% of claims paid but approximately 43% of total payout dollars in 2025. Aon reports that eight-figure payments represented approximately 41% of North American payments in 2025.[4] Aon, Marsh and Euclid data also identify financial statements, material contracts and compliance with laws as important drivers of paid loss.[5]

Claims behaviour also appears to be changing. Some market participants have observed more structured post-closing and end-of-policy-period review exercises, including claims that aggregate individually modest issues into larger financial statements or operational claims. Marsh attributes increased notifications in part to greater product knowledge and confidence in the claims process.[6] That does not prove opportunistic behaviour, but it is consistent with RWI moving from backstop protection towards a more actively considered source of post-closing recovery.

Claims timing reinforces the same point. A growing proportion of North American RWI claims are notified more than 12 months after closing, with Aon reporting that approximately 51% of claims now fall into this category and that substantial paid loss is attributable to such later-notified claims.[7] The practical issue is that many meaningful claims emerge well after closing, particularly where tax, regulatory, accounting or integration processes are needed before the underlying issue is identified and quantified.

Illustrative Portfolio Sensitivity: Frequency, Severity and Retention

The analysis below is a simplified illustration of a portfolio of primary US RWI risks. It is not an estimate of any actual insurer's portfolio and does not represent an appropriate, prevailing or future market price, retention, brokerage level, coverage term or underwriting response. Those matters remain for each market participant to assess independently.

The interaction between claim frequency, claim conversion and severity can be illustrated by reference to a simplified US primary RWI portfolio, using published North American claims data to model underwriting performance.

Assume a portfolio with USD 300 million of gross written premium, written at an average USD 12 million limit and 3.0% rate on line. This implies average premium per policy of USD 360,000 and a policy count of approximately 833, corresponding to approximately USD 10 billion of deployed primary limit. For simplicity, enterprise value (EV) is assumed at USD 120 million per deal, with retention set at an illustrative 0.5% of EV (USD 600,000), with a sensitivity to an illustrative 1.0% (USD 1.2 million). These retention assumptions are used solely to explore how retention movement may affect the model and are not empirical conclusions derived directly from the published claims datasets.

The model uses severity statistics published in North American paid-claim data. The base-case paid-severity assumption is Aon's reported 2025 median North American RWI claim payment of approximately USD 8.2 million. Aon's reported average payment of approximately USD 10.4 million

[4] Aon plc, *2026 Transaction Solutions Global Claims Study* (2026), North America, Chapter 1.1.

[5] Aon plc, *2026 Transaction Solutions Global Claims Study* (2026), North America, Chapters 1.0 and 1.2; Marsh LLC, *Global Transactional Risk Insurance Claims Report 2026* (May 2026); Euclid Transactional, *Global Representations & Warranties Insurance / Warranty & Indemnity Insurance Claims Study* (January 2026).

[6] Marsh Risk, *Global Transactional Risk Insurance Claims Report 2026* (May 2026).

[7] Aon plc, *2026 Transaction Solutions Global Claims Study* (2026), North America, Chapter 1.3.

is retained only as an adverse severity sensitivity; the average was influenced by a comparatively small number of very large claims.[8] WTW reports an average resolved RWI payment of approximately USD 7.3 million.[9]

Frequency is modelled on a notification basis, with a conversion to paid claims. Marsh reports 289 North American notifications in 2025 and more than USD 412 million of policy proceeds.[10] Triangulating that aggregate paid amount against Aon and WTW severity benchmarks implies approximately 40–56 paid claims, or broadly 14%–20% conversion from notification to paid claim. A 20% conversion assumption is therefore used as a central case.

The Marsh notification figure should not be read as a contemporaneous notification rate for the illustrative annual portfolio described above. Reported notifications can arise across multiple policy years and claims-emergence periods, while the 833-policy figure is a simplified annual portfolio assumption derived from premium, limit and rate-on-line. The notification frequencies used in the sensitivity analysis are therefore intended to illustrate plausible portfolio outcomes by reference to published claim-frequency studies, rather than to replicate the experience of any single underwriting year.

Under these assumptions, an 18% notification frequency and 20% conversion rate translate to an effective paid frequency of approximately 3.6%, or approximately 30 paid claims. Applying the Aon median severity of approximately USD 8.2 million gives approximately USD 246 million of paid loss. This corresponds to an approximately 82% gross loss ratio.

However, distribution materially reduces the premium available to absorb loss. Using an illustrative brokerage assumption of 18.5% solely for modelling purposes, net premium is approximately USD 244.5 million. On that basis, the same loss corresponds to a net loss ratio (loss/net earned premium) of approximately 101%, before claims handling, defence, adjustment and internal expenses.

The sensitivity to frequency is significant. At a 23% notification frequency (4.6% paid frequency), the model produces approximately USD 314 million of paid loss, equating to approximately 105% on a gross basis and approximately 128% on a net-of-brokerage basis. At a 26% notification frequency, the equivalent metrics are approximately USD 355 million of paid loss, approximately 118% gross and approximately 145% net.

As an adverse-severity sensitivity, if the Aon average payment of approximately USD 10.4 million is used at an 18% notification frequency, paid loss would be approximately USD 312 million, approximately 104% gross and approximately 128% net.

The retention sensitivity is also illustrative; it demonstrates the relationship between retained risk and insurer-paid loss. As an example, an increase in the assumed retention from 0.5% to 1.0% of EV would reduce insurer-paid loss on claims exceeding the additional retention by approximately USD 600,000 per claim and, applying that simplifying assumption, would reduce the illustrative loss-ratio outcomes. Actual outcomes would depend on the distribution of claim sizes, the extent to which claims erode the additional retention, and any associated effects on claims behaviour, transaction structure and buyer/seller incentives. The sensitivity is illustrative and should not be read as a quantified conclusion directly supported by the published Aon claims data.

[8] Aon plc, *2026 Transaction Solutions Global Claims Study* (2026), North America, Chapter 1.1.

[9] WTW, *RWI Claims Report* (March 2026).

[10] Marsh Risk, *Global Transactional Risk Insurance Claims Report 2026* (May 2026).

The resulting loss ratio is therefore driven by the combined effect of frequency, conversion and severity relative to net premium, rather than by any single assumption.

Published RWI claims data generally reflects indemnity outcomes rather than the full economic cost of claims. It does not capture defence costs, coverage counsel, expert engagement, adjustment expenses or internal claims resource. There is no robust public dataset that allows those costs to be modelled for US RWI. More broadly, external liability-market evidence indicates that large US liability claims are increasingly process-intensive and legally complex. Accordingly, the model should be read as a pure loss-ratio analysis based on paid indemnity, with the implication that claims handling and process costs would increase the economic burden, potentially materially.

The illustrative model primarily reflects a portfolio of primary RWI risks. Primary and excess portfolios may have different frequency and severity characteristics, and nominal excess attachment alone does not fully describe the economic exposure: where attachment represents only a small proportion of transaction value or potential valuation-based loss, a severe claim may erode the primary and lower excess layers relatively quickly. A proper assessment of excess exposure would require claims data matched to transaction value, tower structure, total programme limit and individual layer attachment. Public data is presently insufficient to draw reliable conclusions about excess-layer loss costs, pricing or rate differentials.

In summary, the illustrative model is close to break-even after brokerage and before claims handling and other expenses when median severity is used at an 18% notification frequency. Higher notification frequency or average paid severity produces materially worse underwriting outcomes.

Beyond Uninsured Seller Protections

US buy-side RWI can no longer be characterised simply as replicating the buyer's ordinary recourse against the seller in an uninsured deal. The policy now often sits in a transaction structure where seller recourse is minimal, retentions are low or dropping, representations and warranties are drafted with insurance in mind, and the insured position may be materially more favourable than the buyer would have obtained from the seller alone in an uninsured deal.

One important issue is the interaction between insurance, seller exposure and retention level. Where sellers retain meaningful exposure, warranties, disclosures and liability limitations remain disciplined by the seller's own economic risk. Where seller exposure is nominal and the policy retention is low or drops away quickly, that discipline may be weaker. That point is significant, but it should be understood as part of a wider severity picture that also includes valuation methodology, diligence, claims timing, third-party exposures and claims-control mechanics.

That also affects diligence. Buyers may insure only a small percentage of EV, but the policy can become the practical recovery source for a much larger transactional complaint. Where diligence is thin, full coverage may be difficult to align with the information actually tested before closing.

Marsh's 2025 North America data gives that issue empirical weight. Previously, many market participants adopted a 1% of EV initial retention, with a 0.5% drop-down, which no longer appears to be commonplace. For deals above USD 100 million, Marsh reported that average initial retentions fell below 0.5% of EV, while nil retention structures are now offered for breaches of certain fundamental representations.[11] At the same time, approximately 69% of Marsh-placed North American transactions in 2025 had no seller indemnity.[12] Those data points show a

[11] Marsh Risk, *Transactional Risk Insurance 2025: Year in Review* (2026).

[12] Marsh Risk, *Transactional Risk Insurance 2025: Year in Review* (2026).

significant change in risk allocation and claims economics, but they are one part of the broader sustainability analysis rather than its sole explanation.

Modern RWI enhancements – including softened claim requirements, limited subrogation and more accessible recovery – are common features in the market. The reflection of these features in underwriting assessment, pricing methodology, policy structure and claims approach will vary by individual insurer.

Product expansion can affect severity as well as coverage. Broader representations, softened procedural constraints and limited seller recourse may increase both the quantum and contestability of some large claims. Different insurers will inevitably reach different conclusions regarding the relevance of these issues to their underwriting, pricing and claims practices.

Synthetic coverage is a further example of the product moving beyond the protections ordinarily available in an uninsured transaction. It may serve a legitimate commercial purpose where a conventional seller-backed warranty package is unavailable, but some or all of the insured protections are then created for the purposes of the policy rather than negotiated with, and given by, the seller. That may remove elements of the disclosure, negotiation and recourse framework that would otherwise help define and discipline the risk. Whether, and on what basis, to offer synthetic coverage remains a matter for the independent underwriting assessment of each insurer.

This broader expansion of the insured position also informs the product-separation analysis later in the paper. Once the insured position no longer simply mirrors seller-backed indemnity protection, one illustrative analytical approach is to distinguish between different elements of cover within the same policy: First-Party Loss Coverage, Third-Party Claims Coverage, Regulatory Claims Coverage, Legal Expenses Coverage and Multiplied Damages Coverage. The framework is analytical only. It does not suggest that those categories should be separated in any particular policy, or that market participants should adopt any particular approach.

Arbitration and Dispute Resolution

Court-based resolution remains the default for US RWI disputes. Even where jury trial is waived, litigation is typically public, procedurally extensive and costly, with broad discovery, motion practice and each party generally bearing its own costs. Those features do not determine the overall loss profile, but they can materially affect the cost and conduct of the small number of large, contested claims.

RWI disputes often require a sequential analysis of breach, disclosure, knowledge, causation and quantum, frequently involving accounting, valuation and private M&A concepts. For some market participants, arbitration may be better suited to that type of dispute because it can offer a private forum, decision-makers with relevant expertise and a more controlled procedure. Others may prefer court resolution, existing jury-waiver structures or bespoke dispute provisions. The chosen forum should match the scale, complexity and technical character of the claim.

Forum selection is therefore part of claims management rather than a separate procedural preference. If exposures are analysed separately, Legal Expenses Coverage, Third-Party Claims Coverage, Regulatory Claims Coverage and Multiplied Damages Coverage may raise different dispute-resolution and claims-control considerations.

Incentives and Structural Tensions

Subrogation, Incentives and the Function of RWI

Insurance transfers risk, but it can also preserve discipline by leaving consequences for conduct outside the agreed risk transfer. In RWI, nil seller recourse has supported liquidity and clean exits, but it also alters incentives. Retention levels may affect those incentives in some transactions, but they are only one part of the wider analysis, alongside disclosure quality, recourse for seller fraud, diligence, policy wording and claims-control mechanisms.

Where seller exposure is reduced or eliminated, subrogation for fraud performs a residual but important role by preserving a boundary between insured risk and deliberate non-disclosure.[13] That role has limits. In US law, subrogation is derivative: the insurer generally acquires only the rights the buyer has, subject to the governing law and transaction documents. Fraud is difficult to prove, and many disclosure failures may reflect weak incentives or incomplete processes rather than dishonesty.

Recent English litigation illustrates the relationship between disclosure quality, underwriting discipline and residual fraud recourse. In *Veranova Bidco LP v Johnson Matthey Plc and others* [2026] EWHC 1021 (Comm), the buyer alleged that a significant customer had triggered a contractual pricing mechanism following receipt of a substantially lower competing offer, creating pressure for a material reduction in contract pricing.[14] The court ultimately rejected the fraud claim, but the case demonstrates a broader underwriting challenge that extends beyond the particular English-law issues before the court.

From an RWI underwriting perspective, the significance of the issue was not merely that pricing discussions were underway. A key customer had invoked a contractual mechanism capable of forcing a substantial reduction in pricing under a material contract. Many underwriters would regard that as information going directly to the value of a key customer relationship and the sustainability of projected earnings. The more significant underwriting question is therefore not whether a buyer received some form of disclosure, but whether the disclosure was sufficient to place the insurer on notice that the issue required further investigation, targeted underwriting questions and potentially a different assessment of risk.

In that respect, the case has relevance beyond England. RWI underwriters in both the US and UK routinely assess the adequacy of disclosures relating to key contracts, significant customers, customer concentration risks and developments that may materially affect projected earnings. The case therefore highlights a broader point about disclosure quality and context: information may be disclosed in a technical sense, yet still fail to convey the significance that an underwriter would reasonably attach to it when deciding whether additional diligence, underwriting scrutiny, exclusions or pricing adjustments are warranted.

Subrogation is therefore not a complete answer to the incentive problem. It is a back-end protection. Retentions and seller recourse may provide more immediate front-end discipline in some transactions, but they can be considered alongside the other tools addressed in this paper rather than treated as the principal solution.

[13] *AIG Specialty Insurance Co. v McColgan, 626 F. Supp. 3d 454, 458–60 (D. Mass. 2022) (RWI insurer pursuing fraud and related claims as subrogee and assignee of the insured buyer). The availability and scope of such recourse remain dependent on the transaction documents, policy wording, assignment and governing law.*

[14] *Veranova Bidco LP v Johnson Matthey Plc and others* [2026] EWHC 1021 (Comm).

A balanced approach therefore distinguishes three issues: bad actors should not be insulated from recognised fraud claims; the policy should not assume that fraud recourse alone will restore seller discipline; and retention levels may, in some transactions, influence whether buyers accept nil seller indemnity structures or require more robust disclosure. That does not make retention the central answer; it makes it one relevant lever among several.

Individual insurers may consider whether the policy clearly preserves seller-fraud recourse, and where legally available recourse against specified pre-closing management persons, while limiting anti-subrogation wording to what is necessary to protect the acquired business and intended deal structure. The policy may also address cooperation obligations and the treatment of recoveries where both insured and insurer have borne part of the same loss.

The recovery allocation question is therefore a necessary part of the subrogation analysis. If fraud recourse is preserved, the policy can also address how any recovery is shared where the insured loss exceeds the policy limit and both insurer and insured have borne part of the same economic loss. One illustrative analytical approach is discussed below.

Fraud Recoveries and Proportional Allocation

Recoveries relevant to an RWI policy may arise in several ways, including claims against sellers, management, third parties or other insurance. In practice, the most economically meaningful recovery route is often seller fraud. That is especially true in nil seller recourse structures, where ordinary breach recourse has been displaced by the policy, but fraud recourse is preserved to maintain a consequence for deliberate misconduct.

The allocation of any fraud recovery can be difficult where the insured loss exceeds the policy limit. A traditional insured-first or made-whole structure may allocate recoveries entirely to the buyer until its uninsured loss has been reduced. That protects the insured from being left uncompensated, but it may also produce an economic mismatch: the insurer may have funded a substantial part of the same fraudulent loss, while receiving none of the recovery generated by that loss. Conversely, an insurer-first model can be criticised for allowing the insurer to recover before the buyer has reduced a larger, uninsured loss. Neither outcome necessarily reflects the respective shares of the loss borne by insured and insurer.

One illustrative example is a proportional fraud recovery waterfall. Where loss exceeds the policy limit, recoveries could be allocated between insured and insurer in proportion to the amount of the fraudulent loss ultimately borne by each of them. If the insurer has paid USD 30 million of a USD 100 million fraud loss, and the buyer has borne the remaining USD 70 million, the recovery would follow those loss shares. A subsequent USD 20 million fraud recovery would then be allocated 30% to the insurer and 70% to the buyer, after any agreed treatment of recovery costs.

The principle is not that the insurer should be preferred over the insured, or that fraud recoveries should be used to reduce policy loss before the buyer's uninsured loss is recognised. It is that where both parties have borne part of the same fraudulent loss, recoveries can reduce that loss proportionately. This can take place in a manner where neither party obtains priority merely because one part of the loss was insured and the other was uninsured, or because one recovery claim is pursued before another.

This illustrative example could operate on a costs-first, pro-rata-second basis. Reasonable costs of recovery would be reimbursed first, to avoid discouraging pursuit of the claim. Net recoveries would then be allocated by reference to the respective shares of the loss borne by insurer and insured, with the proportions capable of being recalculated if further recoveries are obtained or if the ultimate loss position changes. That structure is conceptually similar to the allocation of recoveries between parties who have each borne a defined share of an underlying loss, although the legal route in RWI subrogation may be different.

For RWI, the attraction of a proportional model is that it preserves shared interest in recovery. Once a fraud claim exceeds the policy limit, both insured and insurer have a stake in the outcome. A proportional waterfall avoids the cliff-edge that can arise where a small amount of uninsured loss changes the entire recovery allocation. It also avoids the concern that an insurer-first model gives the insurer priority over the buyer's uninsured loss. The result is a neutral allocation mechanism: recoveries reduce the burden of the fraud across the parties who bore it.

Diligence and Coverage

A recurring underwriting issue is the gap between diligence and coverage: lighter diligence, in some cases, without a corresponding narrowing of cover. That does not fully explain current claims experience, because some severe risks are inherently difficult to assess adequately through pre-closing diligence. The underwriting problem is narrower: where the product responds to categories of risk that are only partially susceptible to diligence, coverage, exclusions, retentions and claims controls can operate to reflect that limitation.

Insurers will inevitably take differing approaches. One illustrative analytical approach is to build a more explicit connection between diligence and coverage in categories showing higher claim activity or where the diligence record is thin. This is not a uniform diligence manual. It recognises that some risks are more defensible where cover rests on a clear diligence basis. If that basis is absent, an insurer may address the issue through limitation, exclusion, retention, sub-limits or alternative structures, as it considers appropriate for its own appetite and circumstances.

Applicant-level information may also deserve a greater role in RWI underwriting. Many commercial insurance lines require an application or proposal form through which the insured provides information material to the insurer's assessment of the risk. RWI has traditionally relied more heavily on transaction diligence, disclosure materials, underwriting calls and policy exclusions. That focus is understandable, because the insured risk is transaction-specific. However, as RWI becomes a mature claims-paying product, there may be value in distinguishing between information about the transaction and information about the applicant's own claims and insurance history.

For example, an insurer might ask the insured to provide a limited application covering prior RWI claims, material threatened claims, declined or rescinded coverage, known policy disputes and other insurance-history matters relevant to underwriting judgment. The purpose would not be to penalise ordinary claims activity or to create a generalised character assessment of the insured. It would be to identify heightened claims patterns, prior conduct issues or information asymmetries

[15] US law on the allocation of subrogation recoveries varies by state. Many jurisdictions apply a default "made whole" doctrine under which the insured has priority where available recoveries are insufficient to compensate the full loss, although the doctrine may be modified by clear policy language in some jurisdictions. See, e.g., *International Underwriters/Brokers, Inc. v Liao*, 548 So. 2d 163, 164–65 (Ala. 1989). Treatment may also differ according to whether the insured's unrecovered amount represents loss above the policy limit or first-dollar risk expressly retained through a deductible or self-insured retention. See *City of Asbury Park v Star Insurance Co.*, 242 N.J. 596, 233 A.3d 400, 408–14 (2020). The costs-first, pro-rata allocation described in this paper is therefore an illustrative contractual approach, not a uniform rule of US law, and its operation would depend on the governing state law and the terms of the policy.

that may be material to the underwriting process. Any such process would be most appropriately framed in objective underwriting terms and designed to avoid unnecessary burden or the collection of irrelevant information.

Diligence affects severity as well as frequency. In the categories now driving the economics of the class, it may be appropriate to test whether the facts most likely to generate large, valuation-based or long-tail claims have been examined before the transfer of risk.

That approach may support a more differentiated analysis. Technical asset diligence may be relevant to First-Party Loss Coverage; employment, IP or specialist liability diligence to Third-Party Claims Coverage; tax or regulatory diligence to Regulatory Claims Coverage; and valuation work to Multiplied Damages Coverage. The relevance of those enquiries will vary by transaction and by the underwriting approach of an individual insurer.

Claims

Financial Statements

Financial statements claims deserve separate emphasis because they are among the clearest routes through which a technical accounting issue can become a severe valuation claim. The issue is not only whether the statements are technically compliant, but whether the quality of earnings, revenue recognition, reserves, working capital, related-party balances or accounting controls support the valuation paid. Where the insured position is framed by reference to GAAP or another recognised accounting standard, cover should not be understood as accepting a lower underwriting standard simply because diligence was limited. Financial statements claims are therefore a natural focal point for aligning diligence depth, accounting standard, retention level and treatment of multiplied damages.

Recent Marsh North America data reinforces the point. In North America, 49% of payments in 2025 stemmed from financial statements or compliance with laws breaches.[16] Financial statements breaches are therefore not simply common claim categories; they are a principal route through which accounting issues become valuation loss.

Material Contracts

Material contracts remain one of the clearest sources of severe loss. Recent North American claims studies identify them as a consistent driver of both notifications and paid claims.[17] That is unsurprising: material contract risks can involve revenue concentration, supply dependence, exclusivity arrangements, termination rights, pricing mechanics and change-of-control provisions, each of which may bear directly on enterprise value. Where impairment of a key customer or supply relationship affects earnings on a continuing basis, the resulting claim may readily be framed as a diminution-in-value claim.

Many severe material contracts claims involve non-disclosure of known issues affecting key relationships, such as threatened termination, non-renewal or adverse renegotiation. The risk sits at

[16] Marsh Risk, *Global Transactional Risk Insurance Claims Report 2026* (May 2026).

[17] Aon plc, *2026 Transaction Solutions Global Claims Study* (2026), North America, Chapters 1.0 and 1.2; Marsh LLC, *Global Transactional Risk Insurance Claims Report 2026* (May 2026); Euclid Transactional, *Global Representations & Warranties Insurance / Warranty & Indemnity Insurance Claims Study* (January 2026).

the intersection of diligence, coverage design and incentives: careful diligence may not reveal undisclosed management knowledge, while weak seller or management recourse may reduce the consequence of withholding information that preserves multiple-applied value at signing.

The underwriting response will vary by transaction and by insurer. Individual insurers may consider whether more targeted diligence is appropriate, whether coverage may need to reflect the diligence actually performed, and whether the disclosure regime may need support through effective fraud recourse where legally and commercially appropriate. The examples below are illustrative only and are not intended as recommended market practices or common underwriting standards.

- Diligence focus: in some transactions, insurers may focus more on buy-side testing of key relationships, including customer or supplier engagement where that is proportionate and commercially available.
- Specified-contracts analysis: where broader cover is sought, some insurers may choose to focus underwriting on a defined list of material contracts in respect of which enhanced diligence has been carried out.
- Coverage calibration: where evidence is thinner, some insurers may prefer to reflect that in structure rather than resolve the issue only at claims stage. That may involve retention, sub-limit or quantum considerations, depending on the risk.
- Disclosure focus: in some transactions, insurers may place weight on the quality of disclosure around recent customer communications, threatened non-renewals and informal disputes, particularly where those matters sit outside formal breach notices.

Condition of Assets

Condition of assets representations can generate difficult and potentially severe claims where the underwriting assumption is that physical diligence has been undertaken, but the work done was in fact limited, commercial and observational rather than technical. Site visits and maintenance-record reviews may identify obvious disrepair, but they are not the same as engineering, plant, environmental or technical diligence capable of testing useful life, maintenance condition, operating tolerances or required capital expenditure.

The principal claims issue is the boundary between breach loss and ordinary capital expenditure. Assets deteriorate through fair wear and tear, age and ordinary use. A condition of assets representation is not usually a promise that the buyer is acquiring an as-new asset base. Claims can nevertheless be framed by reference to post-closing remediation or replacement expenditure, even where part of that expenditure reflects deferred maintenance, ordinary lifecycle replacement or broader modernisation.

Betterment is the practical expression of that problem. If repair or replacement leaves the buyer with newer assets, longer useful life, improved efficiency or wider system upgrades, the analysis may need to distinguish between expenditure that restores the position promised by the transaction and expenditure that funds capital improvement. The policy and claims analysis may need to focus on that boundary so that condition of assets claims do not become a source of new-for-old capex funding.

One illustrative analytical approach is to address betterment and fair wear and tear expressly. A policy could state that recoverable loss is limited to the reasonable cost of restoring the asset base to the condition warranted, net of enhancement, improved efficiency, added useful life or other

capital betterment. If broad condition of assets cover is to remain available, the underwriting position may also be aligned with proportionate technical diligence and clearer disclosure around maintenance, useful life, replacement planning and anticipated capex.

Third-Party Claims, Wage and Hour and IP

Third-party claims are a broader severity issue than wage and hour alone. They include claims by customers, suppliers, employees, counterparties, IP owners and other external claimants, as well as investigations or proceedings brought by public authorities and regulators. These matters can be long-tail, expensive to defend and difficult to control once the underlying dispute has taken shape.

Wage and hour is a useful example. Specialist employment liability policies do not generally provide ordinary full-limit cover for wage and hour exposure; protection is often excluded, sub-limited or confined to defence costs. If the same exposure is picked up incidentally under broad compliance wording in RWI, it may add systemic, class-based employment liability severity without the pricing, defence-control or risk-selection structure that usually accompanies that risk.[18]

Notification and Coverage Period

Different insurers adopt differing approaches to notification requirements. The observations below are intended solely to illustrate issues which individual insurers may consider.

Late notification is now a material feature of RWI. The difficulty is not only investigation delay. Late-notified matters may reach insurers after evidence has cooled, witnesses are less available, third-party proceedings are already under way, or quantum has been framed in its most developed form. Published studies show meaningful volumes of claims notified more than 12 months after inception, with some claims emerging materially later in the policy period.[19] This points to a real claims-management issue, even if the data does not demonstrate tactical delay in any particular case.

Against that background, many insurance policies operate a more defined notification structure based on specified triggers rather than an open-ended obligation of promptness. Once a trigger has occurred – for example, a written demand, commencement of an investigation, receipt of formal advice that a breach may have occurred, or identification of facts or circumstances reasonably expected to give rise to covered loss above an agreed threshold – the insured could be required to notify within a period selected by that insurer for the relevant policy. That example structure more closely resembles the discipline often found in SPA notice provisions, while still allowing notice to be supplemented as the position develops.

There is also a separate particularisation issue. Some notifications identify a possible breach but provide little detail on breach, causation, quantum or the facts said to support the claim. An example policy structure could operate to preserve the ability to give protective notice, while requiring the insured to particularise the claim within a defined period, or by the end of the policy period or shortly afterwards. The same point could apply to extended reporting periods. Those provisions are useful where an issue first emerges shortly before expiry, but are less coherent if used

[18] International Risk Management Institute, "Wage and Hour Claims", IRMI Insurance Glossary (accessed 18 October 2026); International Risk Management Institute, "Wage and Hour Insurance Coverage Endorsement", IRMI Insurance Glossary (accessed 18 October 2026).

[19] Aon plc, *2026 Transaction Solutions Global Claims Study* (2026), North America, Chapter 1.3; Marsh LLC, *Global Transactional Risk Insurance Claims Report 2026* (May 2026); Euclid Transactional, *Global Representations & Warranties Insurance / Warranty & Indemnity Insurance Claims Study* (January 2026).

to notify long-known matters or broad lists of underdeveloped issues after the policy period has effectively ended.

For a US policy, an example structure could be to make notification within the defined period part of the claims-made-and-reported mechanism itself, and expressly a condition to cover for the notified matter and any related subsequent claim. The legal analysis will depend on jurisdiction and wording, but the commercial point is straightforward: notification discipline is a key tool for managing severity used across many different classes of insurance.

Properly drafted, a reporting framework can still avoid creating an unfair technical trap. It can preserve the insured's ability to notify on the basis of incomplete but known facts, while limiting the scope for tactical delay and maintaining a workable balance between insured and insurer in the management of developing claims.

Notification discipline cannot change the underlying facts, but it can affect the insurer's ability to investigate, influence strategy, preserve evidence, assess quantum and pursue any available recourse before the claim becomes harder and more expensive to manage.

A more separated product structure would raise the same question in a different form. Regulatory Claims Coverage, Third-Party Claims Coverage and First-Party Loss Coverage may have different notice triggers and different points at which insurer involvement matters. That may make a single generic notification obligation less suitable for some policies, while others may be well-suited to the simplicity of a single framework.

Treatment of Multiplied Damages

The following observations do not advocate any particular market approach and are not intended to encourage standardisation of coverage.

Multiplied damages are now a product-definition issue as well as a drafting issue. Before RWI became common, seller-backed indemnities typically constrained recovery through caps, baskets, damage exclusions and other negotiated limits, although valuation-based damages were not necessarily unavailable as a matter of law. Modern RWI may transfer that exposure more directly where the policy permits loss to be measured using transaction valuation methodologies, making multiplied damages a significant driver of severity.

Valuation-based damages are not a novel creation of RWI and may be available under US transaction law in appropriate circumstances. In *Cobalt Operating, LLC v. James Crystal Enterprises, LLC*, 2007 WL 2142926 (Del. Ch. July 20, 2007), the Delaware Court of Chancery awarded benefit-of-the-bargain damages by reference to the diminished value of the acquired business. In *Zayo Group, LLC v. Latisys Holdings, LLC*, 2018 WL 6177174 (Del. Ch. Nov. 26, 2018), the court considered Earnings Before Interest, Taxes, Depreciation and Amortisation (EBITDA) and enterprise-value methodologies when assessing alleged damages arising from breaches of transaction representations, but rejected the claimed methodology on the facts. These decisions establish that valuation-based measures of damages may be legally available in an appropriate case. They do not establish that sellers in uninsured transactions would ordinarily agree to accommodate multiplied damages within the SPA indemnity regime, which would remain subject to the negotiated definition of loss, damage exclusions, caps, baskets and other contractual limitations. Nor do the decisions make application of a transaction multiple automatic, establish insurance coverage or prescribe how an RWI policy should respond.

Materiality scrapes sit at the same intersection of drafting and severity. They are now common in US private M&A. Published commentary on earlier ABA Private Target M&A Deal Points Study data

reports that materiality scrapes appeared in approximately 90% of surveyed transactions, having increased from approximately 14% in 2005.[20] Their effect in RWI is more than administrative. A retention filters claims by size; materiality filters the substantive promise by significance. If materiality is disregarded for breach, the policy may respond to an issue that was not treated as significant enough to drive diligence, disclosure or the commercial bargain, but which is later advanced as a valuation-based loss. The point should not be overstated: there may be cases where an issue below a contractual materiality threshold is still capable of affecting value once properly understood. But where a claim depends on a scrape to establish breach, a multiple-based damages analysis may not need to be assumed merely because the transaction itself was priced on a multiple. The relevant underwriting question is whether the scraped issue was genuinely capable of affecting enterprise value, and whether that valuation-based severity was intended to be transferred to the policy.

Aon's 2026 study reports that 20.6% of claims on policies placed between 2021 and 2025 alleged more-than-dollar-for-dollar loss and that 68% of total amounts paid in 2025 were attributable to multiplied-loss calculations.[21] For some portfolios, that may point to misalignment between loss driver and product structure; for others, the exposure may already be reflected in underwriting selection, pricing, limit deployment or claims practice.

One illustrative analytical approach is the treatment of multiplied damages as a discrete underwriting consideration: stating whether, and on what basis, loss measured by reference to transaction valuation methodologies is covered; recognising the exposure as a driver of severity; and, where appropriate, recording the extent of transferred valuation-based exposure more expressly (e.g. by the insured nominating and the policy explicitly stating the agreed multiple by which valuation-based loss will be made). That would not convert multiplied damages into liquidated damages: breach, causation and quantum would still need to be established.

Prosecution Costs

Some market forms define covered costs and expenses broadly enough to include "prosecution". If left unqualified, that language may be argued to fund affirmative claim generation, including advisers instructed to identify, develop or pursue alleged breaches. That is materially different from funding defence, mitigation, settlement or resolution of a claim made against the insured.

Different insurers may take different approaches to the scope of costs coverage. For example, some insurers may confine costs to reasonable third-party costs incurred in investigating, adjusting, defending, settling or appealing covered claims or covered proceedings against the insured, together with appropriately defined mitigation costs. Other insurers may choose to provide affirmative cost support; they may do so expressly with separate underwriting, limits, retentions, consent rights, counsel controls or budget arrangements.

[20] Daniel R. Avery, "What's Market: The Materiality Scrape", Goulston & Storrs (28 May 2024).

[21] Aon plc, *2026 Transaction Solutions Global Claims Study* (2026), North America, Chapter 1.1.

Product Separation and the Potential Future of RWI

Product separation is not a taxonomy for its own sake. Its value, if any, is that it may help individual participants consider specific exposures against the central issue in this paper: whether underwriting, pricing and claims handling remain proportionate to the severity now carried by the product.

Commercial insurance products do not remain static. Pollution liability, employment practices liability and cyber insurance each developed because broad policy forms began to carry exposures with distinct frequency, severity, claims-control or underwriting characteristics. The lesson is not that RWI should become narrower, but that product maturity can involve greater specificity: whether by coverage part, endorsement, sub-limit, underwriting module, retention structure or claims-control mechanism.

A single broad form may no longer be the clearest way to carry exposures with different severity, duration, claims-control and underwriting characteristics. Some participants may prefer to identify and underwrite those exposures more separately; others may continue to manage them within a broad integrated policy form.

Over time it is possible that some RWI products may become more explicit in distinguishing between those elements of cover. That does not require separate policies in every case. Nor does it require, or imply support for, a common market form. It could involve distinct insuring clauses, sub-limits, differentiated retentions, election mechanics, excess structures, or clearer interaction with specialist underlying insurance. Different components of RWI may call for different underwriting questions, claims controls or economic treatment, even where they remain within one policy form.

The practical consequence is not that the policy must be broken into separate products. Different elements may receive different economic treatment by different insurers, for example: a higher or non-dropping retention for long-tail regulatory or third-party claims; a sub-limit or consent framework for legal expenses; clearer interaction with EPL, cyber, environmental or other specialist insurance; or express treatment of valuation-based loss. Any modular approach also creates risk of coverage gaps or allocation disputes. That risk would need to be addressed through policy architecture, coordination provisions, anti-stacking language and clear rules for how a claim that falls into more than one function is handled.

The current RWI product can be analysed through five elements of cover. The following illustrative framework provides one analytical approach to distinguishing between those elements and is not intended to suggest any particular product structure.

1. **Legal Expenses Coverage**

Legal Expenses Coverage comprising reasonable costs incurred in investigating, defending, managing, settling or resolving covered claims or proceedings, separate from the indemnity amount ultimately payable. Costs relating to affirmative litigation or claim development may need express treatment if an insurer elects to cover them, rather than being carried by implication through broad costs language.

2. **Third-Party Claims Coverage**

Third-Party Claims Coverage comprising liability arising from claims by private external parties, such as customers, suppliers, employees, contractual counterparties or IP owners, in respect of pre-closing matters giving rise to breach. The analysis can distinguish between genuinely transactional

exposure and employment, cyber, professional, environmental or other specialist liability exposure reached through a transaction representation.

3. **First-Party Loss Coverage**

First-Party Loss Coverage comprising direct economic loss suffered by the insured buyer itself, including diminution in value, remediation loss or other direct loss. This is closest to the traditional conception of RWI, but financial statements, material contracts and condition-of-assets claims each raise different proof, causation and quantum issues.

4. **Regulatory Claims Coverage**

Regulatory Claims Coverage comprising claims, investigations, assessments, proceedings or enforcement action brought by tax authorities, regulators or other public authorities. These matters may justify separate analytical treatment because they can be long-tail, procedurally constrained, difficult to control once commenced, and subject to insurability, notification, defence-control and settlement considerations that differ from ordinary private disputes.

5. **Multiplied Damages Coverage**

Multiplied Damages Coverage comprising established loss measured by reference to the transaction valuation methodology, including the application of an earnings or similar multiple, where recoverable under applicable law and policy terms. It is not a separate breach category, but a way in which claim severity can increase. Underwriting assessment may address not only whether a financial statements, material contracts or other breach exists, but whether the consequences of that breach include valuation-based loss calculated by applying a multiple to the relevant impact on earnings or another agreed financial metric. Whether and on what basis valuation-based loss is included within the cover may be expressly stated. Breach, causation, recoverability and quantum would remain matters to be established under the applicable policy and law.

Conclusion

RWI has clear value. The product has succeeded because it solves a real transactional problem: it enables cleaner exits, reduces execution friction and gives buyers a credible source of recovery. Its continued success depends on whether the current structure remains appropriately aligned with the breadth of protection now commonly granted and the severity of the claims now being paid.

The published claims studies make that question difficult to dismiss as theoretical. Severity and increasing tail risk are the principal concerns, while some recent underwriting years may also show pressure on frequency. Publicly available data discussed in this paper reinforces the point: retentions have fallen below historic norms, no-seller-indemnity structures have become the majority position in North American placements, financial statements claims continue to drive a disproportionate share of payments, and premium and capacity trends are now showing a visible reaction to claims experience. The illustrative portfolio sensitivity points in the same direction. Using median paid severity, the model is close to break-even after brokerage and before claims handling and other expenses at an 18% notification frequency; higher notification frequency or average paid severity produces materially worse underwriting outcomes. The retention sensitivity is illustrative and does not represent an empirical conclusion drawn directly from the published claims datasets.

None of this requires retreat from the product. But the issues identified in this paper may be relevant to the assessment undertaken by individual insurers when considering their own underwriting, pricing, policy wording and claims approaches. The paper raises questions on diligence and coverage, valuation-based loss and multiplied damages, policy retentions, notice and particularisation, fraud recourse and recovery allocation, dispute resolution, prosecution costs and the interaction between RWI and specialist insurance lines. Some exposures now embedded within RWI may, over time, emerge as distinct elements of cover: Legal Expenses Coverage, Third-Party Claims Coverage, First-Party Loss Coverage, Regulatory Claims Coverage and Multiplied Damages Coverage. Others may remain most effectively managed within a broad integrated policy form. The next phase of RWI may involve continued debate about more explicit product design and treatment of the exposures assumed.

The product has succeeded because it pays claims. Its continued success will depend on the market's ability to continue underwriting, pricing and managing the severity it now carries while preserving the value that RWI delivers to buyers and sellers alike.

Author:

Gus Marshall
Chair, Transaction Liability Committee, International Underwriting Association

Global Head of Transaction Liability, CFC

Managing Director, CFC Europe S.A.

IUA Contacts:

Tom Hughes
Director of Underwriting, International Underwriting Association

Faye Hepburn
Underwriting and Claims Executive, International Underwriting Association

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INTERNATIONAL
UNDERWRITING
ASSOCIATION

International Underwriting Association Ltd
1 Minster Court, Mincing Lane
London EC3R 7AA
United Kingdom

T +44 (0)20 7617 4444
E info@iua.co.uk

iua.co.uk

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