

Do I tell my insurer or not? The Quiet Decision That Can Cost You Everything



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Written through the lens of medical indemnity, but the principles apply to anyone covered under a professional indemnity policy. This article is for general education only. Always refer to your own policy wording and seek professional advice where necessary.

Every professional whose work carries personal liability will eventually face the moment.

A patient walks out furious. A client questions your advice. A project goes sideways. Maybe nothing comes of it. Maybe a lawyer's letter lands on your desk eighteen months later.

In that uncomfortable space between something might be wrong and someone is suing me, one quiet question sits in the back of your mind:

Do I tell my insurer now, or do I wait?

Due to my role at DoctorShield and JA Assure, I watch professionals wrestle with this question every week. Most of them are doctors. That is who we cover mainly. But I want to be upfront before you read any further:

although this article is written through the lens of medical indemnity, the principles are universal. If you're a lawyer, accountant, architect, engineer, or consultant under any kind of professional indemnity policy, the mechanics work the same way, and the trap I'm about to describe is the same trap.

It feels like a small administrative choice, telling your insurer about a brewing issue. It isn't. That one decision can determine whether you're fully covered for a future lawsuit, partially covered, or in the worst cases left entirely on your own.

Let me walk you through how this actually works.

First, the two words your policy treats very differently



Most people use "claim" and "circumstance" interchangeably. Your policy doesn't.

A **Claim** is the formal stuff, and most policies define it tightly: the receipt of a formal written demand for civil compensation, civil damages, or other forms of civil relief. A letter of demand, a writ, a regulatory complaint with money attached.

A **Circumstance** is everything before that. Policy wordings typically define it as **any fact, matter, or circumstance which gives rise to a Claim or Inquiry, or has the potential to give rise to a Claim or Inquiry.**

In plain English, a circumstance is an early warning sign. An event, complaint, or interaction where no lawsuit has been filed yet, but where there's a real possibility one might be coming.

To remove the guesswork, most medical indemnity policies will spell out specific **Medical Incidents** that automatically qualify as a circumstance and must be reported. Typical policies explicitly lists eleven:

1. Unexpected fatality
2. Birth defect or injury
3. Paralysis, quadriplegia or paraplegia
4. Serious burns, disfigurement or scarring
5. Brain injury or neurological impairment
6. Amputation
7. Loss of sensory capacity
8. Stage IV decubitus (severe bedsores)
9. Wrong site surgery
10. Healthcare acquired infection resulting in serious injury, disability or death
11. Infant switch or abduction

If any of these happens, you notify. No debate.

There's a part professionals often miss, though. The policy says **"including but not limited to"** the events above. The eleven incidents are the floor, not the ceiling. Any everyday situation that has the potential to escalate into a formal legal demand should also be reported as a circumstance.

For doctors, that often means:

- Allergic reactions or adverse outcomes, even when they're known and disclosed risks
- Unmet expectations, especially in elective or aesthetic procedures, where a dissatisfied patient demands a refund or threatens to "report" you
- Miscommunications that leave a patient or family member believing you made a clinical error
- A patient or family member who explicitly threatens legal action
- A complication where communication has broken down badly

In other professions, the analogues are obvious:

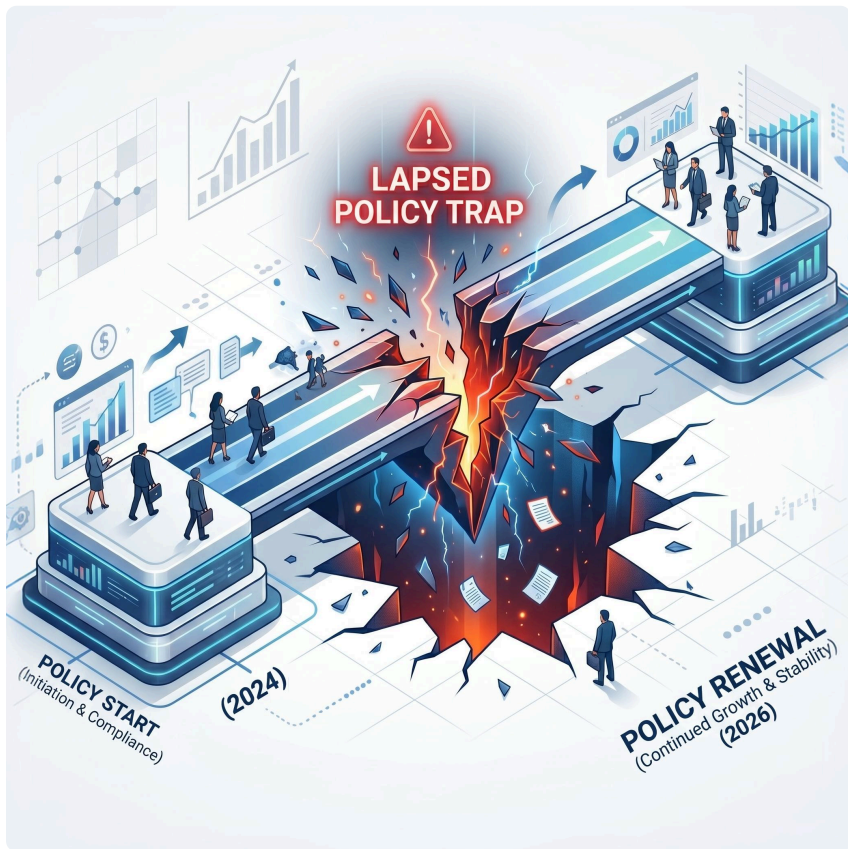
- A missed filing deadline
- A structural defect spotted on site
- A client accusing you of poor advice
- An audit issue that could lead to financial loss
- A project dispute starting to escalate

Different lists. Same principle.

Here's the golden rule, and it's the single most important thing I want you to take from this article: **reporting a circumstance locks in your coverage for that specific incident.** Notify your insurer of a brewing issue while your policy is active, and any lawsuit that emerges from it, months or years later, will be handled as if it were filed today.

That's the mechanism your policy is built around. And it only works if you actually use it.

The silence trap



Most professionals don't stay silent because they're careless. They stay silent because they're human. They hope the issue will fade. They don't want to alarm the insurer. They worry it'll affect their record. They tell themselves there's no claim yet.

Sometimes the issue really does fade.

But here's the scenario that breaks careers. You don't report the early warning. The matter goes quiet. A year later, you switch insurers for a better premium or feature. Eighteen months after that, the patient or client finally files suit.

You'll discover, painfully, that **neither insurer will cover you.**

Your old policy has expired and can't be triggered anymore. Claims made policies don't reach backward in time once they lapse. Your new insurer will reject the claim under the **"Prior Matters" exclusion**, which explicitly voids cover for any claim arising from a circumstance you knew about before the new Period of Insurance began. By staying silent, you've personally assumed the entire financial risk of a lawsuit that could run into seven figures.

I want to share something here that's hard to write.

The most painful part of my job is rejecting a claim. When a dedicated doctor walks in carrying a devastating lawsuit, and I have to tell them we can't help, because they didn't inform their previous insurer about the early warning signs, and then didn't declare that circumstance to us when they enrolled with us, there is rarely anything I can do at that point. The policy mechanics are unforgiving, and that conversation never gets easier. I think about those moments a lot, and honestly, they're a big part of why I felt I had to write this.

Continuous Cover catches you, but it isn't a strategy

What if you stayed with the same insurer all along, but never reported the circumstance until the lawsuit landed?

If your policy has a **Continuous Cover** clause, you may still be protected. The idea is simple. If you've been continuously insured by the same insurer from the date you first became aware of the potential claim, they won't invoke the "Prior Matters" exclusion against you.

But continuous cover is a safety net, not a strategy. Three things you should know:

- It only applies if your failure to disclose was not fraudulent.
- Your payout can be **reduced** to the extent the insurer can show they were prejudiced by your delay. If early mediation could have resolved the matter for a fraction of what trial ended up costing, you may absorb that difference yourself.
- Your coverage limits get capped at the **lower** of your old and current policy limits.

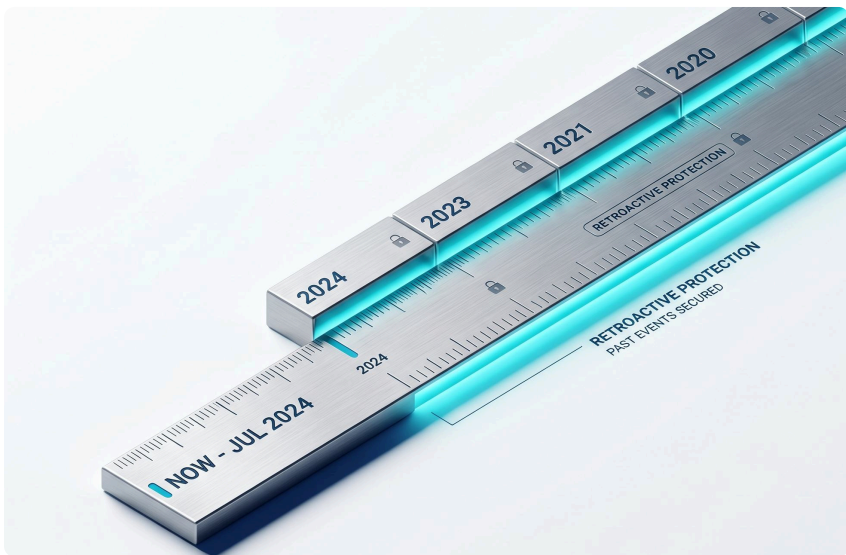
Continuous cover is a safety net in the worst case scenario.

What about the things you don't even know about?

Continuous cover handles incidents you knew about but didn't report. **Unlimited Retroactive Coverage** handles the opposite: incidents you genuinely had no idea about.

This feature means your current policy responds to claims arising from work you did at any point since the day you started practising. If a patient from ten years ago, or a client from a project you barely remember, files suit today over something you were completely unaware of, an unlimited retroactive date makes sure your current policy steps in and defends you.

For anyone with a long career behind them, this isn't optional. It's essential.



Liability doesn't retire when you do

A lot of professionals assume that once they stop practising, the risk ends. It doesn't.

Statutes of limitation stretch for years. Lawsuits can, and do, land in the middle of retirement.

Unlimited Run Off Cover keeps you protected for claims arising from professional services you



provided before you ceased practice, even after you've stopped paying premiums. Typically, insurers may provide this free of charge to doctors who've maintained continuous coverage with us for five consecutive years. Other insurers structure it differently. Some sell it as a separate extension. But the protective idea is the same.

And if the worst happens, when the lawsuit arrives after the insured professional has died, comprehensive policies extend the definition of "Insured" to include **the estate, heirs, or legal representatives** of the deceased or incapacitated practitioner. Your family and your life's savings stay out of the line of fire.

The fear that keeps people silent

Let's name the real reason most professionals don't report circumstances. It isn't laziness or denial. It's the fear of being punished for being honest. ***If I tell my insurer, and the patient never sues, will my premium spike?***

The short answer is no, not by itself.

Insurers don't penalise clients for being proactive. Premium adjustments are driven by the market and by actual claims, typically triggered by real payouts, large ones or frequent ones. A notified circumstance that resolves without legal action and without cost shouldn't, on its own, cause a significant jump.

In fact, insurers actively prefer early reporting, because it unlocks a specific policy extension called **Loss Mitigation**. Most modern professional indemnity policies offer some version of it, though the scope and limits vary, so it's worth checking your own policy schedule to confirm. Where it applies, Loss Mitigation allows the insurer to pay for costs incurred directly in avoiding or mitigating a brewing claim. Things like professionally responding to a request for medical records, funding an expert review, supporting a difficult patient conference, or engaging in early mediation. A single timely intervention has resolved disputes that would otherwise have become seven figure court battles.

Early reporting isn't a confession. It's a defensive move.

So when should you actually pick up the phone?

You don't need to notify your insurer about every uncomfortable conversation. But you should take it seriously the moment there's a real possibility a matter could come back as a claim.



In practice, consider notifying when:

- Any of the listed Medical Incidents in your policy has occurred (refer to your own policy schedule)
- A patient, client, or family member threatens legal action
- You receive a written complaint involving harm, loss, or alleged negligence
- There's an adverse outcome with serious consequences
- A regulator or authority gets involved
- A lawyer's letter or letter of demand arrives
- You discover an error that may have caused harm or loss
- You're asked for records or documents in a hostile context
- Something nags at you, and you think this might come back later

When you're genuinely unsure, ask. A good insurer would much rather hear about a concern early than discover it too late.

Where I'll leave you

You bought professional indemnity so that one difficult patient, one angry client, one mistake, or one complaint doesn't undo a career. But the policy only protects you properly if you use it properly.

Silence feels safe. Quiet, noncommittal, deniable. But in professional indemnity it almost never works in your favour. It dismantles the very protections your policy was designed to give you.

Talk to your insurer early. Even if you're unsure. Especially if you're unsure. That one phone call is what triggers loss mitigation, locks in continuous cover, and preserves your eventual run off and estate protection. You bought the policy to sleep at night. Use it that way.