# Insurance Litigation

*Contributing editors*
**Mary Beth Forshaw and Elisa Alcabes**

2019

GETTING THE DEAL THROUGH

GETTING THE DEAL THROUGH

# Insurance Litigation 2019

*Contributing editors*
**Mary Beth Forshaw and Elisa Alcabes**
**Simpson Thacher & Bartlett LLP**

Reproduced with permission from Law Business Research Ltd
This article was first published in January 2019
For further information please contact editorial@gettingthedealthrough.com

Publisher
Tom Barnes
tom.barnes@lbresearch.com

Subscriptions
Claire Bagnall
claire.bagnall@lbresearch.com

Senior business development managers
Adam Sargent
adam.sargent@gettingthedealthrough.com

Dan White
dan.white@gettingthedealthrough.com

Law Business Research

Published by
Law Business Research Ltd
87 Lancaster Road
London, W11 1QQ, UK
Tel: +44 20 3780 4147
Fax: +44 20 7229 6910


First published 2014
Sixth edition
ISBN 978-1-912228-89-8



Printed and distributed by
Encompass Print Solutions
Tel: 0844 2480 112

CONTENTS

# Preface

## Insurance Litigation 2019

Sixth edition

**Getting the Deal Through** is delighted to publish the sixth edition of *Insurance Litigation*, which is available in print, as an e-book, and online at www.gettingthedealthrough.com.

**Getting the Deal Through** provides international expert analysis in key areas of law, practice and regulation for corporate counsel, cross-border legal practitioners, and company directors and officers.

Throughout this edition, and following the unique **Getting the Deal Through** format, the same key questions are answered by leading practitioners in each of the jurisdictions featured. Our coverage this year includes new chapters on Belgium, Brazil and France.

**Getting the Deal Through** titles are published annually in print. Please ensure you are referring to the latest edition or to the online version at www.gettingthedealthrough.com.

Every effort has been made to cover all matters of concern to readers. However, specific legal advice should always be sought from experienced local advisers.

**Getting the Deal Through** gratefully acknowledges the efforts of all the contributors to this volume, who were chosen for their recognised expertise. We also extend special thanks to the contributing editors, Mary Beth Forshaw and Elisa Alcabes of Simpson Thacher & Bartlett LLP, for their continued assistance with this volume.

GETTING THE DEAL THROUGH

London
January 2019

# Austria

**Philipp Strasser and Jan Philipp Meyer**
**Vavrovsky Heine Marth Rechtsanwälte GmbH**

## Preliminary and jurisdictional considerations in insurance litigation

### 1 In what fora are insurance disputes litigated?

Although in recent years alternative dispute resolution instruments have been promoted by counsellors, the vast majority of liability and cover disputes are tried before civil courts. Depending on the amount at issue, the local district courts will hear cases in which the dispute value does not exceed €15,000, whereas the regional courts are competent where higher amounts are in dispute.

Should one of the parties later file for appeal against a first instance court decision, the appellant may challenge the ruling before the courts of the second and third instance (ie, the Higher Regional Court and the Supreme Court of Justice of the Republic of Austria, respectively).

A number of insurance contracts and conditions contain provisions pertaining to the territorial jurisdiction and even the international jurisdiction, which – if valid and binding – also have to be taken into account when assessing the relevant jurisdiction for a claim or its defence, respectively.

Furthermore, insurance disputes may be submitted to arbitration. As Austria has a long-standing tradition as an arbitration hub and offers the necessary instruments and institutional support (ie, the Vienna International Arbitral Centre and the Vienna Rules) the founding of the Austrian Branch of ARIAS (the AIDA Reinsurance and Insurance Arbitration Society) in 2016 was a predictable and logical consequence. Nevertheless, arbitration is still of minor relevance for insurance or reinsurance disputes.

Even though a number of alternative dispute resolution services and arbitral institutions exist, currently the vast majority of insurance disputes are either settled informally or decided by state courts.

### 2 When do insurance-related causes of action accrue?

The reasons for the emergence of insurance disputes and subsequent court proceedings are manifold. Many insurance-related causes of actions relate to an insured's reluctance to accept a lack of cover for certain damages. Financial loss insurances, especially financial lines policies, and industry insurances have become more elaborate and complex owing to corresponding intricacies of relevant liability issues. Furthermore, non-cover related, but liability-relevant factual circumstances are another major reason for conflict. This leads to one of the main reasons for insurance disputes: breaches of obligations and duties by the insureds under the respective policy and a consequential rescission of the insurance contract as well as a possible revocation of cover by the insurer.

Litigation regarding reinsurance disputes barely occurs; at such level disputes are regularly settled amicably out of court.

The vast majority of insurance disputes (not necessarily specific to Austria) stem from the diametrical interpretation of insurance conditions by the parties involved, especially as the complexity of policy wordings has grown considerably in recent years.

This very general and common problem of a provision's unintentional room for interpretation is sometimes amplified by an idiosyncrasy of the Austrian insurance market. That is, often insurance conditions are not tailor-made for the Austrian market in what would be a costly and time-consuming process, but rather copied from other jurisdictions and only adapted cursorily.

Life insurance litigation will probably gain further momentum as the Austrian Supreme Court of Justice eased the consumers' ability to exercise their right of cancellation of the contract ex tunc by issuing a groundbreaking judgment in 2015. Regarding a large portion of policyholders affected by this ruling, an Austrian consumer association – after having gathered data from more than 7,000 affected policyholders – recently managed to reach a settlement with representatives of the insurance industry. It remains to be seen what effect this settlement will have on the amount of claims brought against life insurers in the future.

### 3 What preliminary procedural and strategic considerations should be evaluated in insurance litigation?

The considerations to be taken into account in insurance litigation by insurers are twofold: one has to assess the risk exposure related to the court proceedings at hand and, at the same time, to safeguard one's recovery claims against third parties.

As with any other dispute, the parties to a possible insurance litigation should evaluate all (known) facts that may be relevant to the question of claim, coverage and recovery. Fundamental considerations are of course the applicable rules on the allocation of the burden of proof:

- Can the occurrence of the event in question be proven?
- Under which further preconditions would such event be insured?
- Is there ambiguity in the relevant provisions of the insurance policy or conditions?
- Do the applicable statutory provisions or the respective case law give rise to legal uncertainties or room for interpretation?
- Will the insurer be able to argue a breach of obligation or duty by the insured?
- How time-consuming and costly will litigation be, approximately?
- Is there a better alternative to a court proceeding or will the initiation of a litigation procedure force the opponent back to negotiation?

The scope and contents of such evaluation will of course be different for each individual case and its depth depends on the matter at stake. Where, for instance, insurance coverage depends on the establishment of liability by an insured or third person, the assessment will also have to take into account a possible 'liability tier'. A dispute between an insurance company and an insured person may then entail one or more court proceedings concerning the establishment of liability and possibly another proceeding regarding the question of insurance cover.

On a more practical level, insurers commonly face an initial information disparity when the insured submits a notice of an occurrence. Typically, the insured has first-hand knowledge of the event that is claimed to be insured under the policy. On the other hand, the insurer is often only aware of the alleged incident itself. Thus, in a first step, the insurance company will request any relevant information and documents from the insured, who is obliged to comply with such request under the Austrian Insurance Contract Act. This problem of shortage of information on the insurer's side is of even greater significance with respect to D&O, errors and omissions (E&O), and warranty and indemnity (W&I) insurance disputes.

Depending on the amount in dispute and the complexity of the case, the preparation of a litigation decision tree might be useful, as this tool facilitates risk assessment and enables quick and accurate decision making throughout the entire dispute.

### 4 What remedies or damages may apply?

Almost any insurance-related litigation concerns the question of insurance coverage. Where the insured is in disagreement with the insurer, he or she may file for specific performance of the insurance contract (ie, the granting of coverage). Depending on whether or not the losses or costs incurred in connection with the insured event are already definite and quantifiable, the insured may choose to recover a specific sum or file for declaratory relief.

In cases where the insurer has terminated or rescinded the insurance contract (or revoked a cover note) because of breaches of obligations and duties by the insureds, the insurer will generally also file for specific performance (ie, for restitution of insurance payments).

Thus, while the question of whether the insured suffered losses or damages as a result of a certain event is of course paramount to most insurance disputes, the parties do not always file for damages but also for specific performance or declaratory relief. Most disputes will, of course, still involve claims for damages and boil down to the following questions:

- Will the insurer have to compensate the insured for past or future losses in connection with a specific event?
- Can liability by the insured (or a third party as in automobile liability insurance) be established?

Claims for damages are of particular importance in recovery actions initiated by the insurer against the liable person or entity, as the insurer will then – after subrogation or assignment of the claims to the insurer – proceed against the injuring party directly.

### 5 Under what circumstances can extracontractual or punitive damages be awarded?

With minor exceptions not relevant to typical insurance disputes, Austrian civil law does not recognise the common law principle of 'punitive damages'. Instead, the Austrian law of obligations regards damages as a purely compensatory measure, not a punitive matter. Thus, both contractual and extracontractual damages may only be claimed relating to an incurred or imminent loss, the amount being limited to the actual prejudice suffered. Such prejudice may include lost profit.

Besides the occurrence of damage itself, the basic requirements of a claim for damages under Austrian law are cause, fault and – unlike the German law of obligations – illegality. The Austrian Civil Code sets forth these four basic prerequisites for both contractual and extracontractual damages. Generally, the burden of proof lies with the party bringing the claim or invoking a fact.

## Interpretation of insurance contracts

### 6 What rules govern interpretation of insurance policies?

In principle, the interpretation of insurance policies and conditions does not differ from the exegesis of any other contract or general terms and conditions. While Austrian statutory law does not provide for insurance-specific principles of interpretation, the existing insurance-related case law has to be taken into account.

Where the parties have not agreed on specifics regarding the provision in question, the Austrian Supreme Court of Justice held that insurance policies and conditions are to be interpreted objectively (ie, based on their wording and its interpretation by an average and reasonably well-informed insured).

Insurance disputes will almost always concern the interpretation of the policy and applicable insurance conditions. While the principles on their interpretation established by doctrine and case law do give guidance, certainty – to the degree possible – can ultimately only be determined by the courts. Experience and pertinent knowledge of the case law will, of course, help make use of the overlapping general principles and rulings.

### 7 When is an insurance policy provision ambiguous and how are such ambiguities resolved?

As stated above, ambiguities of a policy's wording are resolved by carrying out a hypothetical interpretation – how would an average and reasonably well-informed insured interpret the provision? Such fictitious interpretation by the (equally) fictitious insured has to take into account customs and usage as well as linguistic usage. If the ambiguity cannot be resolved by way of this hypothetical interpretation, such ambiguity will, as a general rule, be at the expense of the insurer as author of the relevant provision (and thus, its wording). This rule does not apply in cases where a provision has been individually negotiated.

While the insurer is relatively free in drafting the wording of policy and conditions, the provisions will only be applicable insofar as Austrian law does not regard them as invalid. In this respect, regard is to be had to the statutory provisions on the review of general terms and conditions. This is especially crucial in cases where the insured is a consumer. Even in business-to-business settings, certain provisions may be invalid if included in general (insurance) conditions.

## Notice to insurance companies

### 8 What are the mechanics of providing notice?

The insured is required by law to inform the insurer of a loss (or other event possibly insured under the policy) without undue delay. The notice is to be addressed either to the insurer directly or to an authorised agent or broker responsible for the contract. Where more than one insurance company is involved, notice to the lead insurer suffices.

In addition to these general stipulations of the Austrian Insurance Contract Act, the policy or insurance conditions often contain further contractual rules in connection with providing notice. These may include definite time limits or form requirements.

The notice itself does not have to contain an in-depth description of the event. However, once the notice is filed, the insurer is entitled to request all information and documents pertaining to the event to be supplied and handed over by the insured. In fact, the insured is then obliged to cooperate fully in establishing the facts.

### 9 What are a policyholder's notice obligations for a claims-made policy?

While claims-made policies are definitely of relevance in the Austrian market, they are the exception rather than the rule. In fact, claims-made is, if anything, alien to the Austrian conception of liability insurance.

The typical claims-made policy (ie, mainly financial lines and specialty lines products) available on the Austrian market is not a product developed originally with the Austrian market in mind, but rather a product replicated based on the Anglo-American model. For this reason, no statutory provisions exist for claims-made policies. The policyholder's notice obligations are thus ultimately determined by the policy's terms and conditions. By contrast, the occurrence of the misconduct or negligence, or the loss itself (and not the assertion of the claim), is decisive for the typical Austrian model of liability insurance.

### 10 When is notice untimely?

As elaborated above, the scope of the insured's obligation to notify depends both on the type of insurance and the exact wording of the policy and applicable conditions. Where such wording specifies an exact period of time by which, calculated from the insured's knowledge of the event, the latter has to issue notice to the insurer, this period will be decisive. This of course also applies to notices not in conformity with form requirements set forth in the policy or conditions.

Where, on the other hand, such provisions are either invalid or not included in the relevant wording at all, the general rules apply. In such a case a notice is deemed untimely where the insured is positively aware of the event but does not inform the insurer in due time. When exactly a notice is considered untimely is to be determined on a case-by-case basis.

### 11 What are the consequences of late notice?

From a statutory perspective, the Austrian Insurance Contract Act itself does not contain sanctions for late notice, at least not directly. However, timely notice is 'rewarded' with a suspension of the limitation period. In principle, all claims arising from the insurance contract become time-barred after a period of three years. This period is suspended when the insured notifies the insurer and only continues to run when the insurer, in turn, submits its written and substantiated underwriting decision (ie, whether or not coverage will be granted). In this case, the insured has to sue within one year of receipt of said decision.

Another important (but not equally well-known) statutory limitation period concerns cases where a party other than the insurer and the policyholder is not aware of the existence of insurance coverage. An

example of such third party within the scope of this provision would be a company executive unaware of a D&O policy or the equally unaware beneficiary of a life insurance policy. In such cases, the Austrian Insurance Contract Act provides for a 10-year limitation period.

However, in practice, most insurance policies and conditions will in fact provide for such negative consequences of late notice. For example, the insurer is frequently released from its obligations under the policy entirely if the insured does not issue notice in time. Breaches of obligation by the insured, including but not limited to late notice, are customarily sanctioned with measures relative to the gravity of the breach. These sanctions may range from a mere limitation of coverage to the complete loss of coverage. While a complete loss of coverage may seem disproportionate to some, such sanction actually appears to be adequate in light of the detriment of the insurer in case of late notice: late notice frequently impedes the insurer's possibility to assess the occurrence effectively and to intervene accordingly. It may even make recourse actions against the party ultimately responsible altogether impossible.

The insurer is, however, not entirely free in drafting insurance conditions and setting forth the desired consequences of breaches of obligations and duties. This is because, under Austrian law, insurance conditions are considered general terms and conditions and, as such, are subject to review by the courts (see question 7).

Late notice may not be invoked where the insurer learned of the relevant information via other channels. This could be the case where a third person notified the insurer or the notice is indeed issued by the insured but does not comply with the required form (ie, telephone call versus written form).

In summary, the consequences of late notice will differ from case to case and depend on the extent and validity of the provisions set forth in the insurance conditions as well as the gravity of negligence on the insured's side.

## Insurer's duty to defend

### 12 What is the scope of an insurer's duty to defend?

Austrian liability insurance law distinguishes between the insurer's duty to provide for defence against unfounded claims and the duty to satisfy a third party's claim, where such claim is valid. The insurer's duty to finance defence is set forth in the Austrian Insurance Contract Act's section on liability insurance by way of a general framework. Insurers may choose to incorporate deviating or additional clauses into their respective insurance conditions. When doing so, insurers should heed the fact that some of these statutory provisions are mandatory and may not be deviated from to the detriment of the insured.

The concept of the insurer's duty to defend as envisaged by the Austrian Insurance Contract Act mainly concerns the costs arising in connection with the judicial or extrajudicial defence against the claim raised by a third party. The costs incurred in this context also include the costs of legal representation and the insurer is generally required to advance them, if the insured so requests.

According to settled case law, even costs for 'active litigation' (ie, the conducting of a lawsuit initiated by the insured against a third party) may be covered where (and insofar as) such third party, in turn, sets off liability claims of its own against the claims alleged by the insured. In practice, insurers often stipulate a right to appoint a particular counsel (rather than leaving the choice to the insured) and to instruct the insured as to the course of action.

The scope of the insurer's duty to defend depends not only on the respective policy's wording but also on the type of insurance, as the Austrian Insurance Contract Act also contains specific provisions on certain insurance types such as legal expense insurance.

### 13 What are the consequences of an insurer's failure to defend?

The duty to defend presupposes the emergence of an insured event. As, for example, with general liability insurance, any claim raised against the insured by a third party – whether justified or not – constitutes an insured event, the threshold for the duty to defend to be triggered is quite low.

Where the insurer chooses to disregard such duty without giving proper and accurate justification, this failure to defend constitutes a culpable breach of the policy. In light of this, the insured can sue the insurer and demand performance of its duty to defend. The insured may even claim damages, where the failure to defend results in prejudice that would have been avoided had the insurer attended to its duty.

## Standard commercial general liability policies

### 14 What constitutes bodily injury under a standard CGL policy?

Commercial general liability (CGL) policies typical to the Austrian market usually define bodily injury as including death, injury and damage to health and all consequences of such health impairments like medical expenses, loss of earnings, pension entitlements and compensation for pain and suffering.

### 15 What constitutes property damage under a standard CGL policy?

Property damage, on the other hand, usually includes the destruction or damaging of a thing as well as the manipulation of the physical substance resulting in a reduction of serviceability. As with bodily injury, the financial consequences of such impairments are also covered (consequential pecuniary losses).

### 16 What constitutes an occurrence under a standard CGL policy?

Most CGL policies define the occurrence of an insured event as an incident in connection with the insured risk. That is, the event directly causing the bodily injury or property damage for which the policyholder, other insured companies or their staff are or could be liable.

### 17 How is the number of covered occurrences determined?

The occurrence of an insured event is to be determined based on the wording of the relevant insurance policy or conditions. Although the definitions of an insured event vary in detail, most will contain at least three elements.

The first element concerns the specification of the event triggering the insurance (eg, the occurrence of the relevant misconduct, negligence or damage itself). The second element defines how this event is to be connected with the insured risk. Lastly, the third element divides the claims asserted by the third party into justified claims (thus triggering the insurer's duty to satisfy) on the one hand and unfounded claims (triggering the insurer's duty to defend) on the other.

Most CGL policies not only limit both the maximum insurance payout per occurrence and in total per period of insurance but also contain a clause on serial loss. The latter deems multiple claims stemming from one and the same cause as one single occurrence (see 'Update and trends').

### 18 What event or events trigger insurance coverage?

As indicated above, there are no statutory provisions defining when a certain event triggers insurance cover in a standard CGL policy. Therefore, only the policy itself and the corresponding insurance conditions determine when the insurer is required to provide cover (if and insofar as the insurance conditions withstand judicial review; see question 7). The trigger most commonly stipulated by GCL policies on the Austrian market is the actual occurrence of loss, while the claims-made principle, for example, is more common for D&O policies (see question 23).

### 19 How is insurance coverage allocated across multiple insurance policies?

When determining the allocation of coverage, two scenarios have to be distinguished.

The first scenario encompasses cases where the insurer is, at least initially, unaware of the additional supplementary or overlapping coverage taken out with another insurer. In Austria, these situations are referred to as double insurance. The second scenario concerns cases where the insurer decides against insuring the risk on its own but rather opts to allocate the insured risk between multiple insurers, each bearing the liability pro rata. The insurers will then designate one lead insurer while the remaining insurance companies involved act as co-insurers.

While, when it comes to drafting the relevant provisions, the parties involved are relatively free as far as the co-insurance scenario is concerned, relevant case law as well as a number of statutory rules and requirements have to be observed with regard to double insurance. In this context, the Austrian Insurance Contract Act stipulates, inter alia:

**Update and trends**

Most of the controversial issues currently discussed by insurers, intermediaries and practitioners active on the Austrian market are – at least to a large extent – linked to European Union law. Arguably, the most controversial discussions revolve around the Insurance Distribution Directive (Directive 2016/97/EU) and its transposition into national law. Most uncertainties in this regard concern the question of how to fulfil the wide-ranging European and national legislative requirements in practice. These uncertainties have been amplified by the fact that the Austrian legislators only recently passed the last piece of legislation implementing the IDD's legal framework.

Another hot topic concerns the extent to which monetary fines under the General Data Protection Regulation (Regulation (EU) 2016/679) and administrative fines in general are insurable under Austrian law, which, according to the prevailing view in Austrian literature, is not the case. Consequently, especially in the fields of cyber insurance as well as D&O insurance, all parties involved are currently exploring options as to how and to what extent the insured can be offered coverage for administrative fines or related events in this context.

Yet another topic of increasing debate relates to the effects of the United Kingdom leaving the European Union. While this topic is, of course, not unique to the insurance sector, a considerable amount of policies are affected either directly or indirectly because of the fact that so many primary insurers, reinsurers or co-insurers are based in or acting out of the United Kingdom.

As regards trends and developments on the Austrian insurance market, one can observe an increase in market penetration of Cyber, D&O and W&I products.

- a duty of the insured to notify the involved insurers of the coverage under the other policy without undue delay;
- that the insured cannot apply for and make use of the insurance coverage under multiple policies, where the granting of such coverage would lead to insurance payouts surpassing, in total, either the insured value or the overall loss suffered;
- that the insurers involved in a case of double insurance are jointly and severally liable for the coverage to be granted under their respective policies; and
- that, where an insured intentionally and in bad faith brought about the double insurance scenario solely to gain an unlawful pecuniary advantage, all such contracts are void.

Insurers are well-advised to include subsidiarity clauses in their respective insurance conditions in order to avoid, to the degree possible, the downsides of double insurance scenarios. In effect, such subsidiarity clauses provide that an insurer is merely liable on a secondary tier. This means that coverage has to be granted only where the insured amounts of all policies taken out before the conclusion of the policy at hand are already used up.

Double insurance scenarios are common, for example, in the area of D&O insurance (eg, where an insured person is also insured under criminal defence insurance or general legal expense insurance).

## First-party property insurance

### 20 What is the general scope of first-party property coverage?

The typical first-party property insurance to be found on the Austrian market is not a stand-alone product but rather a supplementary coverage to an existing (liability insurance) policy. This extension of coverage aims at providing compensation for losses including property damage directly suffered by the insured. Even consequential pecuniary losses such as a loss of use or loss of production resulting from the destruction of movable or immovable property may be covered.

As a result of Austria's booming real estate market, first-party property insurance modules with a focus on immovables are becoming increasingly popular. Other insured risks under local first-party property insurance modules include vehicles or personal belongings.

### 21 How is property valued under first-party insurance policies?

Most insurance terms will contain stipulations as to the assessment of value. While similarities between policies and conditions concerning the same insured risks may be observed, the individual provisions all differ in detail, one major distinction being whether the assessment of value takes into consideration the difference in value where used things are replaced by new things. Such deduction – known as the 'old-for-new rule' – is the general rule under the Austrian law of obligations.

### 22 Is insurance available in your jurisdiction for natural disasters and, if so, how does it generally operate?

The Austrian insurance market offers a variety of insurance products against the risks of natural disasters, such as storms, hail, floods and drought. Insurance for natural disasters is of particular economic importance in the agricultural sector as well as for various types of property insurance. Depending on the type of risk and the individual risk exposure, insurers regularly only offer coverage limited to a fixed amount or a portion of the insured sum. Equally, insurers often limit their cover risk by including risk exposure accumulation clauses specifying a maximum total payout for all claims from a single event (per occurrence limit). Most notably, the Austrian Hail Insurance Company, founded in 1947 by a consortium of Austrian insurers, offers a wide range of insurance products covering the risk of agricultural production losses. Currently, this insurer provides coverage for more than 80 per cent of Austrian farmland.

## Directors' and officers' insurance

### 23 What is the scope of D&O coverage?

As indicated above, typical claims-made policies such as D&O insurances are, in concept, somewhat alien to the Austrian insurance market. Thus, statutory provisions as to the scope of coverage do not exist.

Historically, a large number of D&O policies locally available could be described as having gone through a 'two-step import' process. This is because, by comparison, the Anglo-American D&O model first gained importance on the German market. The significance of D&O coverage for the Austrian market emerged only later when policies and conditions were drafted – or more often, amended – based on the insurers' experience gained on the German market. Of course, some D&O products were also drafted directly by Austrian insurers. However, suggesting that these products were completely unbiased from the experiences on other European markets would be short-sighted.

While there is definitely increasing demand for D&O coverage in Austria, insurers should be wary of merely 'importing' foreign D&O products without consulting with local experts. The gap between Austrian and German law, for example, is not necessarily a big one when compared with other legal systems. Experience shows, however, that insurers are well advised to become familiar with these differences in substantive and procedural law before finding out the hard way (ie, after the occurrence of an insured event). This advice should be heeded especially in light of the fact that D&O coverage is relatively cheap on the local market.

The scope of coverage as defined in the typical policies and conditions available differs in detail. Such differences may concern, inter alia:

- the definition of 'pecuniary loss' (covered) and its differentiation from pure financial loss (usually not covered);
- the definition of 'intentional non-compliant acts' as an exclusion of coverage;
- the group of insured persons (eg, inclusion of managerial employees and compliance or data protection officers);
- the group of insured legal entities (eg, inclusion of subsidiaries and affiliated companies);
- the temporal scope, including retroactive coverage as well as run-off cover;
- the insurance deductible (if any); and
- the number and type of modules included such as the insurer's duty to defend or to satisfy, a criminal defence module or the inclusion of legal expense insurance.

Most D&O policies cover both claims of the insured company with regard to an insured person as well as claims brought by a third person against the insured manager or executive.

**24 What issues are commonly litigated in the context of D&O policies?**

The issues most commonly litigated in D&O disputes – aside from possible recourse proceedings initiated by the insurer after having provided coverage – could be divided into two groups.

The first category concerns differences in interpretation. As indicated, this common cause of conflict is amplified by the specific characteristics of the Austrian insurance market (see questions 2 and 23). Even where the relevant wording is seemingly unambiguous, conflicts may revolve around the question of the validity and effectiveness of such provision (eg, a number of D&O policies include coverage of fines and other monetary penalties – a stipulation considered to be against public policy and thus invalid by the courts).

The second category relates to factual circumstances material to the possibilities for action on the insurer's side. Can the insurer prove that the policyholder violated its precontractual duty to disclose, for example by giving incorrect or incomplete information in the questionnaire submitted by the insurer before taking out insurance? Can the intentional violation of the insured's obligation be established with the consequence that the insurer may deny coverage or, where applicable, revoke a cover note and to reclaim past insurance payouts?

## Cyber insurance

**25 What type of risks may be covered in cyber insurance policies?**

Contrary to expectation, cyber insurance does not (yet) play a major role in Austria. This is not to say that cyber insurance policies or supplementary modules are uncommon. In fact, a number of larger enterprises and even SMEs have opted to extend the coverage accordingly; supplementary modules being offered by most insurers. This trend does not, however, seem to align with the ever-growing risks of cyber attacks (eg, viruses, hacks, exploits) and the increasing dependency on electronic infrastructure such as personal computers and file or email servers.

While some cyber insurance policies include only losses suffered by a third person – for example the results of a data leak after a successful cyber attack – others also include losses directly suffered by the insured. The latter category may include the consequences of server downtime or of stolen company secrets as well as costs for external technical support.

**26 What cyber insurance issues have been litigated?**

As cyber insurance products are relatively new – or rather, not yet sufficiently common – on the Austrian market, no case law of relevance in this regard has been published yet. One reason for this lack of litigation may be connected to the circumstances of a dispute relating to a cyber attack: the insured may be reluctant to conduct court proceedings against the insurer when such proceedings could affect the company's reputation, such as by making public successful cyber attacks.

## Terrorism insurance

**27 Is insurance available in your jurisdiction for injury or damage caused by acts of terrorism and, if so, how does it generally operate?**

Terrorism insurance policies or modules are currently not of notable relevance on the Austrian insurance market. The reason for the lack of demand for such products may be connected with the high general feeling of security among the population. According to the 2016 Global Peace Index, for example, Austria is conceived to be the third-safest country in the world.

A spike in awareness was observed shortly after the 9/11 attacks but has since decreased. One of the repercussions of that time was the setting up of a mixed co-insurance and reinsurance pool by the Austrian Association of Insurance Companies. This pool was established in October 2002 and aimed at granting affordable property cover against terrorism exposure.

Vavrovsky Heine Marth

**Philipp Strasser** **philipp.strasser@vhm-law.at**
**Jan Philipp Meyer** **jan.meyer@vhm-law.at**

Fleischmarkt 1
1010 Vienna
Austria
Tel: +43 1 512 03 53
Fax: +43 1 512 03 53 40

Mozartplatz 4
5020 Salzburg
Austria
Tel: +43 662 84 95 16
Fax: +43 662 84 95 16 25

www.vhm-law.at

# Belgium

**Tom Schoors, Bart De Bock and Nick Portugaels**

**Allen & Overy**

## Preliminary and jurisdictional considerations in insurance litigation

### 1 In what fora are insurance disputes litigated?

Belgian insurance legislation does not contain specific rules on the fora for litigating insurance disputes.

Insurance claims are usually brought before civil courts in accordance with Belgian judicial law.

The competent court is the court of the place where the policyholder is domiciled (or if the policyholder is a company, where the company has its registered office), pursuant to the mandatory rules of the Belgian Judicial Code.

Insurance disputes may be brought before the small claims court, the court of first instance, the commercial court or the police court, depending on the value of the claim, the nature of the claim and the capacity of the parties. In the last instance, the court of appeal may rule on insurance cases, and subject to certain conditions, the Belgian Supreme Court.

Belgian insurance legislation prohibits clauses in insurance policies where the parties agree in advance to submit their disputes to arbitration. It is only after the occurrence of a dispute that the parties may decide to settle their disputes through arbitration. This rule does not apply to specific insurance policies such as transport and credit insurance and reinsurance.

Insurance disputes can in general also be brought before the insurance ombudsman. This will suspend the limitation period applicable to insurance claims. The ombudsman will try to help the parties reach an amicable solution, without having the authority to impose binding obligations on the parties. If no amicable solution is reached, the ombudsman may provide non-binding advice to the parties. This advice is not confidential and can be used in court proceedings.

### 2 When do insurance-related causes of action accrue?

Insurance-related causes of action mostly accrue in light of an insurance company's (partial or total) refusal to pay out under the insurance policy because of contractual exclusions, a breach of the policyholder's information obligations before issuing the policy or a breach of a contractual obligation. For investment-linked life insurance policies, the disputes often relate to mis-selling issues and arise when the underlying investments perform poorly.

The limitation period for bringing claims under an insurance policy expires three years from the occurrence of the circumstances that give rise to the claim. A specific limitation period of 30 years exists for certain types of claims under life insurance contracts.

### 3 What preliminary procedural and strategic considerations should be evaluated in insurance litigation?

In recent years, the Belgian legislator has paid a great deal of attention to alternative dispute resolution, also with respect to insurance. The insurance sector itself encourages insurance companies and intermediaries to resolve policyholder conflicts amicably. For example, according to the Belgian professional organisation for insurance companies Assuralia, an amicable settlement is reached in 80 per cent of all cases where legal expenses insurance is involved.

Therefore, it is common practice in Belgium for parties to enter into negotiations when there is an insurance dispute. However, these negotiations are not confidential and may be used in legal proceedings, unless covered by legal privilege (eg, confidential lawyer-to-lawyer communications) or a confidentiality obligation under a specific NDA. The willingness of insurance companies to settle insurance claims depends on several factors: the importance of the commercial relationship, the precedential value and possible reputational risks, inter alia.

In Belgian court proceedings, the successful party is entitled to a judicial indemnity to compensate that party for the legal costs it has incurred.

Lastly, specific attention should be paid to the role and position of the insurance intermediary. Because a majority of the insurance policies in Belgium are concluded through insurance intermediaries, the intermediary is often the first point of contact for the policyholder in the event of a claim and will also perform important claims management obligations. Furthermore, in the event of an insurance dispute, often both the insurer and the insurance intermediary are summoned before the court by the policyholder. In that regard, Belgian case law often holds the insurer liable for the actions (and inactions) of the insurance intermediary, for example, in the event that the insurance intermediary is not licensed, in the event of serious mismanagement or if the insurance intermediary has embezzled funds in the context of investment-linked life insurances.

### 4 What remedies or damages may apply?

The applicable remedies or damages depend on the capacity of the claimant and the type of insurance. In general, the policyholder will claim due performance of the insurance policy by the insurer.

The 2014 Insurance Act imposes the obligation on the policyholder to take all reasonable measures to prevent and limit the consequences of the insured incident. If the policyholder does not comply with this obligation, the insurer is entitled to either reduce its performance under the policy to the amount of the loss suffered by the insurer as a result of the policyholder's non-compliance, or to refuse cover if the policyholder acted with fraudulent intent.

There are specific rules for fraudulent insurance claims and claims that appear to be completely fictitious or overestimated. The insurer may reduce its performance (if the policyholder has acted in good faith) or even refuse cover (if the policyholder has acted in bad faith). Under certain circumstances, the insurer may terminate the insurance policy.

### 5 Under what circumstances can extracontractual or punitive damages be awarded?

In principle, Belgian insurance law does not allow punitive damages to be awarded. The policyholder is only entitled to be indemnified for the actual damage suffered. This implies that the policyholder must be put in the same financial position as if the insured risk had not materialised. The amount of any compensation is therefore limited, and the insurer cannot be liable for additional damages.

Extracontractual damages are relevant in the event of a breach of pre-contractual information obligations and in the event of the nullity of the insurance policy. In the latter case, the aggrieved policyholder could in addition to claiming the nullity of the insurance policy also claim extracontractual damages. Both remedies (a claim for the nullity of the insurance policy and a claim for damages) are often raised together in insurance litigation.

## Interpretation of insurance contracts

### 6 What rules govern interpretation of insurance policies?

The 2014 Insurance Act contains a specific interpretation rule, stating that the interpretation most favourable to the policyholder will prevail. The basic contract interpretation rules of the Belgian Civil Code also apply to insurance policies. The primary rule is that the contract should be interpreted on the basis of the common intention of the parties.

### 7 When is an insurance policy provision ambiguous and how are such ambiguities resolved?

An ambiguity exists when there is a lack of clarity over the meaning of a certain clause of the insurance policy or when two or more clauses of the insurance policy contradict each other. Such ambiguities are usually resolved by applying the interpretation rules applicable to (insurance) contracts.

In the event of an ambiguity in a specific clause of an insurance policy, the 2014 Insurance Act stipulates that the interpretation most favourable to the policyholder will prevail. This rule applies to all terms and conditions of the insurance policy, irrespective of whether they have been individually negotiated by the parties.

In addition to the specific interpretation rule of the 2014 Insurance Act, there are the general Belgian civil law interpretation rules applicable to contracts. The interpretation rule in the 2014 Insurance Act takes precedence for most insurance policies. However, the civil law interpretation rules remain relevant for specific insurance policies, such as the insurance of certain industrial risks. The civil law interpretation rules imply that, if a contract (clause) can be interpreted in various ways, preference should be given to the interpretation (i) pursuant to which the contract may be performed, (ii) which corresponds best to the content of the contract, and (iii) which is customary in the region where the contract was entered into.

In addition, there is a tendency in the Belgian legal literature to give effect to good faith when interpreting contracts, which means that reference is made to the manner in which a normal, prudent and reasonable person would have acted to resolve the interpretation dispute, in accordance with fairness and reasonableness.

## Notice to insurance companies

### 8 What are the mechanics of providing notice?

When a claim occurs, the policyholder must report the claim to the insurer. If applicable, the policyholder may also report the claim to the insurance intermediary (either an insurance broker or agent). Subject to any specific requirements in the policy, there are no specific formal requirements. However, for evidentiary purposes, it is highly recommended that this notice is given in writing.

Under the 2014 Insurance Act, the notice given to insurance companies of the claim for compensation suspends the limitation period. This suspension continues until the insurance company has issued a final decision. This is beneficial to the policyholder since it provides protection when negotiating with an insurance company.

For liability insurance policies, the 2014 Insurance Act states that the policyholder must provide the insurer with all information related to the insured claim as soon as possible, such as all civil and criminal procedural documents, notices of default and registered letters. Furthermore, the policyholder must defend itself against the claim and appear before court, failing which the policyholder must compensate the insurer. In addition, the policyholder must mitigate the damage and, in general, cooperate with the insurer.

In that context, the policyholder is not entitled to compensate the injured party or conclude a settlement agreement without the prior written approval of the insurer. Similarly, the policyholder cannot acknowledge or accept liability to the injured party, as this would prejudice the insurer's rights. Such acknowledgment or recognition is not enforceable against the insurer.

### 9 What are a policyholder's notice obligations for a claims-made policy?

The policyholder's notice obligations are typically described in the insurance policy, in addition to the general notice requirements under the 2014 Insurance Act (see question 8). Specifically for claims-made policies, the time of notification of the insurance claim to the insurer will determine whether the insurer provides cover. If the claim is notified after the insured period (but relates to incidents that occurred during the insured period), the insurer will not provide cover.

### 10 When is notice untimely?

The policyholder's notice obligations are typically described in the insurance policy, including the time frame in which to provide notice.

The 2014 Insurance Act obliges the policyholder to complete the notice of claim for the insurer as soon as possible and where appropriate within the term agreed in the insurance policy. There is no legally determined period in which the notice must be made.

Even if the insurance policy provides for a specific period in which the policyholder must report the claim to the insurer, the 2014 Insurance Act stipulates that the notice of claim may also validly be made after the expiry of this contractual period, provided that notice is given as soon as possible. The policyholder bears the burden of proof.

### 11 What are the consequences of late notice?

The policyholder's notice obligations are typically described in the insurance policy, as well as the consequences of late notice.

The 2014 Insurance Act makes a distinction between the unintentional and the intentional breach of the obligation to provide notice (on time).

If the policyholder unintentionally fails to comply with the obligation to provide notice on time, the insurer may claim compensation provided that the latter can prove that it suffered actual damage as a result of the late notice.

If the policyholder acted with fraudulent intent, the insurer may refuse to provide cover, regardless of whether the insurer has suffered damage as a result of the late notice.

## Insurer's duty to defend

### 12 What is the scope of an insurer's duty to defend?

If the policyholder has notified a third-party claim to the insurer, the (liability) insurer is obliged to defend the policyholder. The insurer must take charge of the dispute as soon as it becomes apparent that the insurer is obliged to provide cover. Absolute certainty on the insurer's obligation to provide cover is not required, since the policyholder may gradually prove it is not liable or it may gradually become apparent that the insurer is not obliged to provide cover.

However, the insurer's right to take charge of the dispute is also a fundamental right of the insurer. This right gives the insurer free choice to, inter alia, appoint a lawyer, negotiate with the aggrieved party and invoke the appropriate legal remedies.

### 13 What are the consequences of an insurer's failure to defend?

There are two limitations to the insurer's duty to defend. First, the duty to defend is limited to civil proceedings. This principle does not apply to criminal proceedings, where the insurer is not in charge of the dispute and the policyholder retains full autonomy. Second, the civil interests of the insurer and the insured must coincide. If the interests do not coincide, the insurer's duty to take charge of the dispute does not apply. For example, their interests are not fully aligned if the aggrieved party's claim is not fully covered by the insurance policy. In such case, the policyholder itself shall account for a portion of the damage. Similarly, the interests of the insurer and the insured no longer coincide if the insurer is entitled to partial recourse against the policyholder or if the cover is limited. Lastly, it is also possible that the insured has a financial interest that is not fully covered by the insurance policy. The right of the insurer to take charge of the dispute is therefore limited to the extent that the insurer is obliged to provide full cover. When a liability insurer neglects its duty to defend the insured in a wrongful way, the insured's remedy consists of forcing the insurer to provide cover.

## Standard commercial general liability policies

### 14 What constitutes bodily injury under a standard CGL policy?

Bodily injury consists of any injury to the body, such as death or wounding.

**Update and trends**

The 2014 Insurance Act is currently being reviewed by a working group with the aim of drafting a new insurance act.

In addition, the Belgian Companies Code is being reviewed and updated. An important new development currently being discussed concerns a liability cap for D&Os. This cap would apply to the D&O's internal or external liability, to liability in the context of bankruptcy proceedings and to the civil consequences of a crime. Four different liability limits are currently foreseen in the draft act, depending on the turnover and the total balance sheet of the company: €250,000, €1 million, €3 million and €12 million.

**15 What constitutes property damage under a standard CGL policy?**

Property damage consists of damage to or destruction of property.

**16 What constitutes an occurrence under a standard CGL policy?**

The insured occurrence is typically described and defined in the insurance policy. The insurer often requires a written notice from a third party in which the policyholder is identified as being liable.

Absent detailed provisions in the insurance policy, a standard CGL policy occurrence is triggered by a dispute (ie, broadly interpreted as the difference of opinion between persons whose interests are involved in a liability-based claim for compensation).

In addition, reference can be made to the definition of complaint in the 'Rules of conduct for complaints management in the insurance sector', which is 'any expression of dissatisfaction – in relation to the insurance activities of the company – to which an implicit or explicit answer is expected'.

**17 How is the number of covered occurrences determined?**

This is typically determined in the insurance policy. The 2014 Insurance Act contains no particular rule on the number of covered occurrences.

**18 What event or events trigger insurance coverage?**

The insurer is contractually liable to provide insurance cover for damage suffered by the policyholder during the insured period stipulated in the insurance policy and within the limits of the insurance policy.

**19 How is insurance coverage allocated across multiple insurance policies?**

The 2014 Insurance Act contains specific rules on 'over-insurance' (ie, when the same loss is insured in multiple insurance policies). According to the mandatory indemnification principle, the performance due by the insurer may not exceed the damage suffered by the policyholder. This implies that if a policyholder is duly compensated by an insurer, it can no longer claim additional compensation under other insurance policies covering the same damage.

If the over-insurance is the result of bad faith on the part of the policyholder, the insurance policy is null and void. If there was no intention of the policyholder to breach the indemnification principle, the insurer's liability to provide cover is reduced proportionately and pursuant to detailed rules set out in the 2014 Insurance Act.

## First-party property insurance

**20 What is the general scope of first-party property coverage?**

A first-party property insurance policy provides cover for damage to property that is suffered by the policyholder. The 2014 Insurance Act distinguishes between (i) insurance pursuant to which the insurer is obliged to perform a specific service (eg, legal assistance insurance), and (ii) insurance for the payment of compensation (eg, fire insurance).

**21 How is property valued under first-party insurance policies?**

The exact valuation of property can be a difficult exercise, for example, as regards insurance for works of art and jewellery, or insurance for loss of profit. To avoid issues over the determination of the value of the (lost or damaged) property once an insured event has occurred, the parties to an insurance policy have the opportunity to determine the property value in advance.

First, the parties may opt for the reconstruction value, the restoration value or the replacement value, even without deduction resulting from depreciation. A policyholder may thus insure goods for a higher value than the real value of those goods, without breaching the indemnification principle, which prevents the policyholder from becoming unjustly enriched.

Second, the policyholder may determine the sum insured in the insurance policy. The insurer has no obligation to verify the insured amount. However, the law contains specific rules on over- and undervaluing the insured risk.

Third, the parties may include an appraised value for the insured goods. If the insured goods have been significantly impaired, each party may reduce the amount of the appraised value or terminate the contract. This appraised value only binds the parties to the agreement. The insurer who is consequently subrogated to the rights of the insured may only claim what is due from the liable party on the basis of the general liability rules.

**22 Is insurance available in your jurisdiction for natural disasters and, if so, how does it generally operate?**

Insurance cover for natural disasters is legally included under simple risks fire insurance (as opposed to fire insurance covering commercial and industrial risks). In other insurance policies, it is up to the parties to decide whether natural disasters are covered.

In principle, the simple risks fire insurance policy provides cover in the event of earthquakes, floods, the overflowing or blocking of public sewers, and subsidence.

## Directors' and officers' insurance

**23 What is the scope of D&O coverage?**

The scope of the D&O coverage is linked to the typical risks that company directors, managers and officers may face, such as: regulatory and other investigations and inquiries; cyber-attacks; risk of data loss; criminal and regulatory fines, penalties, and securities or shareholder claims.

D&O coverage and related indemnities are receiving a higher level of focus and attention from insurers in view of the increasing risks that D&Os are exposed to, both from a regulatory and a Belgian law perspective and their increasing exposure to personal liabilities.

**24 What issues are commonly litigated in the context of D&O policies?**

There are several coverage issues:

- whether the D&O policy will provide cover if there is an investigation in which D&Os are involved;
- whether the D&O policy terms are clear and easy to follow;
- whether the D&O policy will be able to cover claims in all jurisdictions;
- whether there is cover for the cost of (legal) advice in the early stages of an investigation;
- how claims against D&Os will be controlled and settled;
- how the interaction between the D&O policy and the company's indemnification obligations is managed; and
- what cover applies in the event of a conflict of interests between D&Os and the company.

## Cyber insurance

**25 What type of risks may be covered in cyber insurance policies?**

There is no standard cyber insurance cover under Belgian insurance law. However, the market for cyber risk insurance in Belgium is developing at a fast pace. This is not without challenges: the occurrence of cyber risks keeps increasing, regulatory fines increase exponentially and the risk is difficult for insurers to quantify.

Cyber risk insurances typically cover the following:

- First-party insurance:
  - costs of investigations;
  - theft of money;
  - expenses incurred in notifying a breach of business interruption losses as a result of cyber attacks;
  - cyber exhortation; and
  - reputational damage.

- Third-party insurance:
  - cost of losing data;
  - cost of restoring data; and
  - defence costs.
- Any additional cover:
  - crisis management; and
  - forensic services.

**26 What cyber insurance issues have been litigated?**

The Belgian cyber insurance market is evolving at a rapid pace. There has been no published case law on cyber risk insurances yet.

**Terrorism insurance**

**27 Is insurance available in your jurisdiction for injury or damage caused by acts of terrorism and, if so, how does it generally operate?**

There is specific legislation in Belgium requiring certain insurance policies to provide cover against damage caused by terrorism. The 2007 Terrorism Insurance Act's purpose is twofold: (i) the Act intends to ensure that insured persons who suffered damage as a result of a terrorist attack are compensated fairly and in a timely manner, and (ii) the Act intends to guarantee the stability and sustainability of the entire insurance sector. Pursuant to the 2007 Terrorism Insurance Act, insurance companies may join the non-profit entity TRIP VZW/ASBL (TRIP), which stands for Terrorism Reinsurance and Insurance Pool, together with the Belgian State. TRIP creates a pool comprising insurance companies, reinsurance companies and the Belgian state, with the purpose of indemnifying all terrorism risks covered by the insurance policies issued by the members of the pool. A dedicated Terrorism Claims Advisory Committee advises TRIP on the appropriate amount of payouts to the victims, which are allocated to the different members of TRIP.

Insurance policies that are required by the 2007 Terrorism Insurance Act to cover damage caused by terrorism relate to civil liability insurance, accident insurance, life insurance, hospitalisation insurance, etc. In other insurance policies, terrorism risks may be excluded.

ALLEN & OVERY

**Tom Schoors** **tom.schoors@allenovery.com**
**Bart De Bock** **bart.debock@allenovery.com**
**Nick Portugaels** **nick.portugaels@allenovery.com**

Tervurenlaan 268A, Avenue de Tervueren
1150 Brussels
Belgium
Tel: +32 2 780 2222
Fax: +32 2 780 2244

Uitbreidingstraat 72/b3
2600 Antwerp
Belgium
Tel: +32 3 287 7222

www.allenovery.com

# Brazil

**Diógenes M Gonçalves Neto, Roberto Panucci Filho, Gianvito Ardito, Raissa Lilavati Abbas Campelo and Pedro Ivo Gil Zanetti**

**Pinheiro Neto Advogados**

## Preliminary and jurisdictional considerations in insurance litigation

### 1 In what fora are insurance disputes litigated?

Insurance disputes may be litigated before civil courts or referred to arbitration.

If the insurance contract sets forth an arbitration clause (which is very common in large-risk insurance contracts) then the arbitration and its rules as provided in the contract should apply.

In the absence of an arbitration clause, the insurance dispute will be ligitated in civil district courts.

The parties themselves may stipulate the exclusive court to judge claims arising from their insurance contract (choice of forum clause). If no choice of forum clause exists, in general, the relevant court of the insured's headquarters shall apply.

There are no courts specialising in insurance matters in Brazil.

### 2 When do insurance-related causes of action accrue?

A one-year limitation period applies to insurance-related matters.

In cases related to civil liability insurance policies, the insured's term begins when the insured receives a summons in a third-party lawsuit, or when the insured pays the claim to such third party upon the insurer's previous approval.

In other insurance cases, the one-year term starts upon acknowledgement of a damaging act or fact (in disputes over insurance coverage, for instance, the term starts running when the insured receives a coverage denial notice from the insurer).

### 3 What preliminary procedural and strategic considerations should be evaluated in insurance litigation?

The strategy is often case-specific, and the following aspects should be addressed beforehand with lawyers:

- analysing the insurance terms and conditions, the procedures for notification of a loss, and the measures to control or deal with an event;
- handling documents for the loss adjustment, which is one of the most time-consuming phases of a claim;
- analysing whether any specific insurance clause or condition applies to the event;
- checking the insured's and insured group's financial and court background;
- discussing with lawyers and experts hired to conduct the loss adjustment what the expectations regarding the insurance coverage are;
- during the loss adjustment, evaluating the possibility or need of asking any advance payment from the insurer;
- from the insurer's perspective, evaluating the insured's history and the findings in the loss adjustment to define whether the insurance coverage is due, in total or in part;
- for both the insurer and the insured:
  - the governing law and jurisdiction;
  - the litigation procedure envisaged in the insurance policy, if it is an arbitration or court jurisdiction;
  - existing court precedents; and
  - the expected time of litigation in the relevant court; and
- after due consideration, the pros and cons of litigation as opposed to an extrajudicial settlement.

### 4 What remedies or damages may apply?

The parties may sue for specific performance of the contract or any of its commitments and, alternatively, for termination of the contract. In either case, the injured party qualifies for redress of the ensuing damage.

Insurance disputes mostly revolve around the extent of insurance coverage (total or partial), the amount of insurance claims, aggravation of risk, and the harm caused by delayed payment or non-fulfilment of the insurance contract.

### 5 Under what circumstances can extracontractual or punitive damages be awarded?

Under Brazilian law, no indirect or punitive damages can be awarded.

## Interpretation of insurance contracts

### 6 What rules govern interpretation of insurance policies?

Brazil's legal system is based on civil law; therefore, its legal framework comprises numerous laws and codes. By extension, the Brazilian insurance market is regulated by a host of legal documents, including:

- the Civil Code (enacted by Law 10,406 of 2001), which dedicates an entire chapter to insurance contracts and the overarching principles that govern the relationship between insured and insurer;
- Decree-Law 73 of 1966, which allows the regulation of the insurance market and activities via rules enacted by the National Council of Private Insurance (CNSP) and the Brazilian Private Insurance Authority (SUSEP); and
- Supplementary Law 126 of 2007, which sets out the main rules for reinsurance and retrocession transactions in Brazil after dismantling the Reinsurance Institute of Brazil's monopoly of this area.

However, given the adhesion contract nature of most insurance policies, the courts tend to be more pro-insured on interpreting insurance contracts, the more so when the insured is a consumer (especially under the Consumer Protection Code enacted by Law 8,078 of 1990).

The interpretation of insurance contracts must abide by the general rules for interpretation of private contracts as established in the Civil Code.

### 7 When is an insurance policy provision ambiguous and how are such ambiguities resolved?

As a general rule, the interpretation of any contract between private parties must rely on the genuine intention of the parties when entering into the contract, the traditions and customs of the place where it took place, and the principle of good faith of the contracting parties (which is even stricter in insurance contracts).

In addition, insurance contracts may also be subject to the rules of interpretation applying to adhesion contracts (under the Civil Code or the Consumer Protection Code, as the case may be), by which any ambiguous or contradictory provisions in a contract must be interpreted in favour of the party who adhered to it.

## Notice to insurance companies

### 8 What are the mechanics of providing notice?

First, it must be checked whether the insurance contract stipulates any specific notice procedures.

As a general commercial practice, any way of giving written notice to the insured and to the insurer is acceptable (eg, notice by email or even formal letters hand-delivered at the addressee's headquarters).

There are cases in which policies provide not only for notice of loss, but also for notices of risk aggravation and notices for potential loss (ie, not just effective and concrete losses already verified).

**9 What are a policyholder's notice obligations for a claims-made policy?**

In a claims-made policy, policyholders are required to notify the insurer as soon as they become aware of a loss, or third-party claim or damage.

**10 When is notice untimely?**

As a rule, the insurer must be notified once the insured becomes aware of a loss. Untimely notice cannot harm the insurer's right to carry out investigations, protect the salvage, engage in loss adjustment, and even give opinions on any settlement being negotiated with third parties.

Denial of coverage for untimely notice is a common practice in Brazil. However, there are also court precedents recognising the insureds' right to coverage if late notice has neither harmed the insurers' right to investigate nor unduly increased the risk and losses.

**11 What are the consequences of late notice?**

In most of the cases, the possible consequences are: (i) total or partial forfeiture of coverage; and (ii) charging of additional insurance premium.

## Insurer's duty to defend

**12 What is the scope of an insurer's duty to defend?**

It is not a common practice in Brazil to impose the burden of defence on insurers.

Unless otherwise agreed, liability insurance generally provides coverage for the insured's defence costs (ie, the insurer's duty to finance the defence). To secure this kind of coverage, the insured must give timely notice to the insured on any insured event or third-party claim; besides this the insurer will have the right to check whether the estimated costs for the insured's defence are fairly estimated and in keeping with market standards.

In third-party claims, the litigation can be handled either by the insured alone (with frequent reporting to the insurer) or by both insured and insurer (the latter acting as intervening party in most cases, after being formally summoned and joining the litigation), each filing its own defence.

Therefore, the rule is the insured taking over the defence, reporting on the strategy and further steps to the insurer. During the claim settlement procedure and even after a final decision securing the coverage, the insurer may be reimbursed for the defence costs incurred. It is not common to have the insurer directly handle an insured's defence in insurance-related litigation.

**13 What are the consequences of an insurer's failure to defend?**

In very specific situations where the parties have agreed that the defence would be conducted by the insurer directly, any failure to do so may trigger the Brazilian general rules on damages, and the insurer can be required to make good any harm caused to the insured on account of this failure.

## Standard commercial general liability policies

**14 What constitutes bodily injury under a standard CGL policy?**

Considering CGL policy as comparable to civil liability insurance in Brazil, bodily injury generally stands for the physical injury caused to a person's body, excluding psychic or mental harm, unless otherwise set forth in the agreed conditions. In some insurance products, coverage for bodily injuries encompasses death and disability.

**15 What constitutes property damage under a standard CGL policy?**

Considering CGL policy as comparable to civil liability insurance in Brazil, property damage generally stands for physical harm, deterioration or destruction caused to tangible property or assets. Different provisions apply to inclusion or exclusion of financial losses into the concept of property damage.

**Update and trends**

A bill on insurance and reinsurance matters is pending final approval by Brazilian legislative bodies. This bill provides the insureds with increased rights as per (i) the right to access insurers' documents on ascertainment of loss within the claim settlement procedure; and (ii) more protective drafting of insurance contract clauses.

We highlight the following as trends in the Brazilian insurance market: (i) the creation of cyber insurance to cater to technology innovations and even to recent laws on data protection, processing, access, disclosure and liability issues; and (ii) a new regulatory framework for judicial bonds related to labour claims, and also the increase of such market in response to compliance matters and investigations.

**16 What constitutes an occurrence under a standard CGL policy?**

An occurrence under civil liability insurance generally refers to the occurrence of a harmful act or fact for which the insurer is liable under the corresponding coverage (eg, bodily injury, moral damage and property damage to a third party).

**17 How is the number of covered occurrences determined?**

Each insurance policy establishes the number and limitation of covered occurrences. As a rule, the number of covered occurrences directly relates to the maximum amount of coverage stipulated in the insurance contract.

It is also possible to consider ancillary occurrences and multiple claims deriving from the same occurrence.

**18 What event or events trigger insurance coverage?**

The events triggering insurance coverage are those specifically described in the terms and conditions of the insurance policy.

**19 How is insurance coverage allocated across multiple insurance policies?**

Multiple insurance policies over a same interest may be concurrent or in excess. If the policies are silent about it, a concurrence regime shall apply.

Except for life, which may be insured by multiple policies concomitantly on a common basis, other interests may only be insured once, and, in some cases, with express additional percentage (eg, purchase cost plus 20 per cent value).

## First-party property insurance

**20 What is the general scope of first-party property coverage?**

In first-party property insurance, commonly referred to in Brazil as property insurance or operational insurance, a company takes out insurance to protect its assets and operations against property damage, loss of profits and other losses from shutdown. This means the company does not depend on a third-party insurance policy taken out to cover third-party claims.

In Brazil, there are two types of first-party property insurances: all-risk operational policies and named risks.

**21 How is property valued under first-party insurance policies?**

Before offering coverage, the insurer may ask the insured for updated expert reports, the latest balance sheet, and financial information to properly evaluate the insured's operations and assets. The insurer may also carry out its own analysis and on-site inspection to ascertain the value of the insured's assets and operations.

**22 Is insurance available in your jurisdiction for natural disasters and, if so, how does it generally operate?**

In general, natural disasters are excluded from standard conditions of coverage for property and named insurance policies, and must be treated separately in special clauses and additional coverage provisions.

For an all-risk policy, all types of perils are covered unless otherwise expressly stated in an exclusion clause.

Natural disasters, when covered, may stir discussions regarding their status as a proximate or remote cause.

## Directors' and officers' insurance

### 23 What is the scope of D&O coverage?

D&O insurance policies generally cover the losses incurred by directors, officers and other individuals in the exercise of their management roles.

D&O insurance usually offers three types of coverage:

- Type A: coverage for financial losses suffered directly by D&O;
- Type B: reimbursement of amounts incurred by the company as compensation for D&O losses. If a hold harmless agreement is in place, the company may indemnify the D&O for financial losses covered by the D&O insurance and then be reimbursed by the insurance company; and
- Type C: coverage for losses arising from certain claims asserted against the company in the capital markets, especially in cases of joint liability with the D&O.

In Brazil, D&O insurance has following basic coverage:

- defence costs, encompassing all fees, attorneys' fees, court costs, necessary expenses incurred in defences or appeals by or on behalf of D&O; and
- indemnification, covering the damage suffered by D&O on account of their managerial role, excluding punitive, consequential and indirect damages.

SUSEP has recently issued new regulations on D&O insurance by which insurance companies are allowed to provide coverage for fines and penalties, which is especially important for companies supervised by the Central Bank of Brazil, the Brazilian Securities Commission and other governmental authorities.

### 24 What issues are commonly litigated in the context of D&O policies?

The most litigated issues in the context of D&O policies are: (i) coverage in debt reorganisation and bankruptcy scenarios; (ii) coverage in cases involving alleged insider trading; (iii) coverage in cases involving alleged acts of corruption of D&O; and (iv) disclosure of information by the company and officers to the insurer.

## Cyber insurance

### 25 What type of risks may be covered in cyber insurance policies?

Financial protection is offered against civil liability arising from data privacy breaches (either by hackers or resulting from a company's errors and dereliction), including defence costs in investigations and lawsuits. The following items are examples of covered risks:

- public disclosure of private data or third-party corporate data that are confidential or else under the insurer's responsibility or custody;
- contamination of data by malicious code or malware, undue refusal to grant access requested by authorised people, theft of access codes inside the insurer's premises or computer systems, etc;
- actions taken by outsourced companies under the insured's responsibility;
- defence costs, reasonable costs for legal consulting in investigative procedures and costs incurred to notify users about any data breach, etc; and
- control costs and expenses.

### 26 What cyber insurance issues have been litigated?

To our knowledge, no relevant litigation has specifically revolved around cyber insurance issues thus far.

## Terrorism insurance

### 27 Is insurance available in your jurisdiction for injury or damage caused by acts of terrorism and, if so, how does it generally operate?

Injury or damage caused by acts of terrorism is usually excluded, although specific clauses for coverage may be negotiated. In the products offered in the Brazilian market, acts of terrorism are those involving the use of force or violence in attacks directed at persons or properties for political, ideological or religious reasons to disseminate terror, fear, and property or psychic damage on a large scale.

Ordinary coverage encompasses property damage, loss of profits and other damage related to riots, strikes, lockouts and malicious acts.

PINHEIRONETO
ADVOGADOS

**Diógenes M Gonçalves Neto** **dgoncalves@pn.com.br**
**Roberto Panucci Filho** **rpanucci@pn.com.br**
**Gianvito Ardito** **gardito@pn.com.br**
**Raissa Lilavati Abbas Campelo** **rcampelo@pn.com.br**
**Pedro Ivo Gil Zanetti** **pzanetti@pn.com.br**

1100 Hungria Street
01455-906, São Paulo
Brazil

Tel: +55 11 3247 8400
Fax: +55 11 3247 8600
www.pinheironeto.com.br

# Chile

**Ricardo Rozas**

**Jorquiera & Rozas Abogados (JJR)**

## Preliminary and jurisdictional considerations in insurance litigation

### 1 In what fora are insurance disputes litigated?

As an introductory note, the Chilean insurance landscape was altered when amendments to Chile's Commercial Code came into force on 1 December 2013 (the new law). Until 1 December 2013, Chilean insurance contracts were governed by laws dating back to 1865. The changes to the legislation were purportedly made to bring Chilean insurance law into line with modern insurance law at a national and international level.

According to article 29 of the Chilean Insurance Act (also known as DFL 251), any dispute arising from insurance and reinsurance contracts governed by the law shall come under the jurisdiction of the Chilean courts. This rule is mandatory and cannot be repealed by agreement of the parties. Therefore, although there is contractual freedom to agree on the applicable law, any dispute must be settled in principle in the Chilean courts. Nevertheless, once an insurance or reinsurance dispute effectively arises, the parties to the insurance or reinsurance policy are entitled to resolve disputes under Chile's international arbitration rules.

In addition, the new law states that insurance disputes will usually be resolved through arbitration, although an insured has the right to make a claim in the local courts where sums of 10,000 *Unidades de Fomento* (a unit index inflation-linked to the Chilean peso) are at stake. Insurers are now obliged to provide authorised copies of final arbitral awards to the regulator, with the aim of improving the scope of jurisprudence available for parties to consider in the event of a dispute. Arbitral awards will not be binding but we expect that this provision will improve certainty over policy interpretation.

### 2 When do insurance-related causes of action accrue?

The limitation period applicable to non-marine insurance contracts is four years from the date on which the insured had an enforceable right under the policy. In the case of marine insurance the limitation period is two years. However, for life insurance the term will run from the date that the insured had knowledge of the right to claim under their insurance, but this period shall not exceed 10 years from the date of loss.

Limitation periods must be protected according to the general rules contained in the Chilean Civil Code. In this respect, article 2518 of the Civil Code states that the limitation period can be interrupted by filing a lawsuit (known as civil interruption). Interruption will take place when the lawsuit is duly and legally served against the defendant through a service clerk (the receptor judicial). In addition, as per the new law the limitation period can also be interrupted by the insured's notice of the claim. In such a case, the limitation period will be renewed as of the moment the insurer communicates its decision on the matter.

### 3 What preliminary procedural and strategic considerations should be evaluated in insurance litigation?

**Stages of litigation**

Generally speaking, in Chile civil and commercial disputes at first instance comprise three main phases: discussion (exchange of pleadings), evidence and issuance of the judgment.

Unless remedies are waived, under Chilean law the right of appeal arises when the decision of the inferior tribunal causes grievance to one or more parties (there are no specific causes). The appeal remedy is available for most first instance court rulings and is usually heard by a court of appeal. The appeal remedy must comply with basic form requirements. The regular term for appealing is five days but, in the case of a final decision, the period is 10 days counted as of the service of the decision. Depending on the subject of the trial and the type of decision appealed, the processing of an appeal can take up to two years.

Regarding appeal stages, in Chile there is only one appeal stage, and the second instance tribunal is allowed to review both factual and legal issues. Having said this, in Chile it is possible to challenge the decision of a second instance tribunal through exceptional remedies such as cassation (these remedies are heard by the Chilean Supreme Court).

**Evidence**

There are no discovery obligations in Chile, but the parties are free to submit evidence based on documents, witnesses, parties' confessions, inspections ordered by the court, expert reports and presumptions.

In respect of insurance and reinsurance disputes, under the new law, ordinary and arbitration courts are entitled to the following specific faculties relating to evidence issues:

- at the request of a party, to accept additional means of proof to those pointed out above;
- to decree evidentiary measures ex officio at any stage of the trial;
- to request recognition of documents and deal with objections; and
- to assess evidence under the 'sane critic' doctrine.

**Costs**

Except for minor expenses associated with service, paperwork and auxiliary officers, there are no court fees payable in Chile. As to lawyers' fees, they can be recoverable, but only if the judge rules that there was no reasonable basis to litigate.

If the dispute is resolved through arbitration, then arbitrators' and administrative fees will apply. Those cases subject to institutionalised arbitration, such as under CAM Santiago, are subject to a referential table or calculator based on the amount at stake and with caps. In case of ad-hoc arbitration, the arbitrators are free to propose what they believe is reasonable. However, recently some of them have started to use these parameters, which are more objective.

### 4 What remedies or damages may apply?

Generally speaking, under Chilean law in case of breach of contract the parties are entitled to request either the rescission or the forced performance of the contract, plus compensation of damages, which are restricted to costs incurred, loss of profits and, in certain cases, moral damages. However, under the new law there are the following specific remedies.

**Disclosure**

The new law provides that the insured must respond to an insurer's request for information about a risk by honestly disclosing the information requested, to allow insurers to identify the object of the insurance and assess the nature of the risk. If the insured provides information that is false, the insurer can avoid the policy and return the premium. As noted below, the insured must also disclose circumstances that increase the risk during the policy period.

**Gross negligence and recklessness**
Insurers can decline to indemnify the insured if the loss is triggered by an act of recklessness or gross negligence on the part of the insured, unless the policy provides otherwise.

**Termination of the policy and aggravation of the risk**
A policy will be terminated if the risk is extinguished after the policy is entered into. If the risk increases, the premium will be adjusted. If the insured fails to pay premium, the policy will be terminated. Under the new law, the insured must inform the insurer of circumstances that substantially aggravate the risk within five days. However, this provision applies only to risks that the insurer could not have discovered in another way.

**Levels of indemnity**
Insurers can claim a reimbursement from the insured if an insured receives a payment for a value higher than the amount of its loss. If it appears that the insured has acted in bad faith, insurers can seek damages or press for criminal proceedings. Under the new law an insurance contract can never constitute an opportunity for enrichment or gain. In addition, the policy will provide for an indemnity in money, unless the policy provides that insurers will replace or repair the item insured.

**Co-insurance contracts**
Where co-insurers jointly cover the same insured interest, the insured can claim against any of the co-insurers.

### 5 Under what circumstances can extracontractual or punitive damages be awarded?

The concept of extracontractual damages is much wider than that related to contractual ones. According to article 2,329 of the Chilean Civil Code, '. . . all damages that may be attributed to malice or neglect to one person, must be repaired by such person'. There is no general rule as to how courts should award these type of damages, thus its acceptance is determined to the factual background of each case.

As regards punitive damages, they are not contemplated under Chilean law.

## Interpretation of insurance contracts

### 6 What rules govern interpretation of insurance policies?

Insurance and reinsurance contracts are subject not only to the Commercial Code, but also to the general provisions relating to the interpretation of contracts in the Civil Code (article 1560 et seq) plus certain provisions contained in DFL 251.

The Chilean position can be broadly summarised as follows:

- The provisions of the new law are in general mandatory, unless stated to the contrary. However, if a clause is deemed to provide an insured with a greater benefit than is provided under the law generally, the specific terms of a policy will prevail over the Code of Commerce.
- Chilean law considers it of paramount importance to determine the intentions of the parties at the time of contracting and to give effect to those intentions even if they are not reflected in the literal words of the contract.
- A Chilean tribunal will strive to facilitate clauses in contracts with the goal of ensuring that the parties' intentions are fulfilled. Actions can include amending the contract if no provision is made for a given state of affairs.
- Under Chilean law, it is permissible for a tribunal to ascertain the parties' intention by looking outside the contract at, for example, the negotiations between the parties and market practice at the date of contracting.
- In the event of ambiguity in a policy, the interpretation that is more favourable to the insured prevails. Given that DFL 251, article 3 (E), paragraph 3 specifically imposes a duty on the insurer to make sure that the wording is clear and understandable, this presumably remains the position even if the insured or the broker has drafted the wording, or if the wording is the result of negotiation between the insurer and insured.

### 7 When is an insurance policy provision ambiguous and how are such ambiguities resolved?

See question 6.

## Notice to insurance companies

### 8 What are the mechanics of providing notice?

Under the new law, when any event that may constitute a loss occurs, the insured must notify the loss to the insurer or insurers as soon as possible upon becoming aware of the event (this term may be altered by the agreement of the parties). In addition, should there be a loss the insured has also the obligation to take all necessary measures for saving or recovering the subject insured or for keeping its remains. Furthermore, the insured has to prove the loss occurrence and sincerely state its circumstances and consequences.

### 9 What are a policyholder's notice obligations for a claims-made policy?

See question 8. However, careful checking of the precise policy wording is relevant.

### 10 When is notice untimely?

See question 8.

### 11 What are the consequences of late notice?

The effect of an untimely notice has yet to be tested by Chilean courts. However, as per some legal cases prior to the new law, an insurer could deny coverage based on late notice of claim only if it demonstrates prejudice.

## Insurer's duty to defend

### 12 What is the scope of an insurer's duty to defend?

Unless otherwise agreed, under the new law there is no general rule placing the insurer to defend a claim made against the policy holder. However, according to Chilean practice in the absence of express provisions the parties will usually try to reach an agreement on the claim handling or, otherwise, the insured will carry on with its defence and seek for the insurer's liability once coverage has been determined.

### 13 What are the consequences of an insurer's failure to defend?

Should the insurer agree to take responsibility for the defence, failure to comply with any contractual provision may constitute a breach of contract and the insured would be entitled to request either the rescission or the forced performance of the contract, plus compensation of damages.

## Standard commercial general liability policies

### 14 What constitutes bodily injury under a standard CGL policy?

As an introductory note, in Chile insurance and reinsurance companies must word their contracts using the models of policies and clauses available in the Register of Policies of the Chilean regulator (CMF). Strictly speaking, they are able to use non-registered models when this relates to general insurance, where the insured or the beneficiary are legal entities, and when the annual premium is higher than around US$8,150. In addition, non-registered models can also be used for cargo, transport, marine or aircraft hulls, or related insurances. However, in practical terms the use of non-registered models is quite common and careful review of their terms and conditions is always important as they may differ from the registered models.

Normally the Chilean equivalent to a standard CGL policy (the civil liability policy) defines bodily injury as that caused to third parties.

### 15 What constitutes property damage under a standard CGL policy?

Usually under the Chilean equivalent to a CGL policy, property damage is defined as that material damage affecting third parties during the policy term. Since those damages are usually referred to liability arising from provisions of the Civil Code, they would regularly include destruction, deterioration or loss of economic value of the corresponding goods.

**16 What constitutes an occurrence under a standard CGL policy?**

Normally under the Chilean equivalent to a CGL policy, the term occurrence is not defined. However, in general terms it can be deemed as a harmful event of an extracontractual nature that has a connection with an act or omission of the insured and that takes place during the policy period, which in turn may give rise to a claim by the affected third party.

In this respect, the Chilean equivalent to a CGL policy covers payment to be made by the insured owing to their civil liability in connection with damages suffered by third parties, including death, bodily injury, damage to property and expenses for legal defence.

**17 How is the number of covered occurrences determined?**

The Chilean equivalent to a CGL policy would normally consider a group of claims based on bodily injury or property damage as one single loss or occurrence provided that they have originated from the same cause and notwithstanding the amount of claimants.

**18 What event or events trigger insurance coverage?**

Those expressly agreed under the coverage provided by the policy. Events not covered or excluded by the policy cannot trigger insurance coverage.

**19 How is insurance coverage allocated across multiple insurance policies?**

As regards the effects of multiple insurance policies, the insured can claim against any of the insurers and, if there is a balance, can claim against others. However, the total amount of indemnity received by the insured is limited to the value of the insured object.

On a related subject, under the new law co-insurance occurs when two or more insurers, with the approval of the insured, agree to jointly cover a specific risk. In such a case, the insurers are obliged to pay the insurance indemnity in accordance with their respective share.

## First-party property insurance

**20 What is the general scope of first-party property coverage?**

First-party property coverage is usually agreed as per non-registered policies with the Chilean regulator. Its scope would normally comprise sudden and unforeseen losses or damage affecting agreed property of the insured related to their commercial operation at agreed facilities and limited by the applicable exclusions. In addition, these policies usually cover business interruption damages.

**21 How is property valued under first-party insurance policies?**

It is up to the parties to agree the valuation basis, but Chilean practice usually considers the following criteria:

- products in process and finished goods: effective cost incurred at the time of the loss (direct and indirect costs of the product);
- raw material, supplies, machinery spare parts and other merchandise bought from third parties: subject to the formula applied on the subject matter insured, replacement value as new at the time and location of the loss less depreciation;
- buildings, machinery, equipment and other assets: subject to the formula applied on the subject-matter insured, replacement value as new at the time and location of the loss less depreciation;
- reconstruction in a different location: usually capped to the amount that it would cost to reconstruct at the original site. If the insured decides not to reconstruct or replace the damaged property, the indemnity can be based on actual value; and
- insured amount: the insurer is not liable for amounts exceeding those agreed in the policy.

**22 Is insurance available in your jurisdiction for natural disasters and, if so, how does it generally operate?**

Generally speaking, Chilean property policies provide specific coverage for damage caused by fire started by natural phenomena such as earthquakes (fires arising from earthquakes are usually contracted as an additional cover), wind, floods and tsunamis, in accordance with the models of policies and clauses available in the Register of Policies of the CMF.

In this respect, it is worth noting that – following the 2010 earthquake that affected the centre and south of Chile – Chilean adjustment regulations include two provisions specifically aimed at catastrophe losses: first that the Chilean regulator can extend the adjustment to 180 days and second, where there is more than one loss notified at a condominium, each insurer shall appoint only one adjuster.

## Directors' and officers' insurance

**23 What is the scope of D&O coverage?**

Generally speaking, registered D&O policies provide coverage to managers and directors of companies against financial losses (usually it comprises damages, defence costs and investigations costs) as a result of any claim (scope usually expressly established) presented for the first time during the policy period because of negligent or improper acts for acts committed in performance of their duties.

**24 What issues are commonly litigated in the context of D&O policies?**

In Chile D&O disputes are usually related to breach of duties regulated under different laws and provisions, including but not limited to the Chilean Securities Market Law (Law 18,045); the Stock Companies Law (Law 18,046); the Superintendency of Securities and Insurance Law (Decree Law 3538); the Mutual Fund Administration Law (Decree Law 1328); the Foreign Equity Investment Law (Law 18,657); the Mutual Funds Law (Law 18,815); the Custody and Deposits Law (Law 18,876); the UK Financial Services and Markets Act 2000; the United States Securities Act of 1933; and the United States Securities Exchange Act of 1934.


**Ricardo Rozas** **rrozas@jjr.cl**

Isidora Goyenechea 3250, 4th Floor
Las Condes
7550083 Santiago
Chile

Tel: +56 2 2580 9300
Fax: +56 2 2580 9311
www.jjr.cl

## Cyber insurance

**25 What type of risks may be covered in cyber insurance policies?**

Generally speaking, registered cyber insurance policies will provide cover for damages and costs as a result of claims presented within the term established by the policy in connection with the use and processing of private data, including errors and omissions; malicious acts; web security; liability for electronic content; cyber extortion; loss of digital files; and business interruption.

**26 What cyber insurance issues have been litigated?**

Cyber insurance is just emerging and at present we are not aware of significant disputes in Chilean courts.

## Terrorism insurance

**27 Is insurance available in your jurisdiction for injury or damage caused by acts of terrorism and, if so, how does it generally operate?**

Terrorism coverage is usually agreed as per non-registered policies with the Chilean regulator, which usually follow international market forms. In this respect, it is always important to check how terrorism is defined and the applicable exclusions. Having said this, terrorism in Chile is regulated by Law 18314, also known as the Anti-terrorism Act. This law does not have a specific definition but in its articles 1 and 2 establishes the acts that can be deemed as terrorist acts, whose common element is that the illegal act is committed with the intention to cause fear in the general population. From a practical standpoint, it is worth noting that in recent times Chilean authorities and courts have been reluctant to investigate potential offences under the aforementioned law, which normally end up treated as offences under general criminal law. Local loss adjusters have also adopted ambiguous criteria.

# China

**Zhan Hao, Zhang Xianzhong, Wang Xuelei, Wan Jia, Yu Dan and Chen Jun**

**AnJie Law Firm**

## Preliminary and jurisdictional considerations in insurance litigation

### 1 In what fora are insurance disputes litigated?

**Hierarchical jurisdiction**

In China, there are four levels of courts: the primary courts, the intermediate courts, the High Courts and the Supreme People's Court. These courts have first instance jurisdiction over civil cases, including insurance cases. Normally, the primary court will act as the first instance court in most insurance cases. However, if the amount in dispute of a case reaches a certain level or if the case is very influential for society, the intermediate courts or even the High Courts shall have the jurisdiction to hear the case. It is rare for the Supreme People's Court to hear a case in the first instance.

If any party is unsatisfied with the judgment or verdict of the first instance court, that party may bring an appeal to a court of a higher level within the period of time prescribed. The judgment or verdict of the appeal court shall be binding. The only remedy against the binding judgment or verdict can be found in the legal review procedure; however, it is rare and difficult to kick-start this procedure.

**Territorial jurisdiction**

A lawsuit brought on an insurance dispute will fall under the jurisdiction of the people's court where the domicile of the defendant or the insured object is located.

However, the territorial jurisdiction is subject to some exceptions. For instance, insurance disputes that occur in the Dongcheng, Xicheng, Chaoyang and Haidian districts of Beijing shall fall under the first instance jurisdiction of the Beijing Railway Transportation Court. The Fourth Intermediate Court tries the appeals from these four districts for insurance disputes. The maritime courts shall hear cases regarding marine insurance claims and related subrogation litigations.

On 9 September 2018, the Beijing Railway Transportation Court was disbanded. From thereon, first instance insurance disputes that were previously accepted by the Beijing Railway Transportation Court shall now be filed with their respective district courts. Those insurance disputes that were pending before the Beijing Railway Transportation Court at the time of its dissolution shall instead be heard and executed in the name of Beijing Haidian District People's Court, under their existing docket numbers.

### 2 When do insurance-related causes of action accrue?

With respect to property insurance cases, the period of limitation of action for an insured to claim indemnification or payment of the insurance benefits against the insurer shall be two years. The period of limitation of action shall be counted from the day when the insured knew or should have known of the occurrence of the incident covered by the insurance policy.

With respect to life insurance, the period of limitation of action for an insured to claim payment of the insurance benefits shall be five years, which shall be counted from the day when the insured knew or should have known of the occurrence of the incident covered by the insurance policy.

### 3 What preliminary procedural and strategic considerations should be evaluated in insurance litigation?

The following aspects are always considered in insurance litigation.

**The validity of the insurance contract**

The following clauses in an insurance contract that has been concluded by using the standard clauses provided by the insurer shall be void: clauses exempting the insurer from any legal obligation or aggravating the liability of the insurance applicant or the insured, and clauses excluding any legal right of the insurance applicant, the insured or the beneficiary.

Besides these clauses, other issues that will make the policy void include, but are not limited to, fraud, violation of compulsory provisions of law and regulations, and violation of the public interest.

**The insurance assessment report**

An insurance assessment report made before litigation is not binding on the tribunal, but it can be used as a reference. If the tribunal deems it necessary, it can retain another loss adjuster to make an assessment again during the litigation procedure.

**The disclosure obligation of the insurance applicant**

In concluding an insurance contract, the insurance applicant shall make an honest disclosure when the insurer enquires about the subject matter insured or relevant circumstances concerning the insured. The insurer shall have the right to rescind the insurance contract if the insurance applicant intentionally or out of gross negligence fails to perform his or her obligation to make an honest disclosure, and thereby materially affects the insurer's decision on whether to issue the insurance policy or whether to increase the premium rate. If an insurance applicant intentionally fails to perform his or her obligation to make an honest disclosure, the insurer shall bear no insurance obligation with regard to the insured incident occurring before the rescission of the contract, or for returning the paid insurance premiums. If an insurance applicant fails to perform his or her obligation to make an honest disclosure out of gross negligence, which has a material effect on the occurrence of an incident covered by the insurance, the insurer shall, with respect to the incidents occurring before the rescission of the contract, bear no insurance obligation, but may return the paid insurance premiums.

Where an insurer knows something that the insurance applicant fails to disclose and enters into an insurance contract with the insurance applicant, the insurer shall not rescind the contract. Further, if an insured incident occurs, the insurer shall bear the insurance obligation.

**The specific explanation obligation of the insurer**

For those clauses that exempt the insurer from liability in the insurance contract, the insurer shall give sufficient warning to the insurance applicant of those clauses in the insurance application form, the insurance policy or any other insurance certificate, and expressly explain the contents of those clauses to the insurance applicant in writing or orally. If the insurer fails to give a warning or an explicit explanation thereof, those clauses shall not be effective.

**The decision of the insurer**

The insurer shall, after receiving a claim from the insured or the beneficiary, determine the matter without delay. If the circumstances are complex, the insurer shall determine the matter within 30 days, unless the insurance contract provides otherwise.

The insurer shall inform the insured or the beneficiary of the result of the determination. If responsibility lies with the insurer, the insurer shall fulfil its obligation for such indemnity or payment within 10 days after an agreement is reached with the insured or the beneficiary on such indemnity or payment. If there are stipulations in the insurance contract on the period within which indemnification or payment should be made, then the insurer shall fulfil its obligation accordingly. After the insurer determines that the events do not fall within the scope of the insurance cover, the insurer shall, within three days, send a notice refusing to pay indemnification or insurance benefits to the insured or the beneficiary, and give reasons for such determination.

**The payment of premiums**

Once an insurance contract is formed, the insurance applicant shall pay the premiums in accordance with the terms of the contract. In China, the insurance contract always stipulates that the payment of premiums acts as a condition for the validity of the insurance contract.

**Complaints to the China Banking and Insurance Regulatory Commission**

In April 2018, the China Insurance Regulatory Commission (CIRC) and the China Banking Regulatory Commission (CBRC) officially merged to form the China Banking and Insurance Regulatory Commission (CBIRC). The functions of the original CIRC were inherited by the CBIRC.

Whether the insured or the beneficiary complains to the CBIRC (formerly the CIRC) and how the CBIRC deals with the complaint shall influence the litigation. In China, the regulator strictly monitors the insurance market, and the CBIRC has substantial influence over the claim process and result.

### 4 What remedies or damages may apply?

There are two kinds of remedies or damages in insurance litigation: payment of insurance benefits and compensation for loss, which includes repair or replacement.

In addition, the insurer will bear liability for delayed payment, which will always consist of bank interest accrued during the delay period.

In China, there is a clear difference between contractual liability and tort liability, and in an insurance dispute, even if a party violates the insurance contract with malicious intent, it will not incur tort liability or punitive damages.

### 5 Under what circumstances can extracontractual or punitive damages be awarded?

Even though an insurer is obliged to act in good faith while investigating the claim of an insured and in establishing the extent of coverage in a timely manner, the Chinese courts do not accept tort liability when claims have been wrongfully denied. Only in a situation where the insurer does not act in good faith when responding to the claim of an insured, or in a situation where the insurer denies a claim that is not fairly disputable in accordance with the terms of the insurance policy, will the insured be entitled to contractual remedies (eg, court-compelled performance, payment of insurance benefits and any damages caused by the breach). Regarding extracontractual or punitive damages, these are usually not recoverable or awarded.

## Interpretation of insurance contracts

### 6 What rules govern interpretation of insurance policies?

**Semantic interpretation**

Semantic interpretation means interpreting the policy with common knowledge in accordance with the common sense of common people. A semantic interpretation cannot deviate from the wording of the policies, and other methods of interpretation can only be applied when the outcome of the usage of the semantic interpretation is still unclear.

**Other methods of interpretation**

Systemic interpretation refers to interpreting the provisions in accordance with the whole content of the contract, and being aware of the connections between other provisions in the insurance contract.

Contract aim-based interpretation means interpreting the policy in accordance with the real intention of the parties of the insurance contract.

The utmost good faith interpretation is based on the utmost good faith principle, and will interpret the insurance contract using waiver and estoppel rules.

By way of special interpretation, the contents of the schedule outweigh the policy clauses; the handwritten clauses outweigh the printed clauses; and a special exception is that the contents of the application form outweigh the insurance policy and schedule, even if the application form was formed earlier than the latter two parts of the insurance contract.

**The unfavourable interpretation**

Where the insurer and the insurance applicant, the insured or the beneficiary have a dispute over a clause in an insurance contract concluded using the standard clauses provided by the insurer, the clause shall be interpreted as commonly understood. If there are two or more different interpretations of the clause, the people's court or the arbitral tribunal shall interpret the clause in favour of the insured and the beneficiary.

### 7 When is an insurance policy provision ambiguous and how are such ambiguities resolved?

The policy provision becomes ambiguous when the insurer and the insured or the beneficiary have different interpretations of the policy provision. If a policy provision is found to be ambiguous, it should be interpreted in accordance with the following interpretation rules:

- semantic interpretation;
- systemic interpretation;
- contract aim-based interpretation;
- the utmost good faith interpretation;
- special interpretation; and
- the unfavourable interpretation (see question 6).

## Notice to insurance companies

### 8 What are the mechanics of providing notice?

The insurance applicant, the insured or the beneficiary shall, in a timely manner, notify the insurer after becoming aware of the occurrence of an incident covered by the insurance policy. Where an insurance applicant, insured or beneficiary intentionally or out of gross negligence fails to notify the insurer in a timely manner, thus making it difficult to ascertain the nature, cause and extent of the loss of the incident covered by the insurance policy, the insurer shall not be liable for indemnification or payment of the insurance benefits for the indeterminable part unless the insurer knew or should have known about the incident in a timely manner through other channels.

### 9 What are a policyholder's notice obligations for a claims-made policy?

A frequently litigated issue pertaining to notice is the timeliness within which the insured or the beneficiary notifies its insurer of a claim. Typically, an insurance policy will require the insured or the beneficiary to notify the insurer of a claim 'as soon as practicable', 'promptly' or 'immediately'. Generally speaking, notice is required to be given to the insurer within a reasonable period of time, taking into consideration the facts and circumstances of the specific case.

An insurance applicant also has a duty to cooperate with the insurer defending a claim on its behalf. The insurance applicant must keep the insurer informed of all major case developments, respond to the insurer's reasonable enquiries and notify the insurer.

### 10 When is notice untimely?

In determining whether the insured has given the notice in an untimely manner, several factors are always examined, including the following:

- the wording of the policy's notice provision;
- the insured's sophistication regarding insurance policies;
- the insured's awareness that an accident as defined by the policy has happened;

- the insured's diligence in ascertaining whether policy coverage is available;
- whether the insurer was prejudiced by any late notice; and
- the nature and complexity of the insurance incident.

**11 What are the consequences of late notice?**

The insurance applicant, the insured or the beneficiary shall, in a timely manner, notify the insurer after becoming aware of the occurrence covered by the insurance policy. Where an insurance applicant, insured or beneficiary intentionally or out of gross negligence fails to notify the insurer in a timely manner, thus making it difficult to ascertain the nature, cause or extent of the loss of the incident covered by the insurance, the insurer shall not be liable for indemnification or payment of the insurance benefits for the indeterminable part, unless the insurer knew or should have known of the incident in a timely manner through other channels.

In practice, where a late notice damages the subrogation right of the insurer, the insurer may refuse the insured's claim accordingly.

Sometimes, the policy stipulates that if an insurance applicant, insured or beneficiary fails to notify the insurer in a timely manner, the insurer has the right to refuse the insurance benefit, but such policy provision will be deemed invalid by the people's court as a clause exempting the insurer from any legal obligation or aggravating the liability of the insurance applicant or the insured, or clauses excluding any legal right of the insurance applicant, the insured or the beneficiary.

## Insurer's duty to defend

**12 What is the scope of an insurer's duty to defend?**

There is no specific legal provision in Chinese laws and regulations that stipulates the insurer's duty to defend the insured. Only article 66 of the Insurance Law of the People's Republic of China provides that if an insured in a liability insurance contract is brought to arbitration or legal proceedings due to the occurrence of an incident covered by the insurance policy that causes loss or damage to a third party, the insurer shall bear the cost of such arbitration or legal proceedings, and other necessary and reasonable expenses paid by the insured, unless it is otherwise provided for in the insurance contract.

In practice, some liability insurance policies state that when a third party sues the insured, the insurer will have control over the litigation and have the obligation to defend the insured. Under such policy, the insurer will retain a lawyer for defence, determine the settlement, and pay the legal fees and other costs related to the litigation. In the meantime, the insurer will assume liability for insurance indemnification according to the result of the litigation.

The insurer will defend the insured in the name of the insured rather than in its own name.

**13 What are the consequences of an insurer's failure to defend?**

If the insurer fails to defend, it will indemnify the insured for the loss of the litigation, including the damage stipulated by the judgment or verdict, the legal fees paid by the insured and the legal costs incurred by the insured.

If the loss stipulated by the judgment exceeds the insurance limit, the insurer will also pay the excess loss if the insured can demonstrate that the insurer unfairly failed to defend it, and the insured had put its confidence in the defence of the insurer in good faith according to the policy provisions.

If the policy prescribes a specific compensation clause for the defence violation, the insurer will pay such compensation in accordance with the valid clause.

## Standard commercial general liability policies

**14 What constitutes bodily injury under a standard CGL policy?**

Bodily injury means physical damage to a person or to the health of a person that is not caused by a disease. In practice, bodily injury does not include mental damage unless otherwise stipulated in the standard CGL policy.

The purpose of liability (casualty) insurance is to cover bodily injury resulting from the negligence or omissions of an insured.

**15 What constitutes property damage under a standard CGL policy?**

CGL policies generally define property damage as follows: physical damage to tangible property, including but not limited to damage to its shape, contents and parts, and how long the damage to the property lasts; and loss of use of tangible property.

**16 What constitutes an occurrence under a standard CGL policy?**

Occurrence under a standard CGL policy means an event that results in bodily injury or property damage or any loss to a third party caused by the insured. In the claims-based policy, an occurrence means that the third party makes a claim to the insured.

An insurer may, in accordance with the provisions of the law or the terms of an insurance contract, directly indemnify a third party for loss or damage caused by the insured under liability insurance. Where an insured under liability insurance causes damage to a third party and the liability of the insured for indemnity to the third party has been determined, the insurer shall directly pay insurance benefits to the third party according to the request of the insured. Where an insured is negligent in making a request, the third party shall have the right to directly request the insurer to pay the insurance benefits for the damage.

**17 How is the number of covered occurrences determined?**

The following factors determine the number of occurrences:

- agreements about the number;
- definition of occurrence in the CGL policy. CGL policies frequently define occurrence as 'an accident, including continuous or repeated exposure to substantially the same general harmful conditions'. The limit of liability provisions can play an important role in determining how many occurrences are implicated by the underlying claim. A common limit in a liability provision states that 'Our total liability for all damages resulting from any one 'occurrence' will not be more than the limit of liability';
- proximate cause: generally speaking, the same proximate cause leads to the same insurance occurrence and different proximate causes lead to different insurance occurrences; and
- the four unities test, consisting of the responsible persons, causation, timing and location, has had a significant influence on the determination of the number of covered occurrences.

**18 What event or events trigger insurance coverage?**

There are four theoretical events that trigger insurance coverage:

- exposure: a policy is triggered upon the first exposure to the injury-causing or damage-causing event;
- manifestation: a policy is triggered upon the first manifestation of injury or damage;
- injury-in-fact: a policy is triggered when the first injury or damage takes place; and
- continuous: all policies between the date of first exposure and the date of manifestation are triggered.

**19 How is insurance coverage allocated across multiple insurance policies?**

In China, double insurance means insurance where an insurance applicant enters into separate insurance contracts with two or more insurers on the same subject, the same insurable interests and the same insured incident, and the total insured amount exceeds the insurable value.

In the event of double insurance, an insurance applicant shall notify all concerned insurers of relevant information with respect to such double insurance.

For double insurance, the total amount of indemnity paid by all concerned insurers shall not exceed the insurable value. Unless specified otherwise in the insurance contract, the concerned insurers shall undertake their respective obligations for indemnity according to the proportion of the sum insured by each of them to the total amount of the sum insured.

An insurance applicant for double insurance may require the insurers to pro rata refund the insurance premium for the excess of the total insured amount over the insurable value.

In other jurisdictions, when facing the double insurance scenario, a judge will take the intention of the policyholder into account and

**Update and trends**

On 1 September 2018, Interpretation (IV) of the Supreme People's Court on Several Issues concerning the Application of the Insurance Law of the People's Republic of China came into effect (the Interpretation). The Interpretation was announced for the hot issues in practice on 1 August 2018 and includes 21 articles. It focuses on the property insurance contract. It mainly refers to the assignment of the insured subject matter (articles 1, 2, 3 and 5), significant increase of risk (article 4), insurance subrogation right (articles 6–13) and liability insurance (articles 14–20). The Interpretation further clarifies controversies in practice, including (i) that whether the property assignee enjoys the insurance interest depends on whether the insured subject matter and the risk of loss and damage have been delivered to the assignee or not; (ii) that the insurance applicant can be subrogated by the insurer; (iii) that when the insured waives the right to claim indemnity against a third party, the insurer may claim refund of the premium; and (iv) the conditions for a third party to sue the liability insurer. With the Interpretation, insurance companies will be more prudent when designing insurance articles. They may also be inspired, on account of the Interpretation, to pursue subrogation rights more actively.

make differentiated decisions accordingly. However, in China the law addresses double insurance without considering the intention of the policyholder and whether the policyholder intentionally or negligently bought double policies.

## First-party property insurance

### 20 What is the general scope of first-party property coverage?

First-party property insurance policies generally provide coverage on an all-risk or a named-perils basis.

All-risk policies typically provide coverage for direct physical loss to covered property, subject to listed exclusions. To demonstrate the existence of the coverage under an all-risk policy, the insured is not required to demonstrate that the loss was caused by a peril that is specifically identified in the insurance policy. However, the insured generally carries the burden of demonstrating that a direct and physical loss occurred to covered property. If this burden is satisfied, the loss will be covered unless it falls within an exclusion clause. In general, the insurance company bears the burden of demonstrating that an exclusion clause applies.

Named-perils policies provide coverage for specifically listed risks, usually with a coverage grant for direct physical loss to covered property caused by a peril listed, unless the loss is excluded. This means that coverage exists if the loss, in addition to being a direct physical loss, is specifically listed in the perils specified by the insurance policy and does not fall within an exclusion clause. To obtain coverage, an insured must therefore identify a named peril that potentially provides coverage for the loss.

It is not uncommon for property insurance policies to provide all-risk coverage for some of the insured's property and named-perils coverage for other property.

### 21 How is property valued under first-party insurance policies?

**Calculation of the insurance value**

Where an insurance applicant and an insurer have agreed upon and specified the insurable value of the subject matter insured in the insurance contract, it shall be the standard for calculation of indemnity when losses occur to the subject matter insured. If the insurer can demonstrate that the agreed insurance value was determined owing to fraud or misunderstanding, the people's court could overrule such value, but this only happens in rare circumstances.

Where an insurance applicant and an insurer did not agree upon the insurable value of the subject matter insured when they entered into the insurance contract, the value of the subject matter insured shall be the actual value of the subject when losses occur, and such actual value should be assessed by a loss adjuster or another independent organisation.

The sum insured shall not exceed the insurable value. The part in excess shall be null and void, and the insurer shall refund the corresponding amount of the insurance premium to the insurance applicant.

Where the sum insured is less than the insurable value, the insurer shall bear an obligation for indemnity pro rata for the sum insured to the insurable value, unless it is otherwise provided for in the insurance contract.

### 22 Is insurance available in your jurisdiction for natural disasters and, if so, how does it generally operate?

Natural disaster risks are covered by most Chinese insurance products nowadays. Taking personal accident insurance as an example, the natural risks covered generally include, inter alia, earthquakes, tsunamis, hurricanes, floods, fires and lightning strikes. Loss caused by earthquakes or tsunamis is generally excluded in property all-risks insurances, although it may still be covered in additional risk insurances, but at a higher premium rate and within a strict scope of liability.

Natural disaster public liability insurance is a new type of insurance developed in recent years aimed at covering natural disasters. It is insurance whose contributions are made by local governments and is insured by insurance companies. Injuries and fatalities suffered by insured residents, which are caused by natural disasters such as storms, rainstorms, cliff collapses, lightning strikes, floods, tornadoes, squall lines, typhoons (tropical storms), tsunamis, debris flows, landslides and hail, are indemnified under natural disaster public liability insurance.

## Directors' and officers' insurance

### 23 What is the scope of D&O coverage?

Under the laws of the PRC, there are no specific provisions regarding D&O insurance, except for the Guiding Principles on Governing Listed Companies, which provide that a listed company may purchase liability insurance for its directors upon the approval of the general meeting of shareholders.

The parties to D&O insurance generally define D&O policy coverage as follows:

- the insurer will pay on behalf of the insured all loss resulting from a claim first made during the policy period against an insured, except for and to the extent that the company has indemnified the insured;
- the insurer will pay on behalf of the company all loss resulting from a claim first made during the policy period against an insured to the extent that the company has indemnified the insured; and
- the insurer will pay all legal representation expenses in respect of an investigation on behalf of the insured and all legal representation expenses paid by the company on behalf of the insured.

### 24 What issues are commonly litigated in the context of D&O policies?

Issues that are commonly litigated in the context of D&O policies are those where the insurance applicant does not make an honest disclosure about any pecuniary embarrassment or investigation by the government when he or she is concluding or renewing an insurance contract.

The disclosure obligation of the insurance applicant shall be limited to the scope and the content of the inquiry made by the insurer. If the concerned parties have any dispute over the scope and the content of the inquiry, the insurer shall bear the burden of proof. In addition, in the event that the insured is a listed company, the insurer may require the insured to make a disclosure even if this kind of information is published on the government's website or has entered the public domain.

If the insurer, after the conclusion of the insurance contract, knew or should have known that the insurance applicant failed to perform the obligation of honest disclosure but still collected the insurance premium, the concerned people's court shall not uphold the request made by the insurer for rescission of the contract based on the disclosure obligation of the PRC Insurance Law.

Liability under another jurisdiction potentially gives rise to further dispute. Where an insured is fined or a judgment made that it should pay damages in a foreign jurisdiction, the validity of the decree, verdict and rule issued by the foreign court or the foreign government will be contentious.

## Cyber insurance

**25 What type of risks may be covered in cyber insurance policies?**

According to The Interim Measures for the Supervision of the Internet Insurance Business (currently effective) issued by the CIRC (now CBIRC), insurance companies can operate cyber insurance business in the following areas:

- personal accident injury insurance, term-life insurance and whole-life insurance;
- household property insurance, liability insurance, credit insurance and surety insurance insured for applicants or insurants personally;
- property insurance business that could achieve full services of sale, underwriting and settlement of claims independently and completely online; and
- other insurance stipulated by CIRC.

According to the 2018 research report on Internet Property Insurance Users, issued jointly by the Insurance Association of China (IAC) Internet Insurance Alliance and IResearch, 32.8 per cent of such users most frequently buy automobile insurance policies that are at the top of the overall rankings. Fund account security insurance ranks in second place as most frequently bought by 20.5 per cent of users. In third place is medium-to-high-end medical insurance, which is most frequently bought by 14.3 per cent of users.

Experts and scholars are expecting the release of district restrictions on cyber dread disease insurance. However, in the Regulatory Measures on Internet Insurance (Draft) published by CBIRC in October 2018, cyber dread disease insurance is still excluded from being sold in districts, cities or provinces where the insurance company does not have any branches.

**26 What cyber insurance issues have been litigated?**

The most frequently litigated cyber insurance issues include:

- Whether the cyber insurance contract has been established. The court generally holds that an insurance contract could be established online. The key to the establishment of the insurance contract is whether the applicant and the insurer had unanimous declaration of will. The relevant cases are: *China Life Insurance Co Ltd, Linli Branch v He Renqiu, Accident Injury Insurance Contract Litigation* (No. 1397 Xiang 07 Minzhong, 2016) and *New China Life Insurance Co Ltd, Pingxiang Center Branch v Huang Shanqiu, Insurance Contract Litigation* (No. 93 Ping Miner Zhongzi, 2014).
- Whether the insurance company has properly reminded and explained the exemption clause in the insurance contract during the online underwriting process and performed its obligations regulated by the Insurance Law. The court holds that the insurance companies could operate cyber insurance businesses by entering into electronic insurance contracts, but shall obey Insurance Law and clarify the standard terms that would otherwise be invalid if exempting the responsibilities of the insurers. The relevant cases are: *Jiang Weiqing v Liu Juncheng and Ping An, Wenjiang Branch, Motor Vehicle Traffic Accident Liability Litigation* (No. 8021 Chuan 01 Minzhong, 2017), *Yuan Huaiyuan, Shen Huifen and etc v PICC, Ningde Branch, Accident Injury Insurance Contract Litigation* (No. 930 Min 09 Minzhong) and *Jiang Jilian, Li Dongyu and etc v PICC, Shenzhen Branch, Accident Injury Insurance Contract Litigation* (No. 691 Zhe Jia Minzhong Zi, 2015).

ANJIE LAW FIRM 安杰律师事务所

| | |
|---|---|
| **Zhan Hao** | **zhanhao@anjielaw.com** |
| **Zhang Xianzhong** | **zhangxianzhong@anjielaw.com** |
| **Wang Xuelei** | **wangxuelei@anjielaw.com** |
| **Wan Jia** | **wanjia@anjielaw.com** |
| **Yu Dan** | **yudan@anjielaw.com** |
| **Chen Jun** | **junchen@anjielaw.com** |

19/F, Tower D1
Liangmaqiao Diplomatic Office Building
No. 19 Dongfangdonglu
Chaoyang District
Beijing 100600
China
Tel: +86 10 8567 5988
Fax: +86 10 8567 5999

38/F, Tower 3
Kerry Plaza
No. 1-1 Zhongxinsi Road
Futian District
Shenzhen 518041
China
Tel: +86 755 8285 0609
Fax: +86 755 8285 0605

28/F, K.Wah Center
No. 1010 Huaihai Road (M)
Shanghai 200031
China
Tel: +86 21 2422 4888
Fax: +86 21 2422 4800

37/F, Tower 2, Lippo Centre
89 Queensway
Admiralty
Hong Kong
Tel: +852 3798 3298

www.anjielaw.com

**Terrorism insurance**

**27 Is insurance available in your jurisdiction for injury or damage caused by acts of terrorism and, if so, how does it generally operate?**

In 2004, the Jin Mao Tower in Shanghai, which used to be the highest building in China, was the first to purchase a terrorism insurance policy in the PRC. The People's Insurance Company of China underwrote the policy and provided a coverage of up to US$630 million, with US$150 million earmarked to cover the liabilities arising from terrorist activities.

In the PRC, insurance companies sometimes include terrorism as an additional risk under an insurance policy. Moreover, because there have been few terrorism incidents in the PRC, Chinese insurance companies have yet to develop a comprehensive system to process and settle claims for terrorism, and the Chinese insurance companies often exclude terrorism from coverage in insurance policies.

# Colombia

**Sergio Rojas**
**DLA Piper Martínez Beltrán**

## Preliminary and jurisdictional considerations in insurance litigation

### 1 In what fora are insurance disputes litigated?

In Colombia, disputes relating to insurance issues are carried out before the ordinary courts, as long as the parties involved are of a private nature. However, in the event that any of the parties involved in the conflict is of a public nature (ie, state entities), the dispute will be held before the administrative courts.

Nevertheless, if there is a valid arbitration agreement between the parties, the dispute will be held before arbitration proceedings, and there might either be a private or a public arbitration panel, depending on the nature of the parties in the conflict. In recent years, arbitration has played a key role in the resolution of major disputes relating to insurance issues and its use is becoming increasingly common.

Furthermore, with the adoption of Law 1328 of 2009 and Law 1564 of 2012, the existing disputes between an insurance company and a financial consumer may also be solved by the Colombian Financial Superintendency owing to its jurisdictional functions, provided that the controversies are related to the compliance with and enforcement of insurance contracts and not any additional aspects.

### 2 When do insurance-related causes of action accrue?

Determining whether an insurance-related cause of action accrues depends directly on the circumstances of specific cases that arise between parties. However, in general terms, the origin of the action is determined based on the insurance contract subscribed to between the parties, and whether the conflict is about the existence of said contract, its validity and interpretation or the effective enforcement of the obligations contained in such agreement. In other words, the relevant action (its kind and nature) and its admissibility depend on the petitioner's claims (eg, payment of the indemnification, a declaration of nullity by the insurer caused by a reticence on the part of the insured, the declaration of a contractual clause as abusive).

Whatever the type of intended action, it will always be essential to verify the statute of limitations associated with the action arising from the insurance contract, which ranges from two to five years depending on the applicable statute of limitations. It is important to take into consideration issues such as deductibles and the insured value of the corresponding policy.

### 3 What preliminary procedural and strategic considerations should be evaluated in insurance litigation?

When a dispute related to insurance is carried out at the civil courts (if the parties are of a private nature) or at the administrative courts (if at least one of the parties is public in nature), in some cases it may be necessary to perform an extrajudicial conciliation as a prior step, the purpose of which is to reach an agreement between the parties without the need to activate the judicial system.

Similarly, some arbitration agreements establish extrajudicial mechanisms that must be fulfilled before the commencement of the arbitration process, with the purpose of finding a solution to the dispute. Nevertheless, Colombian legislation states that performing those prior steps to arbitration is not mandatory for the parties, even in the case they have stipulated the fulfilment of the extrajudicial mechanisms in the arbitration agreement.

The strategies that should be considered will differ for the insurer and the insured. However, in general terms, it is important to consider the policy coverage, any exclusions, the parties' compliance with their duties as insured and insurer, the statute of limitations, any default interests and the deductibles.

In particular, it is imperative to check compliance with the statutes of limitation, given that the time periods in Colombia are not very broad. Additionally, it is crucial to review the manner in which judges have ruled in previous similar cases, as judges usually take into account judicial precedents when making a ruling in a dispute.

Finally, the parties should assess the costs associated with the process, and the terms or periods in which they are ruled in each jurisdiction, in order to determine, in terms of costs, the convenience of initiating and maintaining a process upon developing a comprehensive settlement.

### 4 What remedies or damages may apply?

Insurance contracts may provide coverage for costs and lost profits if this is what the parties expressly agree on. Additionally, material and moral damage might also be covered, depending on the will of the parties at the moment when the contract was subscribed.

In any case, as a general rule, the insurer's maximum liability is limited to the payment of the insured value and does not extend to the payment of higher or additional amounts.

However, when the insurer does not pay the indemnification within the provided period (one month from the moment at which the insured or beneficiary certifies an occurrence and the amount of the loss), Colombian law determines that the insurer shall pay to the insured a default interest certified by the Colombian Financial Superintendency, without prejudice to other damages arising from the contractual liability of the insurer.

### 5 Under what circumstances can extracontractual or punitive damages be awarded?

In Colombia, there are no punitive damages; the payment made by the insurer has a contractual origin and is limited, as a general rule, to the insured value, without prejudice of the payment of a default interest and of the consequential damages when the indemnification was not timely paid by the insurer, meaning within the month following the date on which the insured or beneficiary properly proves the occurrence and the amount of the loss.

## Interpretation of insurance contracts

### 6 What rules govern interpretation of insurance policies?

The rules governing the interpretation of insurance contracts are covered in articles 1618 to 1624 of the Civil Code, and in general terms establish the following:

- policies should be interpreted restrictively;
- particular conditions take priority over general conditions;
- the actual will of the parties is more important that the literal meaning of the words used;
- the interpretation of a clause that produces a useful effect must be preferred over an interpretation that produces no effect;
- the clauses of the contract must be interpreted in the sense that best suits the contract in its entirety (systematic interpretation); and

- ambiguous clauses are interpreted in favour of the debtor, but when an ambiguous clause has been drafted by a certain party, either the creditor or debtor, the interpretation will be against such party if the ambiguity is caused as a result of a lack of an explanation that must have been given.

### 7 When is an insurance policy provision ambiguous and how are such ambiguities resolved?

A contractual provision is ambiguous when it lacks sufficient clarity and when, once all the methods of interpretation set down in the Civil Code are applied, a doubt about the scope or the way in which such provision should be interpreted still remains, usually where the parties have different and opposite versions regarding the issue.

As mentioned in question 6, when a provision is ambiguous, article 1624 of the Civil Code must be applied, which establishes that such provisions must be interpreted in favour of the debtor, except in the event that such ambiguous provision was drafted by a certain party, either the creditor or debtor. In such case, the interpretation will be against such party if the ambiguity is caused because of the lack of an explanation that must have been given.

## Notice to insurance companies

### 8 What are the mechanics of providing notice?

In accordance with article 1075 of the Colombian Code of Commerce, the insured or beneficiary is obliged to inform the insurer of the occurrence of the loss within three days following the date on which it was known or should have been known. This term can be extended in the insurance contract, but it cannot be reduced.

The specific means to give notice to the insurer are those that are expressly agreed upon by the parties in the insurance policy, which usually refer to written communications, whether physical or electronic, taking into account that it seeks to ensure a greater effectiveness in the notice.

### 9 What are a policyholder's notice obligations for a claims-made policy?

Claims-made liability policies are permitted in Colombia in accordance with the provisions of article 4 of Law 389 of 1997.

Under these kinds of policies, a notice of loss should be performed within three days following the date on which the loss was known or should have been known by the insured, unless the policy establishes a longer term to perform such notice.

Additionally, claims-made policies usually include a provision that states that the insured has the obligation to inform the insurer of any circumstance that may result in a loss as soon as it becomes aware of it.

### 10 When is notice untimely?

Notice of the occurrence of a loss is untimely when it is performed outside the period established in the policy for such purpose or, if the contract does not regulate this aspect, when the notice is performed after three days following the date on which the insured had knowledge or should have had knowledge of the loss.

### 11 What are the consequences of late notice?

In accordance with article 1078 of the Commerce Code, if the notice regarding the occurrence of the loss was not performed in a timely manner, taking into account the term prescribed in the contract or the law in this regard, the insurer will be entitled to deduct the value of the damages caused because of such delay.

However, the insurer must sufficiently prove the damages and the amount that it intends to deduct; otherwise, such deduction may amount to an abusive conduct. It is not legally acceptable for the insurer to proceed with a damage deduction in an arbitrary manner without convincingly proving that the damages were caused and their amount.

In any case, the insurer is not allowed to refuse the payment of the indemnification based on an untimely notice of the loss, or to include in insurance contracts a provision establishing that a delay in a notice of the loss will automatically cause the insured or beneficiary to lose its right to receive an indemnification.

## Insurer's duty to defend

### 12 What is the scope of an insurer's duty to defend?

In Colombia, the duty to defend has no legal recognition; however, in some liability policies the parties agree that the insurer, in addition to paying the indemnification and defence costs, will also hire a legal professional chosen by the insurer to defend the interests of the insured and manage its defence.

In respect of liability policies, it is very common (in the local market) for the insurer to pay the defence expenses, approve the hiring of a lawyer chosen by the insured and manage its defence.

### 13 What are the consequences of an insurer's failure to defend?

If the duty to defend is contractually agreed upon and the insurer does not carry out such duty, this would be a breach of a contractual obligation. Consequently, the insurer would have the obligation to indemnify the insured for any damage caused by not fully complying with its duty.

In any case, as the insurer's duty to defend is not included in the Colombian legal system, if there is no contractual obligation in this regard, failure to defend would not be considered to be a breach of an insurance company's legal obligation.

## Standard commercial general liability policies

### 14 What constitutes bodily injury under a standard CGL policy?

The equivalent in Colombia of the CGL policy (the work premises and operations policy) covers the payment of damages caused by the insured (usually a company) due to a certain extracontractual civil liability incurred with respect to a third party, in accordance with the law.

Under these policies, bodily injury includes death, physical and psychological harm, including economic losses resulting from such damages.

Bodily injury is usually covered within the policy, and this is one of the protections most appreciated by financial consumers in the local insurance market.

### 15 What constitutes property damage under a standard CGL policy?

CGL policies consider destruction, damage or deterioration of a good to be property damage, as well as any economic loss that might arise as a consequence.

### 16 What constitutes an occurrence under a standard CGL policy?

Under CGL policies, an occurrence is a harmful event of a non-contractual nature attributable to the insured that happens during the policy period and that may give rise to a claim against it by a third party for which the insured is legally liable in accordance with the law. Such event is the subject of coverage under the policy.

However, under claims-made policies, occurrence means the claim presented to the insured or to the insurer by a third party, for the first time during the term of the policy, based on an extracontractual harmful event attributable to the insured that occurred during the policy period or during the retroactivity period.

Despite the above, it is common in Colombia for CGL policies to be issued under the occurrence form.

### 17 How is the number of covered occurrences determined?

The number of occurrences is defined in each policy in a particular manner; however, it is common to find policies offered in the local market where there is one single occurrence when the harmful event or events have a common cause, regardless of the number of claimants, claims and legally responsible people.

Despite the above, the policies available differ in how they define what should be understood by 'common cause', meaning that there is no uniform understanding in this regard.

In any case, the maximum liability limit of the insurance company, regardless of the number of occurrences that take place, as a general rule, is the insured value, and in that sense, the insurance company is not obliged to pay additional or superior amounts.

**18 What event or events trigger insurance coverage?**

The events that trigger the coverage are only and exclusively those that have been the subject of coverage by the policy, taking into account the terms and conditions of the contract.

As such, any event not covered by the policy or that specifically fits into any policy exclusions will not trigger coverage.

**19 How is insurance coverage allocated across multiple insurance policies?**

In accordance with articles 1092 to 1095 of the Commercial Code, insurance co-existence can happen when there is more than one insurer. The insured, his or her interest and the risk must all be identified in such case.

The insurers must pay the indemnification to the insured in proportion to the amount of their respective insurance contracts, provided that the insured has acted in good faith, otherwise the contract will be invalid.

The insured must also inform each insurer, in writing, of any insurance of equal nature that it takes out over the same interest with another insurer or insurers; otherwise the contract will be terminated, unless the joint insurance value does not exceed the actual value of the insured interest.

## First-party property insurance

**20 What is the general scope of first-party property coverage?**

First-party property coverage is a policy taken out by the insured to cover damages caused to his or her property. It refers to insurance contracts in which the indemnification is not received through a policy taken out by a third party but through the policy taken out by the actual policyholder, considering that the indemnification cannot be a source of enrichment and that the insurance contract is governed by the principle of maximum good faith on both sides.

Regarding first-party property policies, it is important to point out that in the local market, the policies that stand out the most are those with coverage for damages to insured vehicles under motor insurance, home insurance and certain policies of a corporate nature.

**21 How is property valued under first-party insurance policies?**

Under first-party insurance policies, the value of the insured property is normally determined by the insurance company through an inspection and appraisal procedure. In any case, it is taken into account that the eventual indemnification of the insured may not constitute a source of enrichment for him or her.

On the other hand, this kind of insurance takes into account, as a general rule, that the indemnification may not exceed the actual value of the insured interest at the time of the loss, and takes into consideration the rule of proportional payment in underinsurance cases in which the value of the interest has not been completely insured.

**22 Is insurance available in your jurisdiction for natural disasters and, if so, how does it generally operate?**

Insurances for natural disasters and, in general, catastrophe risks are available in Colombia. The general characteristics of this type of insurance include:

- Coverages usually included in all-risk material damages, home, debtor's life group and agricultural insurance.
- The risks generally covered refer to material losses caused by events such as earthquakes, floods, seaquakes, volcanic eruption and strong winds.
- From a technical point of view, it refers to products structured as catastrophe risks. The general trend in Colombia, especially regarding earthquakes, has tended towards amplifying technical reserves related to this kind of insurance in order to give this brand of insurances more sufficiency. Likewise, in 2017 the controlling entity released a list of modelling firms in order to model the losses estimated in case of an earthquake, a practice that became mandatory in 2011.
- Finally, it should be taken into account that this type of coverage has been developed particularly in the scope of debtor's insurance:
  - securing mortgaged properties from catastrophe risks;
  - horizontal property insurances;
  - cases in which such coverages are mandatory; and
  - agricultural insurances, in order to secure agricultural harvests.

**Update and trends**

***Representation and warranties policies***

The market has started to analyse the chances of implementing insurance policies that cover damages that may be suffered by one or more of the parties of a share purchase agreement when the contract's representation and warranties are breached. This is a novelty that most certainly shall initiate discussions regarding the nature of the policy, the company that should operate as insured and the one operating as beneficiary, and the scope of the coverage, among others.

The massive commercialisation of insurances through financial entities should also be a largely discussed topic. The Superintendence will have to check its restrictive position owing to the impact that it has generated upon the market.

Finally, liability procedures against the insurance companies based in the policies issued for public officers is also a trend. The General Comptroller of the Republic initiated different fiscal liability proceedings seeking for the reimbursement of public resources unlawfully subtracted by officers and, in the context of those procedures, insurance companies were associated because of the policies issued for the public entities. The legal and economic exposure derived from these procedures placed this topic as one of the main trends in 2018.

## Directors' and officers' insurance

**23 What is the scope of D&O coverage?**

D&O policies generally provide coverage to managers and directors of companies against any damages that they are forced to pay as a result of claims by third parties, presented for the first time during the policy period, due to negligent acts (in some cases, these are defined as improper acts) committed by the directors or officers in the performance of their duties during the policy period or during the retroactivity period.

Such policies work as liability policies issued in the claims-made form of coverage and, besides the basic protection they usually offer, may include additional coverage for, inter alia, defence expenses, judicial guarantees, costs for formal investigations, cover for claims for labour issues and corporate image expenses.

D&O policies have met with great success in the local market in recent years, and it is expected that their usage will increase even more in the future.

**24 What issues are commonly litigated in the context of D&O policies?**

Normally in D&O-related disputes, the issues discussed relate to the duties of the directors and officers as established in Law 222 of 1995: diligence, good faith and loyalty.

It is common to find that it is the company for which an insured director and officer provides his or her services that requests the indemnification payment due to a negligent act (improper act) committed by the insured director and officer in the performance of his or her duties. As such, it is more common that such claims are made by the companies that employ the managers and officers rather than independent third parties.

## Cyber insurance

**25 What type of risks may be covered in cyber insurance policies?**

In the Colombian market, cyber insurance is in the early stages of development, and it is only within the past five years that insurance companies have begun to develop products related to this kind of insurance. As such, there are currently not many options in the market for the insurance of cyber risks, as very few companies have developed such a product.

The risks that are normally covered in this type of policy are related to liability for the use and processing of data and arising from breaches of their safety.

These policies may also provide additional coverage, depending on the will of the parties at the time of subscription to the contract, and usually offer coverage related to reputational aspects.

It is expected that these kinds of policies will develop further in the future, especially regarding coverage offered to the financial sector.

**26 What cyber insurance issues have been litigated?**

As noted in question 25, these types of policies are not usual in Colombia, and this market is just emerging. To date, there have been no significant disputes in the courts in such matter.

**Terrorism insurance**

**27 Is insurance available in your jurisdiction for injury or damage caused by acts of terrorism and, if so, how does it generally operate?**

There is coverage for terrorism within the Colombian market. Such coverage is offered by insurance companies as an additional benefit in corporate multi-risk policies and material damages policies. In general, the coverage includes the destruction of goods and damages derived from terrorist attacks (acts or threats of violence that have as their main objective the terrorisation of state entities or the general population).

Because it is mostly considered an additional benefit, the terrorism coverage is often subjected to an autonomous cap for the indemnification (sum insured), which is different from the main sum insured; is often a coverage with a different deductible; and some of the consequential damages, such as lost profit, are often excluded.

**Sergio Rojas** **srojas@dlapipermb.com**

Carrera 7 No. 71- 21
Torre B, Oficina 602
Bogotá
Colombia

Tel: +57 1 3174720
Fax: +57 1 3173032
www.dlapipermb.com

# France

**Nicolas Bouckaert and Aurélia Cadain***
Kennedys

## Preliminary and jurisdictional considerations in insurance litigation

### 1 In what fora are insurance disputes litigated?

In France, insurance disputes are litigated in the following fora:

- first instance civil courts;
- first instance commercial courts;
- courts of appeal; and
- the French Supreme Court (the Court of Cassation).

Several factors are considered to identify which of the above fora has jurisdiction at first instance; namely, the identity of the parties (are the parties deemed to be commercial or civil entities?) and the amounts at stake (is the claim below or over €10,000?).

If all the parties involved are deemed to be commercial entities, the dispute must be brought before the commercial court that has territorial jurisdiction, regardless of the amount of the claim. It should be borne in mind, however, that commercial entities can choose to bring their disputes before another commercial court or indeed a civil court, provided they entered into a valid choice-of-jurisdiction clause.

If all the parties involved are deemed to be civil entities, the dispute must be brought before the appropriate civil court, which will depend on the amounts at stake: if the claim is for less than €10,000, the dispute must be heard by the county court (*Tribunal d'instance*), whereas if the claim is for more than €10,000, it must be brought before the High Court (*Tribunal de grande instance*).

If some of the parties to the dispute are deemed to be civil entities and others are deemed to be commercial entities, the rules are as follows:

- if the proceedings are initiated by the civil entity, it can either elect to bring its claim before the appropriate civil courts or the appropriate commercial courts;
- if, however, the proceedings are initiated by the commercial entity, it has no choice but to bring its claim before the appropriate civil court (and possible choice-of-jurisdiction clauses providing that disputes should be brought before commercial courts are without effect as they cannot be raised against civil entities).

Regarding the above, the following criteria should be borne in mind regarding the identity of the parties: natural persons and consumers are deemed to be civil entities; businesses and insurers are usually deemed to be commercial entities; and mutual insurance companies are deemed to be civil entities.

In all the instances described above, parties are obligated to attempt to solve their disputes amicably before they may initiate proceedings.

Alternative dispute resolution – including, but not limited to, arbitration – is an option, but only in certain circumstances (arbitration clauses, for instance, cannot be invoked against consumers).

Once a first instance decision has been rendered, the parties may initiate appellate proceedings, if they so wish, which does not require obtaining prior permission. The distinction between commercial and civil that exists at first instance disappears at the appellate level, as courts of appeal hear commercial and civil cases alike. A final appeal is then possible before the Court of Cassation, but only on points of law and provided this final appeal meets the Court of Cassation's admissibility criteria.

### 2 When do insurance-related causes of action accrue?

After a loss, the insured has a two-year time limitation period during which it can seek an indemnification from its insurer, in accordance with the terms of the policy at issue (the time limitation period, however, only starts to run from the moment the insured becomes aware of the loss).

If the indemnification of the loss gives rise to a dispute as to coverage and no amicable solution is found, the insured must initiate proceedings for specific performance against its insurer within the two-year time limitation period described above. It should, however, be noted that this time limitation period may be interrupted by the insured (by sending notice to the insurer via registered mail) and that it can only be successfully invoked by the insurer provided the policy at issue reproduces the sections of the French Insurance Code that governs the applicable time limitation and further indicates how the insured may interrupt it.

French insurance law also allows third-party victims to bring a direct action against the liability insurer of the liable party. In practice, therefore, third-party victims tend to simultaneously initiate proceedings against both the alleged liable party and its liability insurer, thereby creating a procedural situation where the liabilities of the insured and its liability insurer are ruled upon in the final judgment. The two-year time limitation period that applies to coverage disputes does not, however, apply to direct actions by third parties against insurers, in which case the applicable time limitation will depend upon the specific rights of the third-party claimant (by way of illustration, actions based in tort or contract law are time-barred after five years, and the applicable time limitation is of 10 years if the third party suffered bodily injury, although it only starts to run from the date its condition is deemed to have stabilised).

### 3 What preliminary procedural and strategic considerations should be evaluated in insurance litigation?

In a possible coverage dispute, two particular issues should be considered as a matter of priority, namely:

- Can the insurer produce a copy of the policy signed by the insured (or can it otherwise prove that the insured was made aware of the full contents of the policy)?
- Can the insurer rely on the questionnaire that was completed by the insured upon subscription?

As confirmed by unvarying case law, an insurer can only invoke specific clauses of the policy (such as exclusion clauses or coverage conditions) against the insured if it can prove that the insured was made aware of the full contents of the policy. If this is not the case, the insurer will not be in a position to successfully raise these clauses to the detriment of the insured however valid the said clauses might otherwise be. In practice, the most common method of proving that the insured was made aware of the full contents of the policy is to produce a copy of the policy that has been signed and initialled by the insured. Alternatively, if the insurer does not have this at its disposal, it would be free to use another method, provided it shows that the insured was made aware of the full text of the policy.

Since 1989, French insurance law has abandoned the spontaneous declarations regime, in favour of that of the insurance questionnaire. Since then, during the subscription phase, the prospective insured has

no longer been under an overriding duty to make spontaneous declarations as to the insurable risk, and merely has to respond to the questions found in the insurance questionnaire submitted by the insurer (mainly on the understanding that the insurer is best placed to identify the issues that are key when accepting or pricing the risk). In practice, this questionnaire potentially has far-reaching consequences, because it is solely on its basis that the insurer can deny or reduce coverage as a result of intentional or unintentional false declarations the insured may have made at subscription. It is, therefore, paramount that the insurer verifies that it possesses a copy of the questionnaire that has been completed and signed by the insured. It is, moreover, very important that the insurer then verifies that all the questions are sufficiently clear and precise, as unclear or generic questions are systematically set aside by French courts and may not be relied upon by the insurer.

If the insurer is contemplating bringing a subrogation claim against the liable third party, it must be particularly attentive to the gathering and preservation of evidence in the hours or days following the loss so as to safeguard its interests. In such instances, interim relief and urgent fact-gathering investigations can be sought and obtained quite rapidly by way of an interlocutory decision obtained from the court that has territorial jurisdiction.

### 4 What remedies or damages may apply?

In the instance of a coverage dispute, the insured would be seeking a judgment condemning the insurer to pay the indemnity owed under the policy (ie, specific performance). As French insurance law is, inter alia, built on the 'indemnification principle' (ie, the principle according to which insurance contracts must only provide indemnification for the loss suffered by the insured and not exceed this threshold), the specific performance sought by the insured is not susceptible to lead to a situation where it has been enriched, as a result of the loss and its indemnification under the policy.

While the insurer would not seek a remedy or damages from the insured, it could invoke applicable terms of the policy to try to limit its liability. The relevant clauses, which would have to be valid, could, for instance, set out a maximum coverage amount or a deductible, exclude certain types of risk or subordinate the effects of the policy to specific conditions (such as yearly technical maintenance operations or the presence of an alarm system connected to a remote surveillance service provider). If the insurer can prove that, upon subscription, the insured failed to provide truthful information regarding the risk, it can either invoke unintentional false declaration or intentional false declaration of the risk, as the case may be. Unintentional false declaration can lead to a proportional reduction of the indemnity owed (based on the premiums the insurer would have requested, had it been given a reliable description of the risk), while intentional false declaration leads to the policy being avoided – and the insurer keeping the premiums paid to date, which therefore become akin to damages.

Naturally, in the instance of a subrogation claim, the insurer may be awarded the damages the liable third party would otherwise have been condemned to paying to the insured (damages awarded to the insurer being capped at the amount of the indemnity it paid to the insured).

### 5 Under what circumstances can extracontractual or punitive damages be awarded?

It follows from the indemnification principle (see question 4) that insureds cannot be awarded damages that go beyond the indemnity that is provided in the policy, as this could lead to the insureds being richer than in the event the loss had never occurred. Specific performance of the policy therefore remains the main avenue available for the insureds.

Extracontractual or punitive damages are not, therefore, usually envisaged. While isolated judgments do, upon occasion, award damages that go beyond the indemnity provided in the policy, on the grounds of the insurer's contractual liability, this is rare and case law does not really enable one to extrapolate clear rules or criteria. Moreover, in instances where the insurer is usually judged to have acted in bad faith in attempting to avoid the policy, the damages are not, strictly speaking, punitive, in that they only aim to put the insured in the position it would have been in had the insurer respected its contractual obligations. In other words, the damages are not awarded to punish the insurer, nor can they lead to the insured being richer than in the event the loss and the insurer's ensuing behaviour had not occurred: the extracontractual damages only aim to provide the insured with compensation for the prejudice it has effectively suffered.

## Interpretation of insurance contracts

### 6 What rules govern interpretation of insurance policies?

The fundamental principle is, of course, respecting the will of the contracting parties. Therefore, if the policy is clear, it should not be interpreted by the courts, but merely applied (enforced). Judgments that interpret clear and unambiguous policies are consequently at very high risk of being overturned upon appeal.

If the policy is ambiguous and requires interpretation, parties and the courts can turn to the interpretation guidelines provided in the Civil Code (though it should be borne in mind that these are but guidelines and French courts are under no obligation to apply them). These rules are as follows:

- if the parties' common intentions cannot be deduced from the terms of the contract, the terms at issue must be given the meaning and effects a 'reasonable person' would give them;
- contracts are to be interpreted in their entirety, and clauses are not to be read independently from one another;
- similarly, contracts that concern the same operation should not be interpreted independently from one another, but together; and
- specific provisions prevail over general provisions.

The above guidelines could be taken into account by parties and French courts when interpreting a policy. There are, however, additional rules that are specific to the way an ambiguous policy would be interpreted (see question 7).

### 7 When is an insurance policy provision ambiguous and how are such ambiguities resolved?

French insurance law tends to have a pro-consumer and therefore a pro-insured slant. Ambiguous policy provisions are therefore often interpreted (or indeed set aside) in the way that is most favourable to the insured.

First, if the insured is a consumer, ambiguities must be interpreted in its favour by application of the relevant sections of the French Consumer Code.

Second, when the contract is non-negotiable and entered into by accepting standard terms proposed by the service provider (as would be the case for virtually all insurance policies entered into by consumers), ambiguities are interpreted in the way that is least favourable to the offeror (ie, the insurer).

Third, certain clauses that are specific and key to insurance policies, such as exclusion clauses, must be drafted in such a way as to be readily understandable by the insured upon first inspection (to avoid any doubt as to what is covered and, conversely, what is excluded from coverage), pursuant to the relevant sections of the French Insurance Code. Exclusion clauses that require interpretation are automatically set aside, as they are held not to be readily understandable, in violation of the imperative rules set out in the French Insurance Code.

## Notice to insurance companies

### 8 What are the mechanics of providing notice?

The mechanics of providing notice to the insurer after the occurrence of a loss are fairly free. Indeed, although the insured is under a legal obligation to notify its insurer of losses that are susceptible to give rise to an indemnity and to do so 'as soon as it is aware of their occurrence and, in any case, within the timeframe provided in the policy', French insurance law does not impose particular means of providing notice. The insured is therefore free to give notice via standard mail, email or over the phone (though this is obviously unadvisable, as it is sure to give rise to issues of proof of notice). Moreover, notice can be given by the insured's agent as well as to the insurer's agent.

Notice should, however, only be given (i) from the date the insured is aware of the loss and (ii) provided the loss is susceptible to give rise to an indemnity under the policy at issue.

**9 What are a policyholder's notice obligations for a claims-made policy?**

Claims-made policies do not impose specific notice obligations on the insured that would go above and beyond the standard notice obligations (see questions 8, 10 and 11) or that would replace them. Therefore, in a claims-made policy, the insured's notice obligation is that described in question 8.

As is the case in other jurisdictions, French insurance law provides that under a claims-made policy the insurer only owes its coverage if, upon subscription, the insured was not already aware of the circumstances that later gave rise to the claim at issue.

In claims-made policies, however, insurers and insureds can agree in the terms of the policy itself that during the life of the policy the insured will be under an obligation to notify the insurer of any and all factual circumstances that do not constitute a loss but are reasonably likely to give rise to a claim and, therefore, a loss, at a later date. If such a factual declaration is made during the life of the policy, and the underlying factual circumstances later give rise to a claim, then the date that is used to attach the loss to a given coverage period will be the date of the factual declaration rather than the date of the claim. This contractual mechanism is often found in claims-made policies as it offers advantages for both the insured and the insurer (ie, more transparency from the insurer's point of view, and more certainty as to coverage from the insured's point of view).

**10 When is notice untimely?**

As indicated above, the insured must provide notice as soon as it is aware of the loss's occurrence and, in any case, within the time frame provided in the policy (this rule applies to all but a few instances, such as hail damage or burglary, where it is French insurance law, rather than individual policies, that dictates the time frame within which notice must be given). Moreover, the French Insurance Code provides that the notice period provided in the policy cannot, in any case, be less than five days.

**11 What are the consequences of late notice?**

If such a sanction is provided in the policy, in the fashion prescribed by the French Insurance Code, and the insured's violation of its obligation causes a prejudice to the insurer, late notice can give rise to a forfeiture of coverage.

In practice, however, it is quite rare that late notice leads to such sanctions.

Indeed, for the insurer to successfully raise forfeiture of coverage, the following conditions need to be met, on the facts:

- the policy clause that sets out the legal duty to provide notice within a timely fashion and provides that failure to do so will give rise to forfeiture of coverage needs to meet certain layout requirements (eg, it needs to be in bold, in capital letters or underlined) so as to stand out compared with neighbouring clauses;
- the insurer needs to prove that the delay has caused it to suffer a prejudice (for instance, it prevented the insurer from participating in court-appointed investigations or safeguarding its interests in the context of a possible future subrogation claim); and
- the insurer must produce a signed and initialled copy of the policy, or otherwise prove that the full text of the policy was brought to the insured's attention, as it will not otherwise be in a position to invoke the policy's coverage forfeiture clause against the insured (see question 3).

## Insurer's duty to defend

**12 What is the scope of an insurer's duty to defend?**

French insurance law does not impose a generalised and overriding duty to defend upon insurers. Policies can, however, include clauses that provide that the insurer has a contractual right or, in certain cases, a contractual duty to defend its insured.

Proceedings management clauses (*clauses de direction du procès*) give the insurer the option to assume control over the way its insured will run its defence, should it so wish.

Incidentally, caution must be exercised by insurers when they decide to assume control over the insured's defence, as by doing so, the insurer is deemed to have waived the right to invoke certain policy terms against the insured at a later date (for instance, exclusion clauses). This rule is, however, subject to certain qualifications: (i) the waiver does not concern all of the policy's terms; and (ii) the waiver can be set aside if, upon taking control of the insured's defence, the insurer makes the relevant reservations of rights (which have to be precise and as detailed as possible, rather than constitute boilerplate clauses, and have to be reiterated in all exchanges with the insured).

Legal assistance clauses (*clauses de défense recours*), on the other hand, give the insurer the obligation of defending its insured, if the insured elects to use it. In that respect, proceedings management clauses and legal assistance clauses are different in that the former is usually tied to a civil liability cover (whereby the insurer may ultimately be compelled to provide an indemnity as a result of the insured being found liable), whereas the latter is, in fact, an autonomous cover.

There are also more comprehensive, autonomous legal protection insurance contracts (*assurance de protection juridique*) that require the insurer to provide more substantial legal support, but we will not discuss them in greater detail, as they fall outside of the scope of this overview.

**13 What are the consequences of an insurer's failure to defend?**

As indicated above, there is no general duty for insurers to defend their insureds.

If, however, an insurer is bound by a legal assistance clause but nevertheless fails to defend its insured when called upon, it would be in violation of its contractual obligations and would consequently expose itself to being condemned on the basis of contractual liability.

## Standard commercial general liability policies

**14 What constitutes bodily injury under a standard CGL policy?**

French civil law and French insurance law defines bodily injury as any harm to or unwanted alteration of a victim's body.

Bodily injury encompasses the injury itself, but also the financial and non-financial prejudices that follow the said injury, which are, inter alia, evaluated by reference to a non-binding legal nomenclature called the 'Dintilhac nomenclature', which lists the types of prejudices victims can claim for as a result of bodily injuries: temporary financial prejudice (eg, hospital fees), permanent financial prejudice (eg, permanent loss of revenues), temporary non-financial prejudice (eg, pain and suffering), permanent non-financial prejudice (eg, handicaps). Moreover, moral prejudice (which is distinct from pain and suffering) can also be claimed for as a result of bodily injury, as can the prejudices suffered by indirect victims (usually the victim's family).

**15 What constitutes property damage under a standard CGL policy?**

Standard CGL policies tend to define property damage in a fairly straightforward way as harm to or loss of a third party's tangible property, objects, substances or animals. Consequential losses, such as loss of revenue or business interruption loss, for instance, would not be covered.

**16 What constitutes an occurrence under a standard CGL policy?**

CGL policies governed by French law will either function on a claims-made or a damaging-event basis. In a claims-made policy, the third party's claim constitutes the occurrence, whereas in a damaging-event policy, it is the occurrence of the damaging event that caused the loss suffered by the third party that constitutes the occurrence.

**17 How is the number of covered occurrences determined?**

In France, CGL policies will usually provide that each individual loss constitutes a separate occurrence. In such a case, the total amount the insured can receive by way of a succession of indemnities for several occurrences of the same risk within a given period will therefore depend on: (i) the deductible applicable to each occurrence; (ii) possible per-occurrence limits; and (iii) a total indemnity limit for the risk at issue.

Certain policies may contain loss aggregation clauses, whereby various losses generated by a common cause are treated as a single occurrence, which may, on the facts of a given succession of losses, be more favourable to the insured or the insurer (depending on the prejudice caused by the losses, the deductible and possible per-occurrence limits). Given the financial impact aggregation clauses can have for both the insured and the insurer, they frequently generate coverage disputes.

**Update and trends**

The European directive 2016/97 of 20 January 2016 on insurance distribution was transposed in mid- to late 2018, thereby greatly increasing insurance distributors' duties and obligations. This development could, in the foreseeable future, lead to more disputes and interesting case law relating to insurance distribution.

Similarly, on 25 May 2018, the European Regulation 2016/679 on General Data Protection came into force. As the framework created by this regulation significantly increases businesses' duties and obligations in the way they collect, handle and use personal data, it may also generate new types of disputes, which could have an impact on liability policies and cyber policies.

**18 What event or events trigger insurance coverage?**

See question 16. Depending on the type of policy, coverage will either be triggered by a claim or the damaging event.

**19 How is insurance coverage allocated across multiple insurance policies?**

As French insurance law is, inter alia, built on the indemnification principle (see question 4), it governs a multiplicity of coverage situations in such a way that the insured should only receive compensation for the loss effectively suffered and should not make a net financial gain as a result of being in a position to claim for the same loss under several policies.

If, therefore, the insured entered into several analogous or overlapping policies in good faith (and without a view to making a profit in the event of a loss), there are no sanctions and the insured can claim for the entire loss from whichever one of its insurers he or she chooses – and French insurance law provides a mechanism whereby the said insurer will, in turn, have the possibility of seeking contributions from the other insurers on risk.

If, however, the insured entered into multiple insurance contracts fraudulently (ie, so as to make a financial profit in the event of an insurable loss), the contracts at issue will be deemed null and void and the insured can face claims for damages.

## First-party property insurance

**20 What is the general scope of first-party property coverage?**

First-party property insurance indemnifies the policyholder (or, if applicable, the additional insureds) for the damage to or loss of property. As such, first-party property insurance policies can cover a very wide range of types of property, such as real estate, fine art or animals.

The scope of first-party property insurance policies can either be defined by the property insured or the types of risks that are insured against. Policies can either be drafted according to a named-risk model (eg, 'this policy only covers the insured's property against damage caused by water damage, fire, hail'), or according to an all-risks-but model (eg, 'this policy covers the insured's property for damage caused by all types of risks except landslides, water damage').

Individuals are habitually free to decide whether or not to take out property insurance, but certain types of property insurance are legally mandatory, such as the obligatory insurance that a tenant has to take out for the property he or she is renting. Moreover, pursuant to provisions to that effect in the French Insurance Code, insurance cover granted for certain types of risks is automatically expanded by law (by way of example, property insurance providing coverage against fire and other risks automatically also provides coverage for damage caused by natural disasters; see question 22).

Finally, damage to the insured property that is caused by an inherent defect of the said insured property is excluded from coverage, unless otherwise agreed in the policy.

**21 How is property valued under first-party insurance policies?**

The methodology used to evaluate the damage and the ensuing indemnity is usually provided in the policy, which will also contain terms that will have an impact on the final amount of the indemnity (deductible, limits per types of risk or total limit for the insured property, etc). Usually, if the loss is partial, the indemnity is calculated by reference to the cost of repairs, whereas if the loss is total, it may be calculated by reference to the commercial value or the use value, depending on the nature of the insured property.

In property insurance, the damage has to be evaluated as at the date of the loss itself.

In accordance with the indemnification principle, first-party property insurance cannot give rise to the payment of an indemnity that exceeds the loss suffered by the insured and therefore leads to a financial gain.

Unless the policy provides otherwise, the insured is free to use the indemnity in whichever it pleases and is under no obligation to allocate it to repairing or replacing the damaged property.

First-party property insurance contracts can also provide additional coverage for consequential losses, such as business interruption losses.

**22 Is insurance available in your jurisdiction for natural disasters and, if so, how does it generally operate?**

Until 1982, French insurance law considered natural disasters to be uninsurable.

On 13 July 1982, a law was passed to create a special legal regime intended to remedy this situation and ensure that the greatest possible number of people would de facto have insurance against natural disasters by providing that property insurance taken out in connection with property located in France was automatically deemed to extend coverage to natural disasters (similarly, policies covering business interruption losses were automatically extended to cover such losses in the instance that they were caused by natural disasters). Furthermore, this coverage extension, which is automatic and de jure, cannot be excluded under the terms of the policy.

The French Insurance Code defines natural disasters as natural phenomena whose intensity is abnormal. For a particular event to be qualified as such, a Ministerial Decision has to be handed down (it follows that the two-year time limitation period only starts to run from the date of this decision, rather than the date of the event itself).

To be covered, damage must be deemed to have been directly and overwhelmingly caused by a natural disaster.

Premiums and deductibles for these automatic coverage extensions are provided in relevant sections of the French Insurance Code (or calculated according to formulas provided in it).

## Directors' and officers' insurance

**23 What is the scope of D&O coverage?**

D&O insurance is not compulsory in France and companies that systematically take out D&O insurance tend to be public listed companies among the biggest capitalisations. As a result, D&O policies tend to be somewhat bespoke, rather than standardised policies, so that it is difficult to make general comments as to market practice.

D&O policies are liability policies taken out by companies for their directors and officers (which creates a situation where the policyholder and the insured are not one and the same). As a general rule, they are drafted in an all-risks-except format. They usually provide coverage for: (i) legal costs in the event that proceedings or investigations are initiated against a director or officer; and (ii) damages or sanctions awarded against the said director or officer (though criminal sanctions and fines are, by definition, uninsurable under French insurance law).

The risks that are habitually covered are:

- mismanagement;
- failure to abide by legal or regulatory obligations;
- directors and officers acting ultra vires; and
- claims against directors to hold them liable for their companies' liabilities (in instances where companies enter into winding-up proceedings and are deemed to have disproportionate liabilities because of mismanagement).

Apart from the criminal sanctions and fines alluded to above, other risks are excluded, such as intentional wrongdoing (*faute intentionnelle*), misappropriation of corporate assets, and certain fiscal sanctions and fines.

The French D&O market is generally regarded as healthy and growing, in part because of the sense of heightened legal uncertainty that results from seemingly ever-expanding domestic and international regulations and compliance obligations.

**24 What issues are commonly litigated in the context of D&O policies?**

D&O coverage disputes tend to be fairly fact- and policy-specific, given the fact that D&O policies are not standardised policies (see question 23) and terms and wordings may vary significantly from one policy to the next.

Certain issues do, however, tend to arise more frequently, such as:

- whether the director or officer claimed against is deemed an insured under the policy (especially in large international companies, which tend to have vast numbers of subsidiaries, frequently buy and sell companies, and have continuously evolving management staff);
- whether a given risk is covered (for instance, when official investigations are initiated against a director, it can take a significant amount of time before he or she is formally informed of the precise grounds on which he or she may be found liable);
- the extent of coverage (covered legal costs, for instance, are sometimes only defined as 'reasonable legal costs' and policies do not always clearly indicate if legal costs are covered in certain extra-judicial matters, such as investigations); and
- coverage disputes between the primary and excess insurers (especially in connection with the D&O insurance programmes of large multinational companies) regarding how their respective layers dovetail.

## Cyber insurance

**25 What type of risks may be covered in cyber insurance policies?**

Cyber insurance is still relatively new in the French market. Cyber insurance policies are not, therefore, particularly standardised and, at present, only the biggest public-listed companies systematically take out cyber insurance. It is, however, a growing segment, because of the increasing types and occurrences of cyber losses or attacks and the media coverage it generates.

Cyber insurance policies cover both damage caused by and liabilities resulting from cyber attacks or other cyber-related incidents. Risks that are generally covered are data losses and business interruption losses, though other types of prejudice may also be covered, such as costs of system decontamination and ransomware.

Regarding data loss coverage, it should be noted that only the cost of the reconstitution of the data is covered and not the value of the data. Moreover, data loss coverage will usually be subject to certain exclusions, such as instances where the insured has no backup policy or mechanisms in place or instances where the loss of data is the result of a regulatory authority ordering its destruction.

Business interruption coverage can sometimes be triggered by both complete or partial business interruptions caused by cyber risks (note that during the NotPetya attack, St Gobain reported a loss of €250 million caused solely by the slowing down, rather than the interruption, of its operations). However, policies usually provide a deductible period, during which coverage will not apply.

The liability coverage provided by cyber policies covers the insured's liability, in the instance that its conduct or internal processes regarding IT and cyber matters cause prejudice to a third party, as well as the insured's defence costs, whether in the event of a third-party claim or in the event of an investigation (sanctions are, however, excluded from the scope of coverage, as they are uninsurable as a matter of public policy).

**26 What cyber insurance issues have been litigated?**

It is too early to say: because cyber insurance still isn't widely subscribed in France, cyber insurance policies have not yet given rise to coverage disputes of note. Moreover, insureds are understandably keen that cyber losses not be overly publicised, which may tend to promote confidential settlements, rather than court proceedings, in instances where coverage disputes arise. As a result of these two factors, for the time being, most cyber coverage disputes effectively revolve around instances where insureds try to trigger the 'silent cyber coverage' arguably found in first-party property damage insurance (ie, such policies that are drafted on the all-risks-except format but do not exclude cyber risks). While these disputes cannot, by definition, enable us to identify cyber-policy coverage disputes and trends, they do highlight the risks associated with silent coverage and the need to consider the possible and unwanted overlap between dedicated cyber policies and garden variety property damage policies, which could be a source of disputes in times to come.

## Terrorism insurance

**27 Is insurance available in your jurisdiction for injury or damage caused by acts of terrorism and, if so, how does it generally operate?**

As a reaction to the wave of terrorist attacks France suffered in the early to mid-1980s, in 1986 French insurance law was modified to include a coverage extension mechanism analogous to that which had been created earlier that decade in relation to natural disasters (see question 22). Since 1986, property insurance that provides coverage against fires has been extended to automatically cover damage caused by acts of terrorism. The relevant section of the French Insurance Code provides that property damage caused by acts of terrorism and consequential losses caused by the said property damage are covered according to the policy terms (deductibles, limits, etc) that apply to fire.

Moreover, if an insured has business interruption loss insurance, it automatically covers business interruption losses that stem from acts of terrorism.

The regime summarised above cannot be excluded under the terms of the policy.

Since 2001, the above-summarised regime has been modified somewhat and been rendered more flexible with regard to large-risks insurance.

Bodily injuries caused by acts of terrorism are, for their part, indemnified by a purpose-built public fund.

* *The authors are grateful to Sébastien Tadiello for his assistance in the preparation of this chapter.*

Kennedys

**Nicolas Bouckaert** **nicolas.bouckaert@kennedyslaw.com**
**Aurélia Cadain** **aurelia.cadain@kennedyslaw.com**

31 rue de Lisbonne
75008 Paris
France

Tel: +33 1 84 79 37 80
Fax: + 33 1 45 63 61 72
www.kennedyslaw.com

# Germany

**Fabian Herdter and Christian Drave**
**Wilhelm Rechtsanwälte**

## Preliminary and jurisdictional considerations in insurance litigation

### 1 In what fora are insurance disputes litigated?

Insurance disputes are litigated before civil courts. The competent court of the first instance is the competent local court for claims up to €5,000 and the competent district court for claims exceeding €5,000. The court of the second instance is the Court of Appeal. In the last instance, the German Federal Court of Justice may hear insurance cases if, for example, the case is of general legal relevance.

Generally, the claimant must bring its insurance case to the local court or district court at the domicile of the defendant. The insured may, however, at its choice also file suit against the insurer at the domestic district of the insured. As a rule, the parties cannot derogate this forum to the detriment of the insured before the dispute arising.

Commercial insurance contracts may refer insurance disputes to the courts of a certain district through jurisdiction clauses or to arbitration by agreement. German law generally respects arbitration agreements in commercial insurance contracts.

Insured consumers may also bring insurance claims not exceeding €50,000 to the insurance ombudsman. The decision will be binding upon the insurer if the claim does not exceed €10,000; otherwise, such decision is merely advisory. Any decision against the insured will not be binding.

Most of the ombudsman's decisions are delivered within three months. Filing the application will prevent the consumer's insurance claim from becoming time-barred.

### 2 When do insurance-related causes of action accrue?

Insurance-related causes of action usually accrue when the insurer refuses to provide cover under a certain policy and the insured believes that it has a valid coverage claim. This is often the case if the insurer:

- disputes that there was an insured event triggering the policy (the insured event must be determined according to the respective policy wording and may vary);
- relies on exclusions from cover;
- argues that the insured did not comply with its obligations (eg, did not provide the information necessary for the insurer to determine whether a claim is covered); or
- disputes the amount of the claim or loss.

Coverage disputes may arise at any time when the above scenarios occur. From the insured's perspective, it is crucial to note that it has to duly notify its claim (see question 8) and that its coverage claim may become time-barred. A general limitation period of three years also applies to insurance claims. The limitation period generally commences at the end of the year in which the insured's coverage claim arose and the insured obtained knowledge of the circumstances giving rise to the claim (or would have obtained such knowledge if it had not shown gross negligence).

### 3 What preliminary procedural and strategic considerations should be evaluated in insurance litigation?

Any insurance litigation is determined by the facts of the matter, the applicable law and the policy terms, and these should be considered carefully. In light of these main aspects, the following preliminary procedural and strategic considerations should be evaluated in insurance litigation:

- which law is applicable to the insurance matter according to the policy terms and statutory provisions;
- when, at the latest, and how the claim must be notified to the insurer and any co-insurer;
- when the insurance claim becomes time-barred, and when at the latest any judicial action must be taken;
- whether the claim must or should be referred to arbitration;
- which civil court is competent to hear the case. In cases where the claimant may choose between several competent courts, the most convenient forum needs to be chosen;
- whether the insured should try to pursue its claim by way of out-of-court negotiations to achieve a lump-sum agreement, or whether the parties may agree on alternative dispute resolution;
- regarding the costs that potential procedural ways to pursue the claim will possibly cause, the most cost-efficient way should be chosen. German procedural law requires an advance payment of court fees upon filing of the matter. As a rule, the losing party bears the legal costs of the winning party plus court fees. Recoverable legal costs are calculated by statute and depend on the amount in dispute. A winning party may not be able to recover all its costs (eg, in cases where its attorneys' fees are based on hourly rates that exceed the amount that it can recover by statute);
- the amount of time possible procedures may take (eg, civil trial of possibly three instances, arbitration);
- whether the claim is also covered by another insurance contract (multiple insurance);
- whether evidence must be secured (eg, by experts, witness statements);
- with respect to consumer policyholders, whether an application to the Insurance Ombudsman is suitable; and
- what obligations the insured has to comply with after the insured event took place (deriving from the policy and the applicable law). For example, pursuant to section 86 paragraph 2 Insurance Contract Act, the insured is obliged to secure any possible recourse claim against a third party that initially caused the loss. If, for example, a tortfeasor causes the insured's house to burn down, the insured has a liability claim against the tortfeasor. If the fire insurer compensates the insured, the insured's liability claim against the tortfeasor will pass over to the insurer ipso jure. In order to secure the insurer's recourse action against the tortfeasor, the insured is obliged to cooperate. The insured may aim for a quick settlement with the tortfeasor before the insurer pays any compensation. If the insured wants to accept partial payment by the tortfeasor, it will thereby reduce the claim that passes over to the insurer upon payment under the policy. The insurer may therefore deny cover. Thus, the insured should try to obtain the insurer's consent before the settlement.

### 4 What remedies or damages may apply?

**Insured's remedies**

In the event that the insurer refuses to provide cover, the insured may claim for performance according to the policy terms.

If the insurer breaches its contractual duties under the policy, the insured can claim any loss caused by a breach of contract by the insurer.

In cases of late payment, the insured may claim interest from the insurer. The statutory interest rate is 5 percentage points above the interest base rate. Pursuant to section 14, paragraph 1 of the Insurance Contract Act, the insurer must indemnify the insured when enquiries necessary to establish the occurrence of the insured event and the extent of the insurer's liability have been concluded. If these enquiries take longer than one month after notification of the claim, the insured is entitled to claim part payment in the amount that it may at the least be expected to claim. Disputes may arise as to when the insured can claim payment or – as the case may be – part payment from the insurer.

**Insurer's remedies**

As the most relevant remedy under German insurance law, the insurer may refuse to perform under certain prerequisites. The insurer is released from liability for any claim if the insured intentionally caused the insured event (in liability insurance: if the insured intentionally caused the loss suffered by the third party). The insurer is further released from liability if the insured intentionally breached a statutory or contractual obligation. If the insured breached the obligation recklessly (gross negligence), the insurer is entitled to reduce its payment by a proportion corresponding to the severity of fault. The insurer remains fully liable if the violation by the insured was only negligent (simple negligence). However, for a release of the insurer from liability, the insured's violation has to be relevant to the occurrence of the insured event or the extent of the insurer's liability. If the insured event would have occurred even without the breach of an obligation, the insurer remains liable for the claim. If the insured breaches an obligation, the court will generally assume that the obligation was violated recklessly. To be fully released from liability, the insurer must prove intentional violation of the obligation. In contrast, the insured must prove that it acted merely negligently to achieve full indemnification.

In the case of non-disclosure of a material circumstance by the insured, German insurance law allows the insurer to terminate the contract and avoid paying future claims by giving one month's notice (in cases of no more than simple negligence), or to withdraw from the contract and treat the contract as void ab initio (in cases of at least gross negligence). Notwithstanding its withdrawal, the insurer may still be obliged to pay a claim if the non-disclosed circumstance is not responsible for the occurrence of the insured event that gave rise to the claim or for the extent of the insurer's liability. In cases of fraudulent misrepresentation, the insurer can avoid the contract and retain the premium paid.

### 5 Under what circumstances can extracontractual or punitive damages be awarded?

German law does not acknowledge punitive damages. Extracontractual damages are rarely subject to German insurance litigation.

## Interpretation of insurance contracts

### 6 What rules govern interpretation of insurance policies?

General principles of contract interpretation also apply to insurance policies. Most insurance contracts are based on standard terms provided by insurers. The interpretation of standard terms is governed by special rules pursuant to the laws on general terms and conditions (section 305 et seq German Civil Code). Mainly, the following key principles apply:

- generally, words shall be given their natural meaning. As a special rule, judicial phrases shall be given their judicial meaning rather than their natural meaning, provided that a clear and consistent judicial meaning of the phrase exists;
- any provision that the parties individually negotiated on shall prevail over standard terms and shall generally be given the meaning that the parties intended;
- insurance policy standard terms shall be interpreted from an objective perspective. The individual understanding of the parties is not decisive. Rather, the courts will establish what meaning the provision has to a reasonable insured without any special knowledge of insurance matters given the wording and context of the policy. It must be noted, however, that single aspects of interpretation are disputed in this context;
- as to the insurer's standard terms, the courts may hold provisions invalid if they unreasonably disadvantage the insured, thereby violating the requirement of good faith. For example, this may be the case if a provision deviates from the essential provisions of the law to the detriment of the insured; and
- certain provisions of the Insurance Contract Act are mandatory. Certain provisions are mandatory to the benefit of the insured only. This means that the parties cannot deviate from the provision to the detriment of the insured. Any provision agreed to the contrary is invalid. The invalid provision is replaced by the respective provision of the Insurance Contract Act.

### 7 When is an insurance policy provision ambiguous and how are such ambiguities resolved?

An insurance policy provision is ambiguous if the interpretation, in accordance with the rules of contract interpretation (see question 6), shows that the provision may have more than one meaning and none of the meanings clearly overrules the others. If an ambiguous provision is part of the standard terms, the provision will be interpreted against the party that drafted the provision (section 305c, paragraph 2 of the German Civil Code). If, for example, a policy provision is utterly unclear to the detriment of the insured, it may be deemed null and void and therefore to form no part of the policy. The policy will then be construed in accordance with the Insurance Contract Act.

## Notice to insurance companies

### 8 What are the mechanics of providing notice?

Pursuant to section 30, paragraph 1 of the Insurance Contract Act, the policyholder shall notify the insurer of the occurrence of the insured event without undue delay after it has learned thereof. Notice should also be made by a third (insured) party as far as the third party is entitled to the right to obtain compensation.

Notice can generally be made orally or in writing, although most policies require notice to be in writing.

### 9 What are a policyholder's notice obligations for a claims-made policy?

There is no statutory law providing special requirements for a claims-made policy. In most claims-made policies, the insured has to give written notice without undue delay after the claim is made.

### 10 When is notice untimely?

There is no exact time limit after which a notice is deemed untimely or delayed. In general, the policyholder has to give notice without culpable delay, that is, within three days of the insured event occurring. In liability insurance, the policyholder shall be obligated to disclose to the insurer within one week those facts that could give rise to its responsibility in relation to a third party (section 104, paragraph 1 of the Insurance Contract Act).

### 11 What are the consequences of late notice?

The consequences of giving late notice generally depend on the gravity of fault (see question 4). The insurer is released from liability for any claim if the policyholder has intentionally breached its statutory or contractual obligation. If the policyholder breached the obligation recklessly (gross negligence), the insurer is entitled to reduce its payment by a proportion corresponding to the severity of fault. However, the insurer remains fully liable if the violation by the policyholder was negligent (simple negligence). Negligent violations are, therefore, without legal effect.

The violation (late notice) needs to be relevant to the extent of the insurer's liability to release the insurer from payment, that is to say, that the late notice of the policyholder essentially complicated the insurer's enquiries necessary to establish the extent of the insurer's liability. The burden of proof for such missing causality remains on the policyholder. However, this principle does not apply in the case of fraud, where the insurer is generally fully released from liability.

If the duty to give notice is in dispute, the court will generally assume that the duty to give notice has been violated recklessly. To be fully released from liability, the insurer must prove intentional violation of the duty. In contrast, the policyholder must prove that it acted merely negligently to achieve full indemnification.

## Insurer's duty to defend

### 12 What is the scope of an insurer's duty to defend?

Pursuant to section 100 of the Insurance Contract Act, in the case of liability insurance, the insurer shall be obligated to release the policyholder from any claims asserted by a third party on the basis of the policyholder's responsibility and to fight off unfounded claims. The insurance shall also cover the judicial and out-of-court costs arising from claims asserted by a third party insofar as the circumstances necessitate the expenditure. Further, the insurer generally covers expenses incurred on the instruction of the insurer for defence in criminal proceedings if such proceedings could result in the policyholder becoming liable in relation to a third party. At the policyholder's request, the insurer shall advance the costs.

### 13 What are the consequences of an insurer's failure to defend?

In general, the consequence of an insurer's failure to defend is a breach of contract on the side of the insurer. The insured is then entitled to file a declaratory action or even to sue performance in cases where the policyholder advanced costs.

## Standard commercial general liability policies

### 14 What constitutes bodily injury under a standard CGL policy?

Standard CGL policies in Germany issued to business organisations provide cover resulting from the statutory liability of the insured for personal injury and property damages. Cover for personal injury is provided in the event of death, wounding or other bodily injury.

### 15 What constitutes property damage under a standard CGL policy?

Property damage under a standard CGL policy is established by the occurrence of an insured event resulting in the damage or destruction of property (material damage).

### 16 What constitutes an occurrence under a standard CGL policy?

The insurer will provide the policyholder with insurance cover in the event that a loss occurs during the period of the insurance. Loss occurrence is the event directly resulting in the injury or damage to the third party. The event directly resulting in the injury or damage to the third party often occurs at a later point in time than the event that set the first causal link to the later damage.

### 17 How is the number of covered occurrences determined?

According to German statutory law, there exists no special provision that determines the number of covered occurrences. It is rather at the discretion of the parties to determine the number of covered occurrences and to agree on the amount insured. Depending on the specific insurance or industrial branch, or both, many different insurance concepts in the market have to be examined on a case-by-case basis.

### 18 What event or events trigger insurance coverage?

Statutory law does not define what event triggers insurance cover in a standard CGL policy. The insurer will provide cover in accordance with the terms and conditions of the policy (subject to relevant exclusion clauses).

Therefore, the parties are basically free to define the event that triggers insurance coverage in a CGL policy. In most CGL policies, the event of loss occurrence (see above) triggers coverage. However, in some policies the parties may agree on the event of claims being made as a trigger for coverage.

### 19 How is insurance coverage allocated across multiple insurance policies?

Multiple insurance is identified if one interest is insured against the same risk with several insurers (section 78, paragraph 1 of the Insurance Contract Act). In such a case, the multiple insurers are liable as joint and several debtors in such a manner that each insurer must pay the sum in accordance with its contract, but the policyholder cannot demand more than the total amount of the loss.

With regard to the internal compensation of the insurers, they are liable to pay in proportion to the amounts for which they are liable in accordance with each respective contract. If foreign law is applicable to one of the insurances, the insurer to whom the foreign law applies may only assert a claim for compensation against the other insurer if it is itself liable to pay compensation under the relevant law (section 78, paragraph 2 of the Insurance Contract Act).

Insurance contracts often contain simple or qualified subsidiary clauses. These clauses have the purpose of limiting the insurer's liability in cases of multiple insurance. The insurer has the intention to rank its own liability and those of other insurers insuring the same risk in order to be liable only in the second degree in case of an insured event. Policyholders should carefully review subsidiary clauses in order to avoid legal uncertainty or even coverage gaps. If the insurer denies coverage under an already existing contract due to a subsidiary clause, policyholders should examine whether the employed clause complies with the laws on general terms and conditions (section 305 et seq of the German Civil Code).

## First-party property insurance

### 20 What is the general scope of first-party property coverage?

As a rule, any legal insurable interest of the insured can be subject to first-party insurance. First-party insurance provides compensation for the loss suffered by the insured. The insured may generally not claim more than the actual loss incurred. However, the parties can agree on how the insured's loss shall be determined. For example, they may agree on a fixed value. First-party policies usually contain agreements on a sum insured. The sum insured is the maximum compensation the insured is entitled to for a claim or as aggregate for several claims under the policy.

First-party insurance may, for example, cover losses resulting from damage to or loss of:

- real estate, industrial plants or machinery affected by fire, storm or water damage, as well as other named perils;
- motor cars, yachts and aeroplanes;
- homes and personal belongings; and
- buildings under construction.

In addition to mere property damage, commercial insurance contracts may cover consequential losses (eg, if a fire in an insured industrial plant causes business interruption).

Depending on the respective insurance contract and branch, first-party property insurance covers named perils (eg, for homes) or provides all-risk cover (eg, in yacht insurance).

### 21 How is property valued under first-party insurance policies?

Under first-party insurance, property is valued according to the parties' agreement in the insurance policy or, if not agreed, according to the Insurance Contract Act. Agreements vary according to the respective branches and policies.

As a non-mandatory statutory rule, the insured may claim the amount that it must spend upon the occurrence of the insured event to replace or restore the insured property to mint condition, minus the reduced market value resulting from the difference between old and new. If, for example, an old crane is wrecked by a storm, the insured may thus only claim the amount necessary to replace the old crane by another old crane of the same type and age. However, the insurer may undertake (and, under German policies, in certain cases often does undertake) to pay the full replacement value without any deduction of the difference between old and new. In this case, the insured may recover the costs for replacing the wrecked old crane by a new crane of the same type.

### 22 Is insurance available in your jurisdiction for natural disasters and, if so, how does it generally operate?

Insurance cover for natural disasters is partially obtainable. In vast areas, insurers do not provide cover for specific perils at all (especially flood risks in flood zones such as coastal regions) or only grant cover against premium increases, sublimits or deductibles.

Basic private real property insurance policies cover insured named perils (eg, fire and supply water leakage). They also cover certain named natural hazards such as storm and hale. However, basic policies do not cover other natural hazards such as earthquakes, landslides and floods. Such risks may generally be insured by special supplementary cover for

natural hazards. Whether insurance cover for natural hazards can actually be obtained, however, depends on the type of risk, the location and exposure of the insured object. Private real property insurance policies cover the buildings rather than the premises or land. For example, after a flood, the insurance would therefore only compensate for damages to the insured's house than for soil erosion at the insured's premises. In addition to real property insurance that covers the insured object or house, insurance cover is obtainable for the contents or household.

Commercial property insurance policies are much more individualised than private policies, depending on the specific risk exposure.

Real property insurance is not mandatory.

## Directors' and officers' insurance

### 23 What is the scope of D&O coverage?

In general, German D&O insurance mainly covers losses of a company resulting from breaches of duty by its own managers or executives (called internal liability cases (insured versus insured)). Insured persons are all authorised representatives and executives, and include board members, directors and managers, and supervisory board members. If insured persons commit a breach of duty (wrongful act) to the detriment of the company, and if the company asserts damage claims against such person, the D&O insurance is triggered for the benefit of the insured person.

In cases where the company or an insured person gives notice of a claim made against the insured person, the D&O insurer has first to examine whether the insured is liable to the (allegedly) aggrieved company. If the D&O insurer considers the claim of the company against the manager to be unfounded, the insurer must fight off the claim and indemnify defence costs, which are comparable with legal protection insurance. The insurer reimburses costs for lawyers, experts and court fees required to fight off the claim. By contrast, the D&O insurer settles the claim of the company if it considers the claim to be justified. However, in most German D&O cases, the insurer will not pay any compensation to the allegedly injured party as long as the question of liability is pending (and, if necessary, not until the court decides the liability matter of the insured company against the insured person in a final judgment).

### 24 What issues are commonly litigated in the context of D&O policies?

D&O claims in Germany are mainly an issue of internal liability (insured versus insured) and not third-party claims. As a consequence, the issues commonly litigated in the context of D&O policies concern claims for damages of a company against a manager based on his or her breach of duty. In accordance with the German Stock Corporation Act and the Laws on Limited Liability Companies, executives who violate their duties shall be jointly and severally liable to the company for any resulting damage to their private assets (section 93, paragraph 2 of the Stock Corporation Act). The members of the management board have to employ the care of a diligent and conscientious manager in conducting business. The mangers shall not be deemed to have violated their duty if, at the time of taking the entrepreneurial decision, they had good reason to assume that they were acting on the basis of adequate information for the benefit of the company. The managers bear the burden of proof in the event of a dispute as to whether they have employed the care of a diligent and conscientious manager.

As the Stock Corporation Act requires a two-tier board structure consisting of a managing board and a supervisory board, such principle also applies to members of the supervisory board as to any breach of supervisory obligations.

Apart from internal liability claims, the majority of external liability claims refer to claims made by insolvency administrators against the insured persons (after companies have become insolvent).

In 2016, the German Federal Court of Justice (BGH) handed down two important decisions (file numbers IV ZR 304/13 and IV ZR 51/14 of 13 April 2016). In the two cases at hand, two companies had claimed for compensation against their current managers for different breaches of duty (insured versus insured). Subsequently, the managers (insured persons) assigned their indemnification claim (insurance cover) under the D&O insurance to the respective company (policy holder).

The BGH held that an insured manager has the right to assign his or her indemnification claim to the policy holding company (so that the company can claim direct coverage from the insurer), and a 'serious' intent of the claimant to pursue its claim for compensation in respect of the manager (who committed the alleged breach of duty) is no precondition for the insured event in D&O insurance. According to the BGH, the occurrence of an insured event in D&O insurance only requires that a claim for compensation is made in writing. The aggrieved policyholder does not need to prove the 'seriousness' of its claim as long as there is no such provision in the respective terms and conditions of the D&O policy.

In its decision of 20 July 2018, the Higher Regional Court of Dusseldorf (OLG Dusseldorf) (file number I-4 U 93/16) handed down that D&O insurance does not cover the claim of a company for reimbursement of payments that the manager initiated despite insolvency of the company pursuant to section 64 of the German Limited Liability Companies Act (GmbHG). According to section 64 GmbHG, the manager shall be obligated to compensate the company for payments made after the company has become illiquid or after it is deemed to be overindebted. However, in the court's view such a claim is not covered by D&O insurance as such a claim would not be comparable with typically insured claims for damages resulting from pecuniary loss. The court stated that section 64 GmbHG would serve as 'provision for compensation of its own kind', the purpose of which is to protect the interests of the company's creditors rather than the interests of the company itself. In our view and according to prevailing literature, the decision of OLG Dusseldorf is inappropriate and not convincing in terms of legal reasons. The decision is not legally binding yet. However, as it stands, the decision will have great impact on managers, insolvency administrators, insurance brokers and insurers. Managers and companies should review the terms of their D&O policies to make sure that claims pursuant to section 64 GmbHG are included (which is the case in modern D&O wordings).

## Cyber insurance

### 25 What type of risks may be covered in cyber insurance policies?

Cyber insurance policies in general cover both first-party losses and third-party losses (cyber liability cover). In addition, cyber insurance policies provide assistance for a variety of aspects, and may especially cover the following types of risks (respectively, losses and costs):

- business interruption losses incurred by the insured in consequence of hacking attacks or data manipulations;
- costs of forensic investigations and data restoration in consequence of data spying and data protection infringements;
- costs of customer notification (eg, a hacker attack on a retailer leads to the disclosure of millions of customer records concerning personal data. The retailer is obliged to inform all customers. The insurer bears mailing costs);
- costs of credit card monitoring;
- costs of public relations to prevent reputational harm;
- contractual compensations resulting from non-compliance with data security standards (eg, the data security standards of the payment card industry);
- third-party losses claimed against the insured in consequence of a data security breach by the insured;
- costs of legal defence; and
- regulatory fines in consequence of data security breaches.

It must be noted that the German cyber insurance market is evolving, and that no market standard currently exists. The insurers' lobby group GDV published standard terms and conditions in 2017, aiming at the needs of small to mid-size commercial insurance buyers. The proposed standard terms and conditions differ from other cyber insurance policies currently available in the German market (eg, occurrence-based trigger rather than claims-made). However, the cyber insurance market does not seem to adopt the standard terms and conditions provided by the GDV.

### 26 What cyber insurance issues have been litigated?

Given that the German cyber insurance market is still evolving, no coverage disputes have yet been litigated in the German courts.

**Terrorism insurance**

**27 Is insurance available in your jurisdiction for injury or damage caused by acts of terrorism and, if so, how does it generally operate?**

Common (commercial) property and business interruption policies typically exclude losses caused by acts of terrorism. However, German insurers provide coverage upon individual agreement up to a limit of €25 million. In excess of such limit, specialty insurer Extremus (formed by a group of carriers) offers coverage for major losses caused by acts of terrorism up to a single limit, annual aggregate respectively, of €1.5 billion per insured company. Personal injury or death caused by acts of terrorism may constitute insured events under personal insurance policies (eg, an 'accident' covered under a personal accident policy).


**Fabian Herdter** **fabian.herdter@wilhelm-rae.de**
**Christian Drave** **christian.drave@wilhelm-rae.de**

Reichsstraße 43 Tel: +49 211 687746 0
40217 Düsseldorf Fax: +49 211 687746 20
Germany www.wilhelm-rae.de

# India

**Neeraj Tuli and Rajat Taimni**
**Tuli & Co**

## Preliminary and jurisdictional considerations in insurance litigation

### 1 In what fora are insurance disputes litigated?

In the absence of any reference to arbitration under the terms of a policy, insurance disputes can be litigated both before a civil court or consumer forum. If the insurer initiates the litigation, it has to be before the civil courts, and consumer fora cannot entertain such disputes.

Both the civil and consumer courts have territorial and pecuniary jurisdiction, and the civil court or consumer forum before which the matter is decided is dependent on the value of the dispute and the geographical limits of the office of the defendant insurance company, within which the cause of action for the dispute arose.

The broad ascending hierarchy of the civil courts comprises roughly 600 district courts, 24 High Courts and the Supreme Court of India, which is the highest court of law in India. Four of the 24 High Courts – Delhi, Mumbai, Chennai and Kolkata– have original jurisdiction to hear matters over a certain pecuniary value, so the civil courts and judges under them do not hear matters involving values higher than that limit. In all other cases, district courts and the competent courts of first instance have an unlimited pecuniary jurisdiction to hear any insurance dispute. There is no right to a hearing before a jury, and cases are decided by judges.

The consumer courts follow a three-tier hierarchy – in ascending order, the district, state and National Consumer Disputes Redressal Commission (NCDRC). There are 626 district consumer disputes redressal commissions, which can accept claims up to a value of approximately US$29,500. There are 36 state consumer disputes redressal commissions, which can accept claims of up to approximately US$148,000 and appeals against the decisions of the district commissions. At the apex is the NCDRC, which accepts matters with a value of over US$148,000 and appeals against the decisions of the state commissions.

For quick resolution of commercial disputes, Commercial Courts were set up by the government in 2015 through the Commercial Division and Commercial Appellate Division of High Court Act, 2015 (the Commercial Courts Act). The Commercial Courts Act defines commercial disputes to include insurance and reinsurance disputes. Commercial courts can accept disputes of values that exceed US$148,000. Insurance and reinsurance disputes that exceed US$148,000, if not heard before the consumer fora, will now be heard and decided by the commercial courts. By way of a recent amendment in 2018, the pecuniary jurisdiction of the commercial courts has been reduced from US$148,000 to US$4,170. In the case of commercial suits, unless the party is seeking an urgent interim measure, the Act prescribes that the parties must compulsorily mediate before the suit is filed.

### 2 When do insurance-related causes of action accrue?

Disputes between the insured and the insurer usually arise when the insured's claim is rejected (in part or in full) by the insurer and which the insured believes is covered under the policy. There can be disagreement between the insurer and the insured in relation to the scope of the insuring clauses, the quantum payable under the policy, the applicability of exclusions or compliance with the policy terms and conditions, etc. Under the Indian Limitation Act of 1963, the cause of action for the purposes of calculating the limitation for filing a suit against the insurer will commence from the time that the claim is denied or the date of the occurrence causing the loss. The prescribed limitation period for filing a claim in the civil court or an arbitration is three years, whereas the limitation period for filing a claim in the consumer court is two years.

### 3 What preliminary procedural and strategic considerations should be evaluated in insurance litigation?

Procedural considerations include identification of the appropriate limitation period and jurisdiction for the institution of the litigation. In relation to strategy, it is important that the preliminary objections to any suit (such as expiry of limitation) are brought to the court's attention at an early stage to attain a dismissal on the basis of the preliminary objections. However, in India, it is very often the case that the preliminary objections are decided after the substantive pleadings are complete, as the courts are unwilling to decide without having had access to all the documentation on the matter.

### 4 What remedies or damages may apply?

The relief available in Indian litigation in cases of insurance disputes are specific performance and claims for damages. In a proceeding, the insured can either require the insurer to specifically perform its obligations under the policy or to pay the claim amount.

Indian courts and tribunals have discretion to award interest from the date when the cause of action arose until the enforcement of the judgment. Interest is usually awarded at a rate of 9 to 12 per cent and, in certain cases based on the conduct of the parties, interest of 18 per cent is also awarded.

The courts may also award the successful party its costs, but the award is at the court's discretion. It is common for cost awards to be made in favour of a successful party, but the level of costs awarded is rarely sufficient to cover the actual costs of litigation. Referring to a statutory upper limit of 4,000 rupees for costs awards in the case of vexatious litigation, the Supreme Court suggested that Parliament should consider raising the limit to 124,000 rupees. In view of the low level of costs awarded, there are, as yet, no material advantages in making a pre-trial offer in civil litigation, so Calderbank letters are hardly (if ever) used.

In a commercial suit, the statutory limits for costs do not apply, thereby allowing costs to be awarded in accordance with the actual expenditure incurred by the winning party. Awarding of costs is not compulsory and remains at the discretion of the court.

In relation to interim reliefs that are available in general, they include temporary injunctions and interlocutory orders that are provided for under the Civil Procedure Code of 1908. Parties also seek interim mandatory injunctions that are available under the Specific Relief Act of 1963. A court may issue a temporary injunction restraining any act or omission to act, or make an order for the purpose of staying and preventing the alienation, sale, removal or disposition of a property in appropriate cases. Interim relief also includes ordering the insurer to pay the insured the admitted sums payable under the policy so that only the disputed amount remains to be adjudicated upon. It is for the court to decide whether any interim relief should be granted, the terms on which it should be granted and the duration of the relief.

### 5 Under what circumstances can extracontractual or punitive damages be awarded?

Indian contract law does not permit the awarding of extracontractual or punitive damages. In cases where no damages have been stipulated in a contract, the courts award reasonable damages that have been incurred by a party. Even in contracts where the damage amount is stipulated, there is a degree of reasonableness attached to the amount the court would ultimately award and courts always examine the actual damages incurred. The courts will examine whether the amount stipulated is in the form of a penalty, and can reduce the amount if it is of the opinion that the stipulated sum is a penalty. The Supreme Court settled the law in this respect in *Fateh Chand v Balkishan Das* AIR 1963 SC 1405, and has reiterated the same in subsequent case law.

Under tort law, Indian courts are also slow to award any form of punitive damages, and compensatory damages are usually awarded. In some rare instances punitive damages have been awarded by the courts; these, however, relate to environmental damage cases and cases of negligence where loss of life is involved.

## Interpretation of insurance contracts

### 6 What rules govern interpretation of insurance policies?

It is a settled legal proposition that while construing the terms of a contract of insurance, the words used therein must be given paramount importance, and it is not permitted for the court to add, delete or substitute any words. It is equally settled that, because upon issuance of an insurance policy the insurer undertakes to indemnify the loss suffered by the insured on account of risks covered by the policy, its terms have to be strictly construed to determine the extent of the liability of the insurer.

The general rule is that where the contract is expressed in writing, oral evidence is inadmissible to explain or vary the terms of a written contract. Although a contract must always be construed according to the intention of the parties, that intention can only be ascertained from the instrument itself and all other evidence of intention is excluded because, when an agreement is reduced to writing, the parties thereto are bound by the terms and conditions of it. One of the Supreme Court decisions laying down this principle is *United India Insurance Company Limited v M/s Orient Treasures Private Limited* Civil Appeal No. 2140 of 2007, which held that when the terms of the policy are clear, plain or unambiguous, and reasonably susceptible to one meaning, the courts are bound to give effect to that meaning irrespective of the consequences.

However, in the event that there is an ambiguity or doubt as to the provisions in the contract, the same is to be construed contra proferentem, that is, against the insurance company.

### 7 When is an insurance policy provision ambiguous and how are such ambiguities resolved?

An insurance policy provision is ambiguous when there is uncertainty as to the meaning or intention of that provision. It can also arise when the same words are capable of two different meanings. When such an ambiguity appears in an insurance policy then it is to be construed contra proferentem, as the terms of an insurance policy are drafted by the insurer in most cases. However, the Supreme Court of India has recently held in the case of *Export Credit Guarantee Corporation of India Ltd v Garg Sons International* (2014) 1 SCC 686 that the rule of contra proferentem does not apply in cases of commercial contracts, because the terms are bilateral and have been mutually agreed upon.

## Notice to insurance companies

### 8 What are the mechanics of providing notice?

The mechanism for the provision of notice to insurers is generally provided in the policy and differs from one policy to the other. Notice can be required to be given by way of post, email or facsimile, and the name and address of the person to whom notice should be given are also mentioned in the policy. We have seen policies where claims or circumstances are required to be reported on a periodic basis by way of a bordereau.

In relation to the contents of the notice, this is also usually governed by the terms of the policy, but generally should contain a summary of the matter including the details of its inception and estimated quantum, along with the supporting relevant information and documentation that would be required by the insurer to assess coverage under the policy. Irrespective of the time period within which notice is required to be given under the policy, insurers always prefer early notification (as soon as the claim or circumstance of the same arises) as they then have the opportunity to effectively participate in the handling of the claim or assume a defence, depending on the policy wording.

### 9 What are a policyholder's notice obligations for a claims-made policy?

In a claims-made policy, the insured is required to give notice to the insurer as and when the claim is made against the insured. The trigger point for this sort of policy is a claim or the circumstances of a claim made against the insured. It is advisable that the notice is given immediately when the insured becomes aware of the claim or circumstance, but the outer limit is usually mentioned in the policy. This can be within a specified number of days or 'as soon as reasonably practicable'. The notice is required to carry all the information in respect of the claim or circumstance that will be required by the insurer to assess coverage under the policy and understand the developments in the matter.

### 10 When is notice untimely?

Notice is usually considered to be untimely when it can be established by the insurer that the notice was not provided to the insurer as soon as practicable and the delay in notification prejudiced the insurers' assessment of the claim.

In *Satpal v United India Insurance Co* RP No. 2068 of 2013, the NCDRC held that '[a]s far as merits of the case are concerned, learned State Commission rightly allowed appeal as there was delay of more than 30 days in intimation to Insurance Company and thus, petitioner violated terms and conditions of the policy.' In *Hukam Singh and Giriraj v United India Insurance Co Ltd* RP No. 4028 of 2012, it held that:

> *The intimation given to the financing bank cannot be a substitute for the intimation required to be given immediately to the insurance company. Purpose of such intimation of theft to the insurance company is to enable the insurance company to take steps to protect their interest by appointing investigators to trace the vehicle. The petitioners obviously have failed to protect the interest of the insured by failing to immediately inform the report of theft in terms of the general condition 5(i)(b) of the insurance policy referred to in the impugned order.*

In *Bajaj Alliaz General Insurance Co Ltd through Shri Ashutosh Singh, Dty Manager v Mr K Eswara Prasad* RP No. 2555 of 2012, it was held by the NCDRC that 'delay in intimation to the insurance company is fatal. In the case in hand, apparently there is long delay in lodging FIR and intimation to the insurance company about the theft of the insured car and in such circumstances, complaint is liable to be dismissed.'

In the case of *HDFC ERGO General Insurance Co v Bhagchand Saini* RP No. 3049 of 2014, the NCDRC held that any delay in the notification of theft to the police or the insurer in motor vehicle policies is fatal to the claim. Over the past few months, the position in *Bhagchand Saini* has been relied on by the NCDRC in *National Insurance Company Ltd v Babu A Sirsat*, MANU/CF/0772/2014, *Bihar State Hydroelectric Power Corporation Ltd v National Insurance Co Ltd*, *Saurashtra Chemicals Ltd v National Insurance Co Ltd* and *Jatinder Singh v Oriental Insurance Co*.

### 11 What are the consequences of late notice?

Insurance contracts require that the claims or circumstances of the claims are intimated to the insurer within the time period specified in the policy. This requirement may be expressed as a condition or a condition precedent to the insurer's liability under the policy, and the consequences of non-compliance will, to some extent, depend upon whether the notification clause is expressed as a condition or condition precedent. If the notice clause is a condition, the insurer will have to show that it suffered prejudice on account of the delayed notice, but if the clause is a condition precedent, then in theory no prejudice is required to be shown for placing reliance on the clause.

Until recently, however, irrespective of whether the notice clause is expressed as a condition or condition precedent, courts previously have stated that the condition relating to notice should not prevent

settlement of genuine claims where there is a delay in intimation or in submission of documents owing to unavoidable circumstances. This is the position that the Indian insurance regulator (IRDAI) has also recommended in its circulars, where insurers were directed not to reject claims unless and until the reasons for delay are specifically ascertained and recorded, and the insurers are satisfied that the delayed claims would have been rejected even if they had been reported in time. Courts and consumer fora have also followed the view that clauses limiting the period for notification of claims are not to be construed strictly, and have often overturned the rejection of a claim where the delay was reasonably justifiable.

The IRDAI also recommends that insurers should incorporate additional wording in the policy documents that suitably highlights that a delay in intimating a claim or submitting the relevant documents to the insurer will be condoned if the delay is proved to be for reasons beyond the control of the insured.

The Supreme Court of India has passed judgments enforcing the agreed terms and conditions between parties. In *Export Credit Guarantee Corp of India Ltd v Garg Sons International*, 2013 (1) SCALE 410, the court allowed a claim to be rejected on grounds that timely intimation of claims was under a credit insurance policy. The court further ruled that the terms and conditions of a contract should be strictly followed '. . . it is not permissible for the court to substitute the terms of the contract itself, under the garb of construing terms incorporated in the agreement of insurance. No exceptions can be made on the ground of equity. The liberal attitude adopted by the court, by way of which it interferes in the terms of an insurance agreement, is not permitted.'

In the recent judgment of *Sonell Clocks v The New India Assurance Co Ltd* AIR 2018 SC 4146, the Supreme Court has held that if the wording of the policy was such as to make the wording of the intimation clause a condition precedent, compliance with such a clause by the insured would be sine qua non to maintain a valid claim.

Despite this ruling of the Supreme Court, this approach is not always followed, and further clarification on the issue is necessary to settle the legal position.

## Insurer's duty to defend

### 12 What is the scope of an insurer's duty to defend?

Insurance carriers that use a duty-to-defend clause in their policies have the obligation to manage the litigation process from the notification of the claim. At the same time, insurers have the right to select the defence counsel who would be appointed. The insured usually has no control over the defence counsel assigned.

The duty-to-defend clause in an insurance policy essentially states that in the event a claim being made against the named insured for an alleged wrongful act, the insurance company providing coverage at the time has the duty to defend the claim, even if it is subsequently found to be groundless, false or fraudulent. Therefore, although the claim lacks merit, the insurer still has an obligation to defend the claim.

### 13 What are the consequences of an insurer's failure to defend?

There does not appear to be any Indian case law relating specifically to an insurer's breach of its duty to defend. We understand, however, that this issue is a subject of dispute in the United States, and the position there appears to be that an insurer that erroneously refuses to defend an insured will have no right to subsequently rely on policy defences and appeal against the order of the court. However, one of the biggest risks associated with an insurance company's incorrect choice not to defend an insured is that it may be held liable for breach of contract, specifically if the insured can establish that his or her claim is in fact covered by the policy.

As set out more fully below, once a company has unjustifiably failed to defend, the insurer is not only prevented from raising policy defences, but also has liability for the amount of the judgment rendered against the insured or for the amount of the settlement; expenses incurred by the insured in defending the suit; and any additional expenses caused by the breach of the insurance contract.

However, this does not necessarily mean that the company is liable for more than its policy limits. Unless the insurer has acted in bad faith by refusing to defend its insured (or by failing to act reasonably to settle a claim within its policy limits), it is not liable for that portion of the judgment or settlement in excess of its policy limits.

An unjustified refusal to defend does not arise where the refusal to defend is based upon a conflict of interest. Further, an insurer has not unjustifiably refused to defend where it has offered a defence under a reservation of rights but the insured rejects the reservation of rights. Where coverage is in question, the insurer is not required to provide an unconditional defence.

## Standard commercial general liability policies

### 14 What constitutes bodily injury under a standard CGL policy?

The scope of bodily injury under a CGL policy may vary from one policy to another, but bodily injury is generally understood to mean any bodily injury, sickness, disease or death that is sustained by a person. Black's Law Dictionary defines bodily injury as 'physical damage to a person's body'.

### 15 What constitutes property damage under a standard CGL policy?

What constitutes property damage under a standard CGL policy may differ in scope from one policy to another, but it is usually understood to mean physical injury to tangible property resulting in the loss of use of that property.

### 16 What constitutes an occurrence under a standard CGL policy?

What constitutes an occurrence under a standard CGL policy may differ in scope from one policy to another, but it is usually defined as an accident, including continuous or repeated exposure to substantially the same general harmful conditions.

### 17 How is the number of covered occurrences determined?

In the event that multiple covered claims are made by the insured in the course of the policy year, the insurer is liable to indemnify the insured until such time as the limit of liability set out under the policy is exhausted.

It appears, therefore, that there can be no predetermined number of covered occurrences to which a policy may respond, and the number of occurrences that trigger coverage under the policy is determined solely by the limit of liability set out under the policy and the time at which such sum is exhausted. There are certain policies that make the deductible applicable individually to each and every loss that arises under the policy.

### 18 What event or events trigger insurance coverage?

The insuring clause sets out what events trigger cover, as, for instance, bodily injury and property damage typically trigger cover under a CGL policy, subject, of course, to other terms and conditions.

### 19 How is insurance coverage allocated across multiple insurance policies?

Policies usually contain an 'other insurance' clause to cater to situations where the claim notified may be covered by two or more policies covering the same risk. This clause will determine how the loss will be allocated or distributed between the policies and the level of risk to be borne by each insurer. This other insurance clause would normally say either that the policy operates in excess of any valid or collectible insurance or that the policy will contribute rateably in proportion to the amount covered under the contract and that covered under the other policy. If both policies operate in excess over one another, or when there are no such terms in the policy, there will be rateable allocation between different policies.

## First-party property insurance

### 20 What is the general scope of first-party property coverage?

The scope of first-party property coverage policies is determined by the terms of the policy. The property policies could be exclusion-based policies where all risks other than those specifically excluded are covered or named-perils policies where only the specific perils named within the terms of the policy would be covered.

The terms and conditions of property and engineering insurance cover are currently governed by the policy wordings specified by the

former Tariff Advisory Committee. Very few modifications to these policy wordings have been permitted.

**21 How is property valued under first-party insurance policies?**

There are various methods of valuation. The choice of appropriate valuation method depends on the purpose of the valuation and on the nature of the assets involved. The various methods used for valuation are as follows.

**Detailed estimate basis**
The detailed estimate method involves working out the bill of materials for various materials such as cement, sand, brick, reinforcement steel, joinery and masonry, along with the cost of labour. Unit rates for various types of work such as brickwork, plastering, reinforced concrete cement and woodwork can also be used for calculating the value of the building.

**Plinth area rate method**
The All India Standard Schedule published by the National Buildings Organisation annually publishes the normal market rate prevailing for construction in a particular area. In the plinth area rate method, such published rates can be used to estimate the value either by perusing the sanctioned plan or by actual measurement. The reinstatement value is obtained by multiplying the plinth area by the rate or unit area.

**Fair value method**
This represents the value in exchange. This method of valuation is applicable to assets that can be currently exchanged in the market for value (eg, whatever may be the cost of production of liquid petroleum gas, its value in the market for sale in exchange for cash is the fair value).

**Depreciation method**
This method involves valuing property by deducting appropriate amounts on a yearly basis as depreciation from the book value of the asset.

**Book value**
This represents the written-down value of the assets in the book of accounts. In the first year, this represents the actual cost of the asset, and with each passing year, appropriate depreciation is charged and the value of the asset is accordingly reduced. Over a period of time, the asset value becomes so low that it will not reflect the true worth of the asset.

**Market value**
In this method, depreciation is allowed on the current replacement value of the asset for the number of years it has been in use to arrive at market value.

**22 Is insurance available in your jurisdiction for natural disasters and, if so, how does it generally operate?**

Insurance policies are routinely issued to provide cover against losses caused by natural disasters. Such disasters include lightning, storm, cyclone, typhoon, tempest, hurricane, tornado, flood and inundation, earthquake, volcanic eruptions and other convulsions of nature. Policies are also issued on an all-risks basis, which would cover losses arising out of any cause whatsoever (unless excluded), and would also cover natural disasters. The operation of these policies is similar to other policies insofar as, inter alia, notification, appointment of surveyor, exclusions, conditions precedents are concerned. However, the court or tribunal is often called upon to decide what the proximate cause was for the loss and whether the proximate cause was a covered peril or an excluded peril.

## Directors' and officers' insurance

**23 What is the scope of D&O coverage?**

D&O policies typically cover liability arising out of alleged and actual acts and omissions of directors and officers of the company in their managerial capacity. The company may also be covered for specific wrongful acts.

**24 What issues are commonly litigated in the context of D&O policies?**

We have not seen much litigation involving D&O policies. Most D&O policies have an arbitration clause, so disputes would first be referred to an arbitral tribunal. However, we believe that issues that could arise under a D&O policy include those relating to whether appropriate disclosure was provided at the time of placement of the policy, timely notification and compliance with policy conditions, application of the exclusion relating to misconduct and allocation.

## Cyber insurance

**25 What type of risks may be covered in cyber insurance policies?**

Cyber insurance policies provide cover, inter alia, for claims arising out of:

- negligent disclosure of personal or corporate information;
- the introduction of unauthorised software, computer code or viruses to third-party data;
- denial of access of an authorised third party to its data; and
- the wrongful appropriation of a network access code of a company.

Policies cover, inter alia, the professional fees incurred in engaging cyber-risk specialists to identify the cause of breaches and independent advisers to advise on mitigation of any adverse effects.

Tuli & Co
Solicitors and Advocates

**Neeraj Tuli** **neeraj.tuli@tuli.co.in**
**Rajat Taimni** **rajat.taimni@tuli.co.in**

7A Lotus Towers, Community Centre
New Friends Colony
New Delhi 110 025
India

Tel: +91 11 4593 4000
Fax: +91 11 4593 4001
www.tuli.co.in

**26 What cyber insurance issues have been litigated?**

We have seen a growing number of cyber insurance covers being issued and claims being made under them. However, since cyber cover is comparatively recent in this jurisdiction, we have not come across any litigation involving cyber policies.

**Terrorism insurance**

**27 Is insurance available in your jurisdiction for injury or damage caused by acts of terrorism and, if so, how does it generally operate?**

Yes, terrorism insurance cover is provided in India through the Terrorism Risk Insurance Pool. The pool was formed as an initiative by all non-life insurance companies in India in April 2002 after terrorism cover was withdrawn by international re-insurers following 9/11. The pool is adequate for any eventuality, as its size has crossed 45 billion rupees.

# Ireland

**Sharon Daly, April McClements and Aoife McCluskey**

**Matheson**

## Preliminary and jurisdictional considerations in insurance litigation

### 1 In what fora are insurance disputes litigated?

In Ireland, the jurisdiction in which court proceedings are brought depends on the monetary value of the claim. The District Court deals with claims up to a value of €15,000 and the Circuit Court up to a value of €75,000 (€60,000 for personal injury cases). Claims with a monetary value in excess of the Circuit Court jurisdiction are heard by the High Court, which has an unlimited monetary jurisdiction.

The High Court has a specialist court, the Commercial Court, which deals exclusively with commercial disputes. Proceedings are case-managed and tend to move at a much quicker pace than general High Court cases; the average time from entry into the list to full hearing varies between one week to six months depending on the time required for hearing. Entry to the list is at the discretion of the judge and may be refused if there has been any delay. Insurance and reinsurance disputes can be heard in the Commercial Court if the value of the claim or counterclaim exceeds €1 million and the court considers that the dispute is inherently commercial in nature.

The Commercial Court judges place a strong emphasis on mediation and the Commercial Court Rules provide for up to a four-week stay of proceedings to allow the parties to consider mediation.

Insurance disputes before the courts in Ireland are heard by a judge sitting alone and not a jury.

If an insurance contract contains an arbitration clause, the dispute must be referred to arbitration. However, there is an exception for consumers, who are not bound by an arbitration clause in an insurance policy if the claim is less than €5,000 and the relevant policy has not been individually negotiated.

The Financial Services and Pensions Ombudsman (FSPO) is a statutory officer who deals independently with unresolved complaints from consumers about their individual dealings with all financial service providers, including insurers. The FSPO has broad powers and may direct insurers to: pay compensation up to a maximum of €250,000; change their practices in the future; and rectify the conduct complained of (for example, requiring the insurer to pay a disputed claim).

### 2 When do insurance-related causes of action accrue?

For actions in contract, the cause of action accrues on the date of the breach (and not when the damage is suffered). The general position under Irish law is that claims for breach of contract must be brought (by issue of proceedings) within six years of the date on which the cause of action accrued (section 11(1)(a), Statute of Limitations Act 1957).

Where a complaint is made to the FSPO, the FSPO does not generally have jurisdiction to investigate complaints where the conduct complained of occurred more than six years before the complaint is made. However, if the complaint relates to 'long-term financial services', namely products or services where the maturity or term extends beyond five years and one month, or life assurance policies not subject to annual renewal, the six-year rule does not apply. The limitation period for such long-term financial services is: (i) six years from the date of the act or conduct giving rise to the complaint; (ii) three years from the earlier of the date on which the consumer became aware of the said act or conduct or ought to have become aware; or (iii) such longer period as the FSPO may allow where it is just as equitable to extend the period.

### 3 What preliminary procedural and strategic considerations should be evaluated in insurance litigation?

The strategic considerations will vary depending on the nature of the dispute, the parties involved and their relationship.

Where an insurer seeks to decline cover of a claim or avoid a policy, the declinature or avoidance letter will be a key proof in any subsequent litigation and should therefore be drafted carefully. Timing is also critical. An insurer should not use the same lawyers to provide coverage advice and to defend the claim under a reservation of rights.

Before commencing any proceedings, the contractual documentation should be reviewed, and in particular jurisdiction and choice of law clauses, to identify the appropriate jurisdiction and forum for the dispute. If the contract contains an arbitration clause, the dispute must be referred to arbitration. The contract may also stipulate an alternative form of dispute resolution such as mediation.

In general, consideration should also be given at the outset to the availability of evidence and witnesses.

It is usual practice in Ireland for a pre-action letter to be sent before proceedings are issued, as there is a potential for costs exposure in not having done so.

It should also be noted that the Mediation Act 2017 requires solicitors to advise their clients of the merits of mediation as an alternative dispute resolution mechanism in advance of issuing court proceedings. In addition, in order to issue proceedings, the Act requires the solicitor to swear a statutory declaration confirming that such advice has been provided and this declaration must be filed with the originating document in the relevant court office.

### 4 What remedies or damages may apply?

The remedies available to an insurer depend on the breach.

In case of a breach of the duty of utmost good faith, the remedy is to declare the contract void. Under the Marine Insurance Act 1906, this remedy is available for non-disclosure (section 18) or material misrepresentation (section 20) by the insured. However, avoidance is generally considered to be a draconian remedy and the Irish courts have traditionally been reluctant to uphold avoidance with the result that insurers can be left without an effective remedy. An insurer is not entitled to decline cover of the claim in lieu of avoidance, unless the relevant policy contains an innocent non-disclosure clause to this effect.

The Irish courts are willing to uphold policy avoidance for material non-disclosure where the proposal form is clear and unambiguous and the proposer's duty to disclose is not qualified by reference to answering the questions in the proposal form to the best of the proposer's knowledge.

The remedy for breach of warranty (including basis of contract clauses) is repudiation; however, warranties are construed very strictly.

Breach of a condition precedent to cover entitles insurers to decline cover of a claim without a requirement to demonstrate prejudice, whereas breach of a condition that is not stated to be a condition precedent to cover entitles the insurer only to damages.

Normally, damages are an adequate remedy for breach of an insurance policy. However, if damages are deemed neither adequate nor appropriate, the law of equity may intervene and the court may grant the remedy of specific performance.

Unless the contract provides otherwise, the general actions for breach of contract are available to the insured. Accordingly an insured

would have an action for damages arising from the failure of the insurer to pay a valid claim.

The Consumer Insurance Contracts Bill 2017, which was published on 20 January 2017, proposes amendments to the law relating to consumer insurance contracts (although the proposed definition of consumer is broad). There is no clear timeline for its implementation. It is based on recommendations made by the Law Reform Commission in its report on Consumer Insurance Contracts in 2015 and largely mirrors the provisions of the draft bill proposed in this report.

The bill provides for the following:

- the pre-contractual duty of good faith is abolished;
- avoidance of an insurance policy will no longer be the main remedy. In cases of non-disclosure and misrepresentation, the principal remedy will be damages in proportion to the failure by the insured (however, avoidance is retained for fraudulent breaches on public policy grounds);
- warranties (including basis of contract clauses) are abolished and replaced with suspensive conditions; and
- a consumer will be entitled to seek damages where an insurer unreasonably withholds or unreasonably delays in making a payment for a valid claim.

### 5 Under what circumstances can extracontractual or punitive damages be awarded?

The Irish courts occasionally award punitive or exemplary damages on public policy grounds. The Irish Supreme Court has confirmed that exemplary damages can be awarded where the damage caused was deliberate and malicious, and calculated to unlawfully cause harm or gain an advantage. The award of damages must be proportionate to the injuries suffered and the wrong done.

Exemplary damages are insurable in Ireland. The Law Reform Commission considered this issue in a report published in 2000 ('[a]ggravated, exemplary and restitutionary damages') and considered that public policy considerations in favour of prohibiting insurance for exemplary damages were not sufficiently strong to necessitate legislation in this area. It is therefore a matter for individual insurance companies whether they choose to expressly exclude exemplary damages from cover.

## Interpretation of insurance contracts

### 6 What rules govern interpretation of insurance policies?

Insurance contracts are subject to the same general principles of interpretation as other contracts. The Irish Supreme Court has confirmed in two judgments, *Analog Devices v Zurich Insurance and ors* and *Emo Oil v Sun Alliance and London Insurance Company*, that the principles of construction as set out by Lord Hoffmann in *ICS v West Bromwich Building Society* should be applied to the interpretation of insurance contracts.

In summary, interpretation is the ascertainment of the meaning that the document would convey to a reasonable person having all the background knowledge that would reasonably have been available to the parties in the situation in which they were at the time of the contract. The background or 'matrix of fact' should have been reasonably available to the parties and includes anything that would have affected the way in which the language of the document would have been understood by a reasonable person. The previous negotiations of the parties and their declarations of subjective intent are excluded from the admissible background. The meaning that a document (or any other utterance) would convey to a reasonable person is not the same thing as the meaning of its words. The meaning of the document is what the parties using those words against the relevant background would reasonably have been understood to mean. The rule that words should be given their 'natural and ordinary meaning' reflects the common sense proposition that we do not easily accept that people have made linguistic mistakes, particularly in formal documents. On the other hand, if one would, nevertheless, conclude from the background that something must have gone wrong with the language, the law does not require judges to attribute to the parties an intention that they plainly could not have had.

The court will apply an objective approach to determine what would have been the intention of reasonable persons in the position of the parties.

Where a contractual term is ambiguous, the interpretation less favourable to the drafter is adopted using the contra proferentem rule (see question 7).

In circumstances where the policyholder is a consumer, the European Communities (Unfair Terms in Consumer Contracts) Regulations 1995 (as amended) and the Central Bank of Ireland's Consumer Protection Code 2012 will apply to the contract.

### 7 When is an insurance policy provision ambiguous and how are such ambiguities resolved?

An insurance policy wording is ambiguous if a provision can have more than one meaning or if the policy is silent in relation to a particular situation. In addition to the rules set out in question 6, the contra proferentem rule will be applied where there is ambiguity. This rule provides that, if a term is ambiguous, it is interpreted against the person who drafted it. This is usually the insurer and thus the ambiguity is interpreted in favour of the insured. However, if drafted by the broker, the ambiguous term would be interpreted against the insured. Recent case law in England has cast some doubt on the automatic application of a contra proferentem approach to the construction of exclusions in insurance contracts, but to date these decisions have not been followed in Ireland.

## Notice to insurance companies

### 8 What are the mechanics of providing notice?

Notice requirements vary from policy to policy. The policy wording will typically confirm to whom a claim should be notified and the manner in which the notification should be made. Typically, notice must be given in writing within a specified time period after the policyholder becomes aware of a claim or a circumstance likely to lead to a claim.

### 9 What are a policyholder's notice obligations for a claims-made policy?

Claims-made policies generally require claims to be notified during the policy period and as soon as reasonably practicable or within a specified time limit. Claims-made policies may also require or permit circumstances that may give rise to a claim to be notified to insurers. The policy may contain a discovery period that allows claims to be notified within a specified period following the expiry of the policy period.

Where the notice requirements are stated to be a condition precedent to cover, the insurer is entitled to decline cover for a breach without any requirement to establish it has suffered prejudice as a result of the breach. In the absence of a condition precedent to liability, the only remedy available to insurers for breach of a notice condition is damages.

### 10 When is notice untimely?

See question 9. If an insurer wants to ensure compliance with a notification requirement, it must make timely notification a condition precedent. Where the notification is of a circumstance and not a claim, the courts have interpreted the knowledge of the policyholder on a subjective rather than objective basis.

### 11 What are the consequences of late notice?

The consequences of late notice will often be specified in the policy.

Where the notice requirements are stated to be a condition precedent to cover, the insurer is entitled to decline cover for a breach without any requirement to establish it has suffered prejudice as a result of the breach. In the absence of a condition precedent to liability, the only remedy available to insurers for breach of a notice condition is damages.

In practice, the Irish courts are reluctant to permit insurers to decline claims for technical breaches of notice conditions, particularly where there has been a failure to notify a circumstance. While the test to be applied is objective, the court will consider whether the insured had actual knowledge of the particular circumstance that it is alleged should have been notified to insurers. The knowledge of the insured is subjective.

## Insurer's duty to defend

### 12 What is the scope of an insurer's duty to defend?

This is a matter of contract and Irish law does not impose a duty to defend on the insurer. The policy may impose such a duty or may simply

**Update and trends**

**Brexit**
Following the United Kingdom's decision to leave the EU and the subsequent triggering of article 50 of the Treaty on European Union, many financial services companies have established or are in the process of establishing a subsidiary in a country with access to the single market to mitigate the potential loss of passporting rights post-transition period (which has been agreed to be December 2020). Ireland's well-established prudential regulation, common law jurisdiction, and well-educated, English-speaking and flexible workforce, together with its close proximity to the United Kingdom has cemented its status as a thriving hub for the insurance industry. Authorisation-related activity since the Brexit vote has continued to increase, including queries regarding insurance authorisations. It is anticipated that the increase in authorisation-related activity will continue.

**Insurance Distribution (Recast) Directive**
The European Union (Insurance Distribution) Regulations 2018 transposed the Insurance Distribution (Recast) Directive (IDD) into Irish law on 1 October 2018. The IDD creates a minimum legislative framework for the distribution of insurance and reinsurance products within the EU, and aims to facilitate market integration and enhance consumer protection. Notably, the IDD brings all insurance distributors within the scope of a regulatory framework, which may result in increased regulatory investigations and disputes.

**Emerging technologies and risks**
***Drones***
Drones are an emerging and rapidly developing technology, and new legislation is proposed in Ireland to increase existing drone regulation and impose criminal liability for certain drone offences. The draft bill (the Small Unmanned Aircraft (Drones) Bill 2017) imposes an obligation on commercial drone operators to have insurance for any liability arising from drone operation, including potential collision with persons or property, and it will be a criminal offence to operate a drone for commercial use without insurance. There is no clear timeline for the implementation of this bill. As the market continues to grow, it seems inevitable that drone insurance will be a growth area.

***Driverless cars***
Driverless cars and autonomous vehicles present particular challenges for the motor insurance industry. The existing Irish legislative framework is driver-centred and will need to be updated to facilitate driverless cars on Irish roads. The United Kingdom has introduced a single insurer model under the Automated and Electric Vehicles Act 2018, where both driver and driverless technology are insured under one policy. While this has not yet been considered by the Irish legislature in any meaningful way, it can be anticipated that the legislature is likely to follow the approach taken in the United Kingdom, given the similarities between the existing road traffic frameworks in both countries.

***Cyber insurance***
The market for cyber insurance is growing and is seen as one of the biggest growth areas in the insurance industry globally. According to industry data, the global cyber market was estimated to be worth around US$4.3 billion in premiums in 2017. Fitch believes cyber insurance premiums could increase to US$20 billion by 2020. Cyber insurance is still a relatively new product on the Irish market. However, it has become more popular in recent times and a number of insurers are now offering cyber products in Ireland as a result. Cybersecurity has become a board issue in 2018 in light of the introduction of the GDPR and the Directive on the Security of Network and Information Systems, meaning that companies are more focused on cyber risks and potential insurance requirements. In addition, there has been an increasing number of cyber attacks in Ireland in recent years and the Irish government's National Risk Assessment 2018 states that this increase is in part owing to the sophistication of tools for carrying out cyber attacks. It is expected that cyber will be a growth area in Ireland in the coming years. In our view, the market leaders over the next five years will be those insurance companies that branch away from the traditional insurance business model towards a more technology-friendly operating model. In today's digital economy, consumers want instant access to relevant and simplified information and this extends to complex insurance products. Embracing the benefits that technological advances can offer to the design and distribution of innovative insurance products will enable progressive companies to meet the needs and expectations of consumers in a more effective and efficient manner.

**Developments related to third-party funding of litigation**
In May 2017, the Irish Supreme Court confirmed in *Persona Digital Telephony Ltd & Another v Minister for Public Enterprise* [2017] IESC 27 that third-party funding of litigation is unlawful, and indicated that any changes to the law in this regard in Ireland would be a matter for the legislature, not the courts. In July 2018, in the case of *SPV OSUS Limited v HSBC Institutional Trust Services (Ireland) Limited & Ors*, which concerned the legality of an assignment of a cause of action, the Irish Supreme Court called upon the Irish legislature to urgently reform the area and introduce rules surrounding the third-party funding of litigation, failing which the Supreme Court itself may intervene.

The Irish High Court has previously made clear that after-the-event insurance is valid; therefore, post-*Persona Digital* and *SPV OSUS Limited*, ATE insurance is the only valid third-party funding in this jurisdiction.

**Representative actions in consumer litigation**
The European Commission has published a draft Directive that proposes a new type of European-wide collective redress mechanism for consumers. This would allow a 'qualified entity' to take a representative action before a member state court, on behalf of a group of consumers who have been affected by a breach of consumer protection laws, to seek redress for the affected group. This would increase litigation risk for industry sectors that are subject to EU regulation, including insurers. The draft Directive will require further consultation in the European Parliament and the European Council and is likely to be amended before publication in the Official Journal. It is anticipated that it will be adopted before the next EU Parliament elections, scheduled for May 2019.

provide that the insurer has a right to associate in the defence of the claim.

**13 What are the consequences of an insurer's failure to defend?**

This will depend on the extent to which the contract imposes such a duty on the insurer. The insured may have a remedy for damages for breach of contract in the event that the insurer breaches a contractual duty to defend. In the event that an insurer takes on the defence of the claim, it must defend the claim subject to the contract of insurance. The interests of the policyholder and the insurer are not always aligned and this can lead to negotiations between them on how to settle or defend the claim.

## Standard commercial general liability policies

**14 What constitutes bodily injury under a standard CGL policy?**

Commercial general liability is not a standard type of cover available in Ireland. Bodily injury is, however, a term that is used in liability policies. The definition used varies from policy to policy but typically refers to physical injury, including illness and death.

**15 What constitutes property damage under a standard CGL policy?**

See question 14. In public liability policies, property damage is typically defined as loss or destruction of or damage to material property.

**16 What constitutes an occurrence under a standard CGL policy?**

See question 14. Liability policies are occurrence-based. Occurrence will be defined in the policy but usually the relevant occurrence is the event that triggers the bodily injury or property damage suffered by the third party.

Product liability policies can be occurrence or claims-made policies.

**17 How is the number of covered occurrences determined?**

It is very common for both claims-made and losses-occurring policies to contain aggregation wording that provides that claims or occurrences arising out of a single event, source or cause will be treated as a single claim or occurrence for the purposes of the limit of indemnity and excess. Whether the aggregation clause favours the insurer or insured is highly dependent upon the facts and the specific wording of the aggregation clause.

**18 What event or events trigger insurance coverage?**

If the insured suffers loss or damage that is an insured risk under the policy, and the claim is made in compliance with policy terms and conditions, a claim will be triggered.

In the case of insurance policies covering the risk of damage to the insured's property, this is typically when damage to the property occurs. The trigger is set out in the policy wording in the case of property policies. In the case of a policy that covers the risk of liability to third parties, a claim will be triggered when the third party seeks to be compensated by the insured or the insurer suffers loss as defined in the policy.

**19 How is insurance coverage allocated across multiple insurance policies?**

It is often the case that more than one policy responds to the same loss. In such circumstances the parties will need to understand how the responsive policies interact and which policy responds first.

There is a distinction between double insurance and where there are layered policies to cover different levels of cover. Where there are different policy layers, the excess policy is not triggered until the primary policy has been exhausted. Where there is double insurance (ie, two or more policies covering the same risk on behalf of the same insured), the principle of contribution applies.

Section 80(1) of the Marine Insurance Act 1906 provides that each insurer shall contribute rateably to the loss in proportion to the amount for which the insurer is liable under contract.

It is also necessary to consider whether its policies contain rateable contribution clauses, non-contribution clauses or excess clauses.

## First-party property insurance

**20 What is the general scope of first-party property coverage?**

First-party property coverage is essentially property insurance for loss or damage to an insured's goods or buildings, or both, following the occurrence of an insured event. The policy can either specify the insured event (earthquake, fire, flood) or be an all-risks policy. All-risks material damage property policies are common in Ireland. There is no standard wording. It is accepted that there is a limit on the range of risks covered and that the policy may expressly exclude or include particular risks.

**21 How is property valued under first-party insurance policies?**

The insured cannot recover more than his or her actual loss on the basis of the principle of indemnity (unless the policy provides otherwise).

In the absence of 'reinstatement as new conditions', insurers are liable for the value of the property at the time of the loss, destruction or damage. Insurers will generally seek to agree the value based on reinstatement costs less a deduction for betterment, the cost of an equivalent modern replacement or market value.

**22 Is insurance available in your jurisdiction for natural disasters and, if so, how does it generally operate?**

We are not aware of any insurance products in Ireland that are aimed solely at providing cover for loss caused by natural disaster. However, there are insurance products available in Ireland that typically cover damage to property as a result of natural disasters (such as hurricanes, floods, wildfires and earthquakes). For example, home insurance policies in Ireland typically provide cover for damage to buildings and contents caused by fire, explosion, lightning, earthquake, storm or floods.

## Directors' and officers' insurance

**23 What is the scope of D&O coverage?**

Legislation in Ireland prohibits a company from including in its constitutional documents and contracts any provision that indemnifies its directors and officers from liability to the company in respect of negligence, breach of duty, default or breach of trust. There is one exception to this, which provides that a company may indemnify a director or officer from any liability incurred by that director or officer in successfully defending civil or criminal proceedings taken against him or her.

A company is, however, permitted to purchase directors' and officers' (D&O) insurance in relation to the negligence, breach of duty, default or breach of trust of a director. D&O policies generally cover damages awarded against the director, legal costs in relation to an action and in certain circumstances, the costs of the director in relation to any official investigation taken by the regulatory authorities in Ireland. However, D&O policies generally exclude cover for fraud and criminal fines imposed.

D&O cover is available in Ireland for side A (loss suffered by director or officer as a result of a claim that has not been indemnified by the company), side B (indemnifications by the company to the director or officer) and side C (actions brought against the company). Side A cover is the most common form. On side A the director is the insured person, whereas for both sides B and C the insured person is the company.

**24 What issues are commonly litigated in the context of D&O policies?**

In Ireland, D&O policies commonly respond to restriction and disqualification applications made in the context of insolvency.

From a coverage perspective, insured versus insured claims may be covered depending on the policy wording. There has been an increase in insured versus insured claims in recent years, in particular where, for example, a liquidator has been appointed to the company.

Issues of non-disclosure and late notification can arise in the context of D&O policies.

Matheson

**Sharon Daly** **sharon.daly@matheson.com**
**April McClements** **april.mcclements@matheson.com**
**Aoife McCluskey** **aoife.mccluskey@matheson.com**

70 Sir John Rogerson's Quay
Dublin 2
Ireland

Tel: +353 1 232 2000
Fax: +353 1 232 3333
www.matheson.com

## Cyber insurance

### 25 What type of risks may be covered in cyber insurance policies?

Cyber policies frequently cover the cost of responding to a breach as well as providing first-party and third-party cover.

Breach response coverage may include the cost of IT forensic experts to investigate how the breach occurred, whether it is ongoing and to identify system weaknesses, PR to manage the fallout publicly and to prevent or minimise brand damage, as well as legal experts and other costs associated with the notification process.

First-party cover relates to the insured's loss and covers business interruption costs owing to the breach.

Third-party coverage includes defence costs and damages arising from third-party claims against an insured where, for example, the insured's negligence enabled the data breach to occur.

### 26 What cyber insurance issues have been litigated?

Cyber insurance is still a relatively new product on the Irish market; however, it has become more popular in recent times. We are not aware that any cyber insurance coverage issues have been litigated before the Irish courts as of yet. There have been data breaches and it is highly likely that the cyber policies have responded in these cases.

## Terrorism insurance

### 27 Is insurance available in your jurisdiction for injury or damage caused by acts of terrorism and, if so, how does it generally operate?

There are insurance products available in Ireland that cover damage to property and loss of income as a result of terrorism. Cover extends to physical damage to commercial buildings and their contents resulting from terrorism and associated business interruption expenses, including profit loss and increased operational costs.

# Italy

**Alessandro P Giorgetti**
Studio Legale Giorgetti

## Preliminary and jurisdictional considerations in insurance litigation

### 1 In what fora are insurance disputes litigated?

As Italy is part of the EU, jurisdiction in matters relating to insurance is determined in accordance with the provisions of section 3 (articles 10 to 16) of Council Regulation (EC) No. 1215/2012 of 12 December 2012 on jurisdiction and the recognition and enforcement of judgments in civil and commercial matters. A particular situation arising from this Regulation is the concurrent jurisdiction of the state of residence of the victim of a motor accident, which traces back to the EU Court of Justice, in judgment No. 6 dated 13 December 2007-C463, interpreting the old Regulation (EC) No. 44/2001 on jurisdiction and the recognition and enforcement of judgments in civil and commercial matters. In that binding precedent the court affirmed that the injured party may sue, with direct action, the foreign motor liability insurer before the judges of the states where he or she resides, provided that direct action is provided for by the national law (and in Italy it is) and that the insurer has a domicile within the territory of an EU member state.

Another frequent problem related to this Regulation was where to sue the producer of a defective product. In this respect, under the EU Court of Justice judgment No. 45 dated 16 January 2014 C45/13 with regard to the determination of the place of the damaging event in cases of liability for defective products, it shall be the place where the relevant defective product is fabricated. The court pointed out that the proximity of the venue to the producer should be considered the most convenient for the possibility of collecting evidence to ascertain the alleged defect, and the best place for proper administration of justice.

When Italy is the member state with jurisdiction over a dispute pursuant to Council Regulation (EC) No. 1215/2012 of 12 December 2012, the competent Italian court to hear the dispute will be determined by the Code of Civil Procedure.

### 2 When do insurance-related causes of action accrue?

The cause of action accrues when the insured event materialises, and this can substantially differ depending on whether property or casualty insurance is involved.

In property insurance the cause of action, or right to indemnity, is fully accrued when the insured event occurs and produces damage to the insured property. It is from that initial moment that the statute of limitations will start to run.

In liability insurance the cause of action, or right to guarantee, is fully accrued when the insured, for the first time, has been formally held responsible by the damaged third party by way of a registered letter or by the service of a writ of summons in court or the service of any other pleading initiating litigation. It is from that initial moment that the statute of limitations will start to run.

### 3 What preliminary procedural and strategic considerations should be evaluated in insurance litigation?

There are a few main preliminary procedural and strategic considerations to be carefully considered when an insurance litigation becomes a reality:

- Is there any advantage or benefit in conciliating the controversy during the compulsory mediation?
- Is there any concurrent jurisdiction that might have competence to hear the case and that might give a significant advantage under the procedural or substantial point of view?
- Also, is the case suitable for a declaratory relief action, or it is better to adopt a passive attitude and wait to be sued?
- Finally, can the case be litigated using the faster short track procedure provided by article 702-bis of the Italian Civil Code or should it be litigated in accordance with the usual, slower, procedure providing a larger and more complete discovery?

### 4 What remedies or damages may apply?

When insurance disputes are litigated, the parties can choose to act on contract or on tort.

If the action is for the maintenance of a contract, the remedy is to have the insurance or reinsurance declared operative, and therefore the insurer or reinsurer is obliged to pay the due indemnity or provide the guarantee within the policy limits, eventually with legal interest from the date on which the litigation was launched or from the date established by the insurance contract.

If the action is for breach of contract, the remedy is to have all foreseeable damages awarded that could be caused by the breach. Typically, this includes a sum equitably determined by the court that in general reflects the due indemnity or the denied guarantee plus monetary devaluation to compensate the loss of power of acquisition, a sanction for frivolous litigation and interest. Unless a specific interest rate has been contractually agreed within the insurance policy, the legal rate shall apply. The legal interest rate was set by a Department of Justice Decree, and the current rate is as low as 0 per cent per annum.

In November 2014 article 17, paragraph 1 of Law No. 162/2014 changed the old system by way of modifying article 1284 of the Civil Code so that the interest legal rate shall be determined in accordance with paragraph 2, article 5 of Legislative Decree 9 October 2002 No. 231, which implemented EU Directive No. 2000/35/EC in Italy. Thus, for 2017, the current annual rate should be 8 per cent, which will eventually change in accordance with variations in the European Central Bank's rate.

Whenever the case involves a criminal act (ie, an attempted or successful fraud or similar situation) the insurer may act on tort and claim compensation for all the costs incurred, from the administrative costs to open and run the case, compensation for the financial prejudice owing to the creation of the claim and cost reserves, to restitution of any money paid to the insured plus the monetary devaluation to compensate the loss of power of acquisition and interest.

### 5 Under what circumstances can extracontractual or punitive damages be awarded?

In Italy, following the leading precedent, decision No. 1183 of 19 January 2007 of the Court of Cassation, punitive damages are considered alien to the Italian legal system, and therefore contrary to internal public policy. A subsequent Court of Cassation decision No. 1781 of 8 February 2012 confirmed in full this precedent.

In this perspective it is interesting to point out the Court of Cassation interlocutory order No. 9978 of 16 May 2016, which presented to the United Sections of the Court a question concerning a possible exequatur of foreign judgments ordering the payment of punitive damages, on the ground that the traditional approach – based on an

outdated conception of public policy – might no longer fit the Italian system of compensatory remedies because of the introduction of remedies with no restorative function. Such remedies are essentially punitive, which would support the conclusion that even in Italy the condemnation to damages might have a deterrent and punitive function along with its restoration purpose.

As a consequence, it is currently not permissible to insure against punitive or exemplary damages in Italy, even if it is possible to do so for punitive damages legitimately awarded in other jurisdictions.

## Interpretation of insurance contracts

### 6 What rules govern interpretation of insurance policies?

Under Italian law, insurance is a typified contract, which means that it is thoroughly regulated by the Civil Code. Articles 1360 to 1371 of the Civil Code dictate hermeneutic rules for the interpretation of all contracts, including insurance contracts.

For insurance contracts, article 1888 of the Civil Code provides that while an insurance contract can be orally stipulated, the proof of its existence and of its terms and conditions shall be in writing. This provision, along with a clear and properly drafted wording, prevents a number of disputes on the object, scope and extension of the contract. Notwithstanding this, there are some cases where the policies are badly drafted or the risk transferred particularly complicated, with the consequence that the policy wording needs a judicial interpretation.

### 7 When is an insurance policy provision ambiguous and how are such ambiguities resolved?

Should a problem of interpretation arise, the contract shall be interpreted using the general interpretation rules provided by the Civil Code, which mainly relate to the will of the parties and good faith.

Furthermore, depending on whether the insurance wording was thoroughly negotiated between the parties or was a prepared and preprinted form, some mandatory rules provide significant differences in the interpretation and enforcement of contracts.

In the case of a negotiated contract, this is constructed in accordance with good faith and the parties' original intentions, including parties' actions before and after the interpretation became an issue, and any added clause or cancellation that modifies the original policy text shall prevail. Conditions precedent or essential conditions must be properly addressed in the policy so that the insured's attention is directed to the conditions so that no misunderstanding or misinterpretation can arise from them.

On the other hand, whenever the insurance contract is in a preprinted form designed to uniformly regulate a number of contractual relationships principally with consumers or involving mass risks, the basic rule is to interpret the contract against the party that drafted the policy wording if the wording contains onerous clauses (eg, clauses modifying the litigation venue, enshrining forfeitures, limiting the right to oppose objections, restricting the freedom to contract with third parties, or imposing tacit arbitration, extensions or renewals of the contract).

## Notice to insurance companies

### 8 What are the mechanics of providing notice?

Once an insured event has taken place, in accordance with article 1913 of the Civil Code, the insured shall inform the insurer or reinsurer of such event within three days from the day on which he or she became aware of the loss occurrence, unless the insurer or reinsurer has already had notice of the loss.

Notice of claim is given by any means of communication, but in general a receipt of the given notice is required should an issue arise about the timing of the notice to the insurance company.

### 9 What are a policyholder's notice obligations for a claims-made policy?

Except where the insurance contract does not provide differently, a policyholder's notice obligations for a claims-made policy are the same as any other insured: within three days from the day on which he or she became aware of the loss event – or ought to be aware of the loss event – the insured shall inform the insurer or reinsurer of such event or occurrence. The only difference in the case of a claims-made policy is that the duty arises not from the day on which the insured completed the relevant damaging action or omission, but from the day on which the policyholder received the first communication from the damaged third party, holding him or her responsible for the damage caused.

### 10 When is notice untimely?

A notice is untimely either when it is given beyond the three days provided by article 1913 of the Civil Code, or beyond the longer terms agreed by the parties and listed in the policy.

### 11 What are the consequences of late notice?

Should the insured fail to give notice within three days of the loss event or totally omit giving notice to the insurance or reinsurance company, this does not authorise the reinsurer or insurer to deny liability unless prejudice has been suffered, and in this case the indemnity can only be proportionally reduced to reflect such prejudice.

## Insurer's duty to defend

### 12 What is the scope of an insurer's duty to defend?

According to article 1917, the insurer has a duty to defend until the automatic sub-limit for defence costs, equal to at least one-quarter of the policy limit, is exhausted or until the insured has negotiated a settlement with the injured party that was not finalised because the policyholder withheld his or her consent to the settlement.

Should the sub-limit for defence costs be exhausted while the case is ongoing, the insurer will be obliged to defend and bear the relative costs until the end of that phase of the proceeding.

Finally, it is important to note that if the judgment or arbitration award should exceed the policy limit, the defence costs shall be apportioned between the policyholder and the insurer in accordance with their respective interests in the award.

### 13 What are the consequences of an insurer's failure to defend?

There are a number of consequences if an insurer fails to defend. The first and most immediate would be to be joined by the policyholder to every litigation the damaged third party brings against the insured. The second is that the insurer or reinsurer will have to bear all litigation costs, including its own insured's costs. The third and last consequence is that the policyholder could claim breach of contract against the insurer or reinsurer and seek special damages according to article 96 of the Civil Procedure Code for abusive or frivolous litigation.

## Standard commercial general liability policies

### 14 What constitutes bodily injury under a standard CGL policy?

Bodily injury is any negative modification of the physical or psychological situation of a human being. The concept of injury is strictly connected to the alteration of the person's health with reference to his or her original state (ie, the passage from health to illness, or the aggravation of a pre-existing disability or pathological condition).

### 15 What constitutes property damage under a standard CGL policy?

Property damages are any material harm suffered by an object owned by the insured upon the occurrence of certain events covered by the insurance.

Property damage can be divided into direct property damage and consequential property damage. Direct damage is any material harm caused by the insured event by way of an immediate physical contact with the insured's object. Consequential property damage is that not immediately and materially connected with the event, but linked to it only as an indirect consequence; this second category of property damage is insured only if expressly named in the policy wording as covered damage.

### 16 What constitutes an occurrence under a standard CGL policy?

The term 'occurrence' in CGL contracts could indicate both the fact that a third party alleges damages as a consequence of a specified action or omission of the policyholder holding him or her liable for damages and claiming full compensation; or the specified action or omission from which the claimed damages stem.

**17 How is the number of covered occurrences determined?**

Policies usually determine each loss event as an occurrence, unless the policy wording incorporates a claims series clause, according to which several adverse events attributable to a single cause are jointly considered as one occurrence. This is common, especially in product liability insurance, where a single common defect can determine a series of separate third-party claims that are all considered one occurrence backdated to the first loss occurrence and applying to all that year of coverage, despite the fact that some of them may have occurred in the following years of coverage.

**18 What event or events trigger insurance coverage?**

Each loss event is an occurrence triggering insurance coverage unless a claim series clause is incorporated into the insurance contract, and in this case only the very first loss event triggers the insurance coverage.

**19 How is insurance coverage allocated across multiple insurance policies?**

Whenever multiple insurance policies are insuring the same risk there is a situation of indirect co-insurance where each and every insurer will concur to the indemnity in proportion to its policy limit without joint and several liability. The insured shall claim from each of the insurers their respective due indemnity.

In cases where concurrent tortfeasors are insured with different liability insurance companies, claimants can claim the full indemnity from one insurer who will then have the right of recourse against the other insurers for their quota shares. If one of the insurers should become insolvent, its quota share shall be divided among all the remaining insurers in proportion to their policy limits.

## First-party property insurance

**20 What is the general scope of first-party property coverage?**

The scope is to indemnify any loss, covered under the terms of the insurance that the policyholder suffered to his or her own property. Article 1900 of the Civil Code excludes from the scope of any property insurance damage caused by gross negligence, or by the wilful acts of the contracting party, the insured or the beneficiary. Notwithstanding this provision, gross negligence can be covered by way of specific contractual provision and against a corresponding remuneration that increases the policy premium.

**21 How is property valued under first-party insurance policies?**

In a first-party property damage claim, the assessment of the damaged or lost property is determined by its condition and by the market price at the time of the loss occurrence, unless other criteria have been negotiated by the parties and contractualised in the insurance policy wording.

To determine the damaged property's economic value, the following factors are usually taken into account: the age of the property, date of purchase, purchase price, its rarity on the market and any other facts pertinent to a correct appraisal.

**22 Is insurance available in your jurisdiction for natural disasters and, if so, how does it generally operate?**

About 78 per cent of Italian homes are exposed to a high or medium-high hydrogeological or earthquake risk, but natural disaster insurance, albeit available, is not common as just 30 per cent of householders have a policy against such risks.

Most of the earthquake covers aim to guarantee the insured against material damage to properties, including that resulting from fire, explosion and explosion as a consequence of another insured risk.

The most common policies on the market have relatively low policy limits and high deductibles, as well as numerous coverage exclusions. Among these, the most common are clauses excluding the policy operativity for other natural events (even if closely related to the seismic event such as volcanic eruptions, tidal waves, floods and landslides), or excluding damage as a result of theft or looting, indirect damages to productive activities exerted in the insured buildings, and all damage to buildings (or parts of them) under construction or not in compliance with the urban planning and building regulations, or having a particular historical or artistic value.

**Update and trends**

Cyber risk and the implementation of the GDPR are the most relevant issues for Italian companies. There has been a significant increase in requests for insurance coverage along with requests for preventive management of the data risk. Litigation over cyber risk and breach of personal data security is increasing and it is expected to further increase both in number as well as in damages award severity.

D&O coverage remains stable, registering an average 8 per cent decline that reflects the relative prosperities of the years 2017 and 2018 that reduced the litigation in this sector.

Medical malpractice litigation, following the Gelli Law (8 March 2017, No. 24) that reformed the Italian National Health Service, remained stable and a source of heavy losses owing to the severity of the court awards. In reality this trend should slowly reverse, bearing in mind that the new law renders the civil responsibility of doctors grounded on tort, and the patient shall have the burden of proof of the error or omission, the damage, and the causation link between the former two. Moreover, the doctor will respond only for gross negligence for having acted in breach of the clinical care practices and recommended guidelines for the specific illness. This will render the litigation far more complex for the claimant, drastically reducing the overall litigation numbers.

The natural disasters (floods, landslides and earthquakes) that characterised 2017 and 2018, and the associated costs, led to the redrawing of the Italian geographical map of natural disaster risks. In addition, a rise in the prices of the property insurance is expected, even if there is a greater demand for coverage by businesses and individuals, sensitised by the devastation suffered. It is therefore expected that this trend will become another source of insurance litigation in the short and medium terms.

On the other hand, policies against damage resulting from floods are less widespread. In this case, the guarantee is usually extended to damages resulting from fire, explosion and explosion as a result of the insured risk, which must (according to the most used clauses) manifest in a violent and devastating manner and produce its effects on a plurality of goods or buildings in the neighbourhood. Some policies include damage caused by flotsam carried by water and damage resulting from floods caused by earthquakes or landslides. Some contracts exclude damage to premises placed at a certain height (eg, any underground or basement rooms), or damage deriving directly from landslides or ground subsidence, even if resulting from severe flooding events.

Even less frequent are policies to guarantee all other catastrophic risks such as tidal waves, volcanic eruptions and avalanches.

## Directors' and officers' insurance

**23 What is the scope of D&O coverage?**

D&O policies are designed to cover the risk of the individual liability of a director or officer from lawsuits as well as some regulatory actions undertaken by stakeholders or shareholders, regulators, state investigators or others alleging wrongdoing on the part of the board of directors, the officers and – in Italy – also the members of the internal auditing board. Some policies also provide cover for the indemnities the corporation is obliged to grant to their directors and officers for the same individual liability arising from the same lawsuits or regulatory actions based on alleged wrongdoing on the part of the board of officers.

**24 What issues are commonly litigated in the context of D&O policies?**

The bankruptcy context is probably the source of the largest and most commonly litigated issues in the context of D&O policies. The following controversial issues are often the source of such litigation: the misrepresentation of the D&O risk at the time of the insurance negotiation; the existence of the liability resulting from errors and omissions of the directors and officers; and the assessment of the economic prejudice that the alleged errors or omissions may have caused.

Other typically thorny issues litigated in the context of D&O policies are defamation, mobbing and harassment claims.

Among financial risks, 'derivative representation' and creative financing through junk bonds are still commonly litigated issues in

connection with D&O insurance, whereas among the industrial operative risks, air and water pollution are among the most frequent causes of litigation.

## Cyber insurance

**25 What type of risks may be covered in cyber insurance policies?**

Cyber risks should be expressly insured with an ad hoc special coverage, but they can fall under a number of other insurances whenever such risk is not expressly excluded. A cyber risk could be a source of claim not only under electronic insurance policies and related extended warranties, but also under the following types of policies:

- product liability and recall insurance;
- some specific professional indemnity insurance;
- D&O liability insurance;
- business interruption insurance; and
- in financial lines, under bankers' blanket bond or payment protection insurance.

**26 What cyber insurance issues have been litigated?**

Recently, a few high-profile data breaches have caused the party that suffered the breach to litigate with its insurer for remedial costs such as consumer notifications, customer support and costs of providing credit-monitoring services to affected consumers, and for business interruption and extra expenses related to the improvement of the party's security measures.

## Terrorism insurance

**27 Is insurance available in your jurisdiction for injury or damage caused by acts of terrorism and, if so, how does it generally operate?**

In light of recent terrorist attacks and kidnappings by terrorists, along with the risk of political violence, a debate arose in Italy about the possibility of providing a dedicated coverage against 'terrorism and political risk', but to date such insurance has not been made available. One of the reasons might be that these covers may be void according to article 1346 of the Civil Code (unlawfulness of the insurance object), especially if insuring against the ransom to the terrorist and considering the fact that it falls to the Italian state to manage the negotiations with the terrorists when an Italian citizen or company is at risk.


# Studio Legale Giorgetti

**Alessandro P Giorgetti** **giorgetti@giorgettilex.com**

Via Fontana 28
20122 Milan
Italy

Tel: +39 02 5457 734 / +39 02 5457 923
Fax: +39 02 5518 0282
www.giorgettilex.com

# Japan

**Keitaro Oshimo**

**Nagashima Ohno & Tsunematsu**

## Preliminary and jurisdictional considerations in insurance litigation

### 1 In what fora are insurance disputes litigated?

Judicial remedy pertaining to insurance disputes is pursued through court, arbitration or alternative dispute resolution proceedings. If the relevant insurance policy contains a forum selection clause, the dispute would be brought to the battleground as agreed. Commercial policies, the holders of which are enterprises, often state that any dispute over the sums payable by the insurance company shall be resolved and determined by agreement of two neutral adjusters as selected by the policyholder and the insurance company respectively, or an independent third party as selected by the two adjusters if they fail to reach agreement on the sums payable by the insurance company. The clause is not considered to be an arbitration agreement in that neither the agreed decision of the two adjusters nor the decision of the independent third party is final and conclusive, and hence, despite the frequency with which we see such clause in commercial policies, the clause is said to be rarely used. Standard D&O insurance and some other commercial policies contain a forum selection clause, which sets forth that courts in Japan shall have jurisdiction over any lawsuit pertaining to this insurance contract. The clause is intended to exclude foreign jurisdictions in such instance where directors or officers of foreign subsidiaries or other offices are covered as the insured persons under a D&O policy issued for Japan-based multinational corporations. In the area of consumer-instigated disputes, typically in the life insurance industry, they are often brought to alternative dispute resolution proceedings sponsored by the insurance industry. If the ADR panel issues a recommendation for settlement after hearing the allegations of both sides, the insurance company must follow the recommendation and settle the dispute in principle.

### 2 When do insurance-related causes of action accrue?

Typically, insurance-related causes of action accrue on the occurrence of the insured event as specified in the insurance policies. If the insurance policies set forth the insurer's liability-attaching point differently, the right of the policyholder shall accrue in accordance with the policy language.

### 3 What preliminary procedural and strategic considerations should be evaluated in insurance litigation?

Given the uncertainty inherent in most lawsuits, it would always merit consideration for both parties to discuss, on a without-prejudice basis, the matter in question to reach an amicable resolution before instigating a lawsuit. Insurers especially would need to show good faith in the course of such discussion so as not to be accused of wrongful denial of claims. Wrongful denial could expose the insurer to a tort liability or an administrative sanction imposed by the insurance regulators, or both. If the dispute is over the scope of coverage or the interpretation of the policy language of commercial policies, it would be useful for the policyholders to ask the views of the insurance broker that mediated the execution of the insurance contract. Due consideration should be given to whether it may be feasible to proceed with fully fledged adversarial proceedings given the availability of replacing insurance cover or the existence of other insurance policies issued by the insurer.

### 4 What remedies or damages may apply?

Typically, the policyholders would attempt to prove and recover the insured sum within the limits of insurance that are set on each occurrence or an aggregate basis in the relevant clauses in the insurance policies or declarations attached to the policies.

### 5 Under what circumstances can extracontractual or punitive damages be awarded?

Punitive damages are generally not awarded or enforceable by courts in Japan. As such, punitive damages are generally not insured under liability insurance policies.

## Interpretation of insurance contracts

### 6 What rules govern interpretation of insurance policies?

There is no statutory set of rules on the construction of contracts. Generally speaking, we follow the black letter, and as long as the contract language is complete and clear, the wording of the contract, or the ordinary meaning assigned to the wording, will govern. No provision in a contract should be construed in isolation but in harmony with other terms and conditions set forth in the contract. If the language is not so certain or if the contract does not address the issue in question, we also consider the expectations of the parties, so long as they are objectively reasonable and in line with the purpose or context of the contract, which may be supported by legitimate evidence on the factual background surrounding the parties at the time of execution of the contract. In insurance contracts, the language is often not the product of negotiation between the parties, but is authored unilaterally by insurers and offered to their customers on a 'take it or leave it' basis. Moreover, the entire policy provisions are often not disclosed to the customers before execution of the insurance contracts. Such circumstances would support courts' decisions to construe the insurance contracts in favour of aggrieved policyholders. As regards the burden of proof, the policyholder must show that the insuring agreement covers the alleged claim, and the insurer bears the burden of proving that the exclusion clauses would apply in order to deny its liability under the policy by virtue of the exclusion clauses. If the circumstances warrant it, the court would construe exclusion clauses strictly.

### 7 When is an insurance policy provision ambiguous and how are such ambiguities resolved?

As indicated in question 6, the policyholders do not necessarily have to first establish ambiguity in the insurance contracts before relying on evidence about the factual background or otherwise in pursuit of policy construction in their favour. Moreover, policy language that seems to be ambiguous in isolation is often not so ambiguous if it is viewed alongside the entire agreement or the objective or context of the contract.

## Notice to insurance companies

### 8 What are the mechanics of providing notice?

As for 'claims-made' policies, the insurance is called on at the time when the relevant claim is made in accordance with the claim provisions contained in the policy (see question 9). The policies set formal notification procedures to be followed by the policyholder in respect

**Update and trends**

The Financial Services Agency (FSA), which is the Japanese governmental agency in charge of financial services, started publication of its annual administration policy in 2015. The 2018 version was published on 26 September 2018 and the summary English translation is available at: www.fsa.go.jp/en/news/2018/20180926.html.

It states that the FSA will continue to place customers at the centre of its financial service supervision. It also urges financial service providers generally to find or improve sustainable business models in light of changing business circumstances, such as digitalisation or increased use of artificial intelligence.

The FSA specifically urges the life insurance sector to improve the transparency of investment-type life insurance or pension in the course of their distribution through such agents as banks or security houses to the customers. For instance, the FSA shows its dissatisfaction with the lack of visualisation of the risks or expenses associated with such investment-type products as foreign-denominated life annuities. It is anticipated that the Life Insurance Association of Japan will include desired disclosure methods in its voluntary guidelines with due consideration of the rules enforced in other jurisdictions, such as the key information document requirement under the Packaged Retail and Insurance based Investment Products regulations in the European Union regime. Once the voluntary guidelines are amended and adopted by the association, they will be honoured by industry-wide best practice and followed in principle by all member life insurers.

of details of such underlying claim made against the policyholder. As for 'occurrence-based' policies, which are more prevalent in the industry, the insurer's liability is attached on the 'occurrence' of the insured event. The policies nonetheless impose notification obligations on the side of the policyholders, and failure to make due notice could expose the policyholder to a reduction of insurance benefits otherwise payable under the policy (see questions 10 and 11). The Insurance Law (Law No. 56, 2008) also simply states that when policyholders or beneficiaries become aware of the occurrence of the insured event, they shall notify it to the insurer without delay. It seems that the rationale for the notification obligations is to enable the insurer to provide guidance to minimise the loss; conduct incident examination swiftly so as to ensure the timely payment of the insurance benefits; and perform timely capture claims for such purposes as accounting, reserving and evaluation of the book of business.

### 9 What are a policyholder's notice obligations for a claims-made policy?

As for occurrence-based policies, the link between an insured event, such as bodily injury or an accident, and the relevant insurance policy is solely the physical facts of such insured event. Failure to notify on the side of the policyholders does not change this. As for claims-made policies, the link is the claim first made by the underlying plaintiff against the policyholder for compensation for the damage allegedly suffered. Failure to notify by the policyholders does not change this. However, if the policy states that the claim must be notified to the insurer during the policy period, it means that the policyholder must fulfil the notice obligation to link the claim to the relevant policy.

### 10 When is notice untimely?

There is no authoritative ruling or guidance on when notice is untimely, but the Supreme Court case mentioned in question 11 suggests that a mere failure to meet the notice period as set forth in the policy (say, 60 days from the day of the occurrence) would not deprive the policyholders of a right to recover the insured benefit in full.

### 11 What are the consequences of late notice?

The Supreme Court decision of 20 February 1987 (Minshu 41-1-159) indicates that the insurer has to demonstrate prejudice in order to deny all or any part of benefits payable under the policy were it not for failure to make due notification. Namely, an insurer may deny coverage if it has successfully demonstrated 'extraordinary bad faith' on the part of the policyholder in respect of the late notice in breach of the agreed policy wording. Otherwise, the insurer may reduce its claim payment obligation only to the extent of the actual damage suffered due to the late notice and only after successfully demonstrating the actual damage. The court in this case suggested that 'extraordinary bad faith' could be established if the insurer demonstrated intent of the policyholder or beneficiary to deceive the insurer to pay insurance benefits. If such intention did exist, the insurer could terminate the policy retroactively pursuant to a termination clause regardless of whether the notification is made to the insurer.

## Insurer's duty to defend

### 12 What is the scope of an insurer's duty to defend?

Unless the policy explicitly states that the insurer assumes the position to defend, it is the insured who shall defend against claims, and the insurer will only indemnify the insured against the defence costs. A liability insurer shall indemnify policyholders from expenses incurred by them to defend a claim made against them in accordance with the terms of liability insurance policies. If the insurer owes the duty to defend, the defence expenses will be paid within or outside the limit of the insurance as agreed in the insurance contract.

### 13 What are the consequences of an insurer's failure to defend?

If the insurer owes the duty to defend, the insurance policy specifically sets forth the scope of such duty or right to investigate, defend and settle any claims as long as the claim is covered by the insurance policy. The insurance policy, however, is unlikely to set forth the consequence of an insurer's failure to defend. Under the general theory of contract and tort laws, the aggrieved policyholder would be able to recover damages with a reasonable connection to the negligence of the insurer. Reasonable expenses borne by the policyholder to defend the claim could be recoverable from the negligent insurer by virtue of such general theory even when the relevant insurance policy is silent on the consequence of an insurer's failure to defend.

## Standard commercial general liability policies

### 14 What constitutes bodily injury under a standard CGL policy?

Typically, bodily injury is defined to mean 'bodily injury, sickness or disease sustained by a person, including death resulting from any of these at any time'. It may follow to clarify that 'bodily injury includes mental anguish, mental injury and death as a result of physical injury to that person.' If the insurance policy addresses 'advertising injury' or 'personal injury' as well, the bodily injury definition also clarifies that 'bodily injury does not include any injury included in advertising injury or personal injury'. The definitions mentioned above would suffice if a manifest injury is caused instantly by an accident. However, if a disorder is caused gradually as a result of exposure to a harmful substance over a long time, it is not clear whether a bodily injury means the gradual micro-level change of cells or the manifestation of the disorder. We do not have established rules to determine what constitutes bodily injury in this instance. Needless to say, the issue relates to how to determine its occurrence as well.

### 15 What constitutes property damage under a standard CGL policy?

Typically, 'property damage' is defined to mean:

> *(a) physical injury to tangible property, including all resulting loss of use of that property (and all such loss of use shall be deemed to occur at the time of the physical injury that caused it); or (b) loss of use of tangible property that is not physically injured (and all such loss of use shall be deemed to occur at the time of the 'occurrence' that caused it).*

### 16 What constitutes an occurrence under a standard CGL policy?

Typically, occurrence is defined to mean 'an accident, including continuous or repeated exposure to substantially the same general harmful conditions'. A variety is 'an accident, or continuous or repeated exposure to substantially the same general harmful conditions'. With respect to advertising injury and personal injury, occurrence is defined to mean an offence committed by an insured resulting in advertising injury or personal injury. In a standard Japanese-language CGL policy, occurrence is not defined.

**17 How is the number of covered occurrences determined?**

If the relevant insurance policy specifies the manner of counting the number of occurrences, we follow this specific provision. For instance, if, in respect of limits of liability, the policy sets forth that the occurrence limit is the most the insurer shall pay for loss resulting from any one occurrence regardless of the number of the insured, the number of claims made against any insured or the number of persons making claims, such provision would govern the manner of counting, or integrating, occurrences for the purpose of the occurrence limit. A standard Japanese-language CGL policy does not define occurrence or offer the manner of counting occurrences. As indicated in question 6, where interpretation of the number of occurrences is reasonably possible, the parties would be allowed to count the number of occurrences in light of 'reasonable expectations', taking into account such background facts as expected frequency and sums of the insured events against the sum of the occurrence limit and the aggregate limit.

**18 What event or events trigger insurance coverage?**

As indicated in question 8, the 'trigger' to call on the insurance policy is occurrence in the case of occurrence-based policies. In the case of claims-made policies, the trigger is a claim against the insured person lodged by an underlying plaintiff.

**19 How is insurance coverage allocated across multiple insurance policies?**

The allocation would follow the 'other insurance' clauses in the relevant insurance policy. Typically, such clause sets forth explicitly the manner in which the policy shall contribute with any other collectible insurance that covers a claim covered under the policy. If the policy is written as excess, the 'other insurance' clauses or other documents as attached to the policy form, such as the declarations, clarify the order of application or the manner of liability sharing among the multiple policies, for instance, by way of showing the attaching point and the cap of each of the layers assumed by excess liability insurers. In the unlikely event that the insurance policy does not contain such clauses, section 20 of the Insurance Law (Law No. 56 of 2008) provides that if a risk is covered by policies issued by multiple insurers, the insured person may recover from any such policies up to their full insured sum, up to the full amount of the loss. Once the payment is made by one insurer, the allocation will be made among the multiple insurers on a pro rata basis.

## First-party property insurance

**20 What is the general scope of first-party property coverage?**

As regards comprehensive insurance for movables, for example, this offers indemnification of physical injury and any extraordinary expenses resulting from the loss of use, including destruction and clean-up expenses.

**21 How is property valued under first-party insurance policies?**

Typically, the relevant policy states that unless otherwise specifically agreed by way of endorsement attached to the policy, the insurer shall determine the sum of recoverable compensation based on the value of the insured property at the place and time of the occurrence of the property damage and if the property injury can be repaired to the state of the property immediately before the injury, the expense required for such repair work shall be the sum of recoverable compensation. In the case of automobile insurance, an endorsement to apply the standard secondary market price of a vehicle equivalent to the insured automobile is attached to the insurance policy automatically. Section 18 of the Insurance Law states that the recoverable sum shall be determined based on the value of the insured property at the place and time of the occurrence of the damage; and that the recoverable sum shall follow the agreed value of the insured property if there is such agreement, but if the agreed sum materially exceeds the actual value, the recoverable sum shall be determined in light of the actual value. In theory, if such agreed valuation of the insured property at the time of execution of the insurance contract by far exceeds its actual value, it would cast doubt over whether such contract constitutes a lawful and valid insurance contract.

**22 Is insurance available in your jurisdiction for natural disasters and, if so, how does it generally operate?**

Losses caused by natural disasters, especially earthquakes, volcanic eruptions and tsunamis, are typically excluded from insurance coverage broadly. If they are covered, specific riders to insure them are typically attached.

## Directors' and officers' insurance

**23 What is the scope of D&O coverage?**

A standard D&O insurance policy offers indemnification in respect of the sums the insured persons become legally obliged to pay as damages in connection with their business conduct, including omission, in the capacity of directors or other similar positions, and reasonable defence expenses, only if the underlying claim is made against the insured persons during the policy period. The recoverable sum does not include any taxes, fines, administrative penalties, or punitive or exemplary damage, if any, charged to the insured persons. The policy does not extend to the directors' liability determined to be owed to their employer as the result of shareholder lawsuits. However, directors can buy an endorsement to extend the cover to such liability owed to the employer at their own cost. If the directors win a shareholder lawsuit, it is not the endorsement but the policy that will cover their defence expenses.

**24 What issues are commonly litigated in the context of D&O policies?**

Typically, a dispute is over the application of exclusions. For instance, the exclusion provisions state that the insurer will not cover if the underlying claim is made against a director because of his or her action

NAGASHIMA OHNO & TSUNEMATSU

**Keitaro Oshimo** **keitaro_oshimo@noandt.com**

JP Tower, 2-7-2 Marunouchi
Chiyoda-ku
Tokyo 100-7036
Japan

Tel: +81 3 6889 7532
Fax: +81 3 6889 8532
www.noandt.com/en

with actual or constructive knowledge about the resulting violation of laws. The argument would then centre on what set of background facts would suffice to establish the constructive knowledge. The exclusion provisions also state that the insurer will not extend cover to all directors broadly in respect of a series of claims if any director is aware, or could reasonably be expected to be aware, of facts showing the likelihood of a threatening claim against him or her before the date of commencement of the policy period. Application of the exclusion in some cases could make the D&O policy almost meaningless to protect directors, and it would provoke strong arguments against it. We do not have established rules on the construction of these exclusions.

## Cyber insurance

### 25 What type of risks may be covered in cyber insurance policies?

A standard cyber insurance policy offers indemnification in respect of the sums insured persons become legally obligated to pay as damages to data owners in connection with divulgence, virus infection or other cyber destruction of their personal data or trade secrets as well as defence expenses, notification expenses and other expenses incurred in order to minimise adversely the effects of data divulgence or cyber attacks. An endorsement to cover losses and expenses caused by network interruption is available as an option.

### 26 What cyber insurance issues have been litigated?

Cyber insurance is a new type of insurance, and it is too early to analyse litigation issues. It is anticipated that, like all other lines of insurance, the application of exclusions or the amount of damages or losses would be disputed in cyber insurance lawsuits.

## Terrorism insurance

### 27 Is insurance available in your jurisdiction for injury or damage caused by acts of terrorism and, if so, how does it generally operate?

Insurance to cover against injury or damage caused by terrorism is generally available in Japan. How it operates varies depending on the type of business. Typically, personal accident insurance offers automatic coverage against injury caused by terrorism. Overseas travel accident insurance to indemnify extra travel expenses caused by terrorism is also available. Property insurance, such as fire insurance or construction insurance, also offers indemnity against damage caused by terrorism with limitation on the insured sum, such as ¥1 billion per insured premises.

# Korea

**Sung Keuk Cho and Hanna Park**
Cho & Lee

## Preliminary and jurisdictional considerations in insurance litigation

### 1 In what fora are insurance disputes litigated?

Insurance disputes can be resolved by litigation before the court (including mediation at the court), or through arbitration and conciliation at the Financial Supervisory Service or the Korea Consumer Agency.

A conciliation procedure at the Financial Supervisory Service can be commenced upon application by the interested party (insured) to the Financial Supervisory Service.

### 2 When do insurance-related causes of action accrue?

A cause of action usually accrues when loss caused by an accident specified in an insurance policy occurs. On the other hand, regarding liability insurance under the Korean Commercial Act (KCA), the cause of action for seeking payment of insurance proceeds accrues when the insured's liability has been confirmed through the insured's payment of damages to a third-party victim, an admission of debt, an amicable settlement or the court's judgment (article 723, section 1 of the KCA).

Under Korean law, a third-party victim is also entitled to file a direct action against the insurer that executed a liability insurance contract with the insured when a loss due to the insurance accident occurs to him or her (article 724, section 2 of the KCA). In other words, under the KCA, a direct action by a third party is allowed in all liability insurance.

### 3 What preliminary procedural and strategic considerations should be evaluated in insurance litigation?

Compared to cases when the insured or victim files a lawsuit in the court, an application for conciliation to the Financial Supervisory Service or Korea Consumer Agency may occasionally save time and costs. In the case of conciliation by the Financial Supervisory Service, the dispute would be considered by a committee comprising members with professional knowledge of insurance, and thus may be preferred by the insured or victim having no such professional knowledge. On the other hand, conciliation by the Financial Supervisory Service will not be binding on the parties, whereas an arbitration award will be binding.

However, because it would be difficult to deem that an application for conciliation to the Financial Supervisory Service (not conciliation by the court) will stop the time bar period, it will be safer to file a lawsuit in the court before the expiry of the three-year time bar period if it is drawing close.

Conciliation before the Financial Supervisory Service will immediately be stopped if a lawsuit is commenced during the conciliation process. Thus, a detailed survey and serious consideration of the application for conciliation to the Financial Supervisory Service or Korea Consumer Agency, and of the cause of the accident and the scope for damages, along with securing evidence in this regard, will be required.

The insurer needs to confirm whether:

- the insured has any other insurance policy covering the same risk;
- there is a third party responsible for the accident;
- the third party has any meaningful assets;
- the policyholder or insured has failed to disclose or has misrepresented material facts either intentionally or by gross negligence; and
- the policyholder or insured has notified the facts where the risk of accident has manifestly changed or increased. (In the event of failure of duty of notice or disclosure, the insurer can rescind the insurance contract within one month of the date of knowing such fact, according to articles 651 or 652, section 2 of the KCA.)

### 4 What remedies or damages may apply?

In liability insurance, in the case of direct action by a third party, monetary compensation for, inter alia, medical costs already incurred or for future treatment (including the costs of caregiver and medical accessories), property loss (including loss of business), or pain and suffering, may be claimed. Pain and suffering, in the case of liability insurance, is considered and recognised taking a variety of circumstances into account, usually up to an amount below the maximum amount of 100 million won set by the court (as from 1 March 2015). If there are aggravating circumstances, pain and suffering can be recognised up to an amount below the maximum amount of 200 million won in case of a traffic accident, up to an amount below the maximum amount of 400 million won in case of mass casualty incident, up to an amount below the maximum amount of 600 million won in case of commercial torts against customers and above 200 million won in case of defamation (as from 24 October 2016). Korea does not allow punitive damages.

### 5 Under what circumstances can extracontractual or punitive damages be awarded?

Under Korean law, extracontractual or punitive damages are not awarded.

## Interpretation of insurance contracts

### 6 What rules govern interpretation of insurance policies?

For the interpretation of insurance policies, the KCA, the Act on Regulation of Terms and Conditions (ARTC), and the Korean Civil Code, etc, will apply. The ARTC is a distinctive Korean law applying to all standardised contracts, including insurance policies.

Under article 638-3 of the revised KCA, when insurers execute an insurance contract with the insured (or policyholder), the insurer shall deliver the insurance policy to the insured (policyholder) and explain the important terms of the policy to the insured (policyholder). In the event of a breach of such duty of explanation, the insured (policyholder) can cancel the insurance contract within three months of the execution of the insurance contract.

Further, under article 3, section 4 of the ARTC, in the event of the insurer's violation of its duty to explain the important clauses (the points of which, the knowledge or the lack of knowledge can have an effect on execution of the insurance contract), in principle, such term cannot be deemed to be a part of the insurance contract.

### 7 When is an insurance policy provision ambiguous and how are such ambiguities resolved?

In Korea, ambiguities occasionally arise in relation to, inter alia, the scope of the insured, the covered risks and any exclusions in the policy terms.

When there is ambiguity in the wording of a policy, the purpose or intent of the parties in the individual insurance contract are not considered; rather, an objective interpretation according to the standard of an average person will be employed. However, when the wording can still be interpreted as having various meanings even after the

objective interpretation, that wording will be interpreted favourably to the insured (according to the principle of construction against the drafter).

## Notice to insurance companies

### 8 What are the mechanics of providing notice?

A policyholder, insured or insurance beneficiary shall dispatch notice to the insurer as soon as he or she becomes aware of the occurrence of an accident without delay (article 657, section 1 of the KCA), and notice can be given by any means including writing, oral statement, telephone or email. Since a notice in writing may be required according to an insurance policy, it would be proper to send a notice by 'contents-certified mail', a kind of registered mail. A notice should be made to the insurer, not to the insurance broker, who is usually deemed to have no authority to receive notice, unless otherwise authorised. (On the other hand, an insurance agent has been deemed to have authority to receive notice, and it is explicitly stipulated in article 646-2, section 1 of the revised KCA.)

According to the standard general liability policy used in Korea, the notice obligation arises as to the time and place of occurrence of an accident; the details of the accident (victims and witnesses, etc); and when the claim is made or a lawsuit is filed by a third-party victim against the insured.

### 9 What are a policyholder's notice obligations for a claims-made policy?

According to the 'claims-made' policy used in personal liability insurance, the policyholder shall notify the insurer without delay of the occurrence of an insurance accident (article 722 of the KCA). If the policyholder notifies the insurer of the accident after expiry of the policy period specified in the 'claims-made' policy, the insured of that policy may not be indemnified.

### 10 When is notice untimely?

Unless specified otherwise in the insurance policy, a policyholder, insured or insurance beneficiary has an obligation to provide the insurer with notice 'without delay' upon becoming aware of the occurrence of an accident. Unlike 'immediately', the phrase 'without delay' is construed to mean 'as soon as practicable with reasonable care'. However, it is not clear what is considered 'untimely' under Korean law, and this would be determined on a case-by-case basis.

### 11 What are the consequences of late notice?

The insurer is not liable for the damages additionally incurred as a result of late notice (article 657, section 2 of the KCA). This is the same regarding late notice by the insured to the insurer of a claim by a third party against the insured in the case of liability insurance (article 722, section 2 of the revised KCA). However, the burden of proving the causal relationship between late notice and additionally incurred damages rests on the insurer.

## Insurer's duty to defend

### 12 What is the scope of an insurer's duty to defend?

According to article 720 of the KCA and the standard liability insurance policy used in Korea, the insurer has a duty to pay the insured's defence costs such as the court costs and lawyers' fees that the policyholder or the insured paid. In addition, when a third-party victim seeks damages against the insured, the insurer can settle this claim, on behalf of the insured, from his or her own monies, depending on the insurer's decision, and seek the necessary cooperation from the insured. However, the insurer does not personally bear the duty to defend.

As discussed in question 2, a third-party victim has the right to claim damages directly against the insurer (article 724, section 2 of the KCA). In such event, the insurer will defend the case for itself as well as for the insured, and the policyholder or the insured (or both) will have the duty to provide the insurer with the necessary cooperation (article 724, section 4 of the KCA).

On the other hand, according to the standard liability insurance policy used in Korea, in the event that the quantum of damages for which the insured will be legally liable to third-party victims clearly exceeds the limit of liability under the policy, or the insured fails to provide necessary assistance without justifiable reasons, the insurer may not act for the insured in respect of the procedures of settlement, arbitration or litigation.

### 13 What are the consequences of an insurer's failure to defend?

If a policy provides for an insurer's duty to defend but the insurer fails to do so, the insurer will be liable for damages based on breach of contract. However, the insured has to prove that the damages suffered are owing to the insurer's failure to defend.

## Standard commercial general liability policies

### 14 What constitutes bodily injury under a standard CGL policy?

Bodily injury under a standard CGL policy means bodily injury, sickness or disease sustained by a person, and death resulting from any of these.

### 15 What constitutes property damage under a standard CGL policy?

Property damage under a standard CGL policy means physical injury to, or destruction of, tangible property; loss of the use of tangible property that has been physically destroyed; or loss of the use of tangible property that has not been physically destroyed.

### 16 What constitutes an occurrence under a standard CGL policy?

Occurrence under a standard CGL policy typically means not only a sudden accident, but also one of continuous, repeated or cumulative exposure to substantially the same general harmful condition that causes bodily injury or property damage.

### 17 How is the number of covered occurrences determined?

Occurrence under a standard CGL policy means an accident including continuous, repeated or cumulative exposure to substantially the same general harmful condition that causes bodily injury or property damage, regardless of the number of insureds or victims or the number of claims.

When determining an occurrence, whether there is a unity in terms of cause, locality, time and intent are important factors to be considered.

### 18 What event or events trigger insurance coverage?

The insurer shall indemnify the following losses, in accordance with the policy, sustained by the insured because of legal liability toward the victim of the insured for bodily injury or property damage due to an accident that is provided for in the policy, and that occurred during the policy period and within the territory provided in the policy:

- legal compensation for losses that the insured is liable to pay to the victim;
- suing and labour expenses incurred by the policyholder or insured in preventing or minimising the loss;
- defence costs;
- a surety bond premium within the limit of liability under the policy (however, the insurer has no duty to provide security); and
- costs incurred in complying with the insurer's demand.

Under an occurrence policy, coverage is triggered by the occurrence of the insured accident. In a claims-made policy, coverage is triggered by a claim for losses by the victim after occurrence of the accident (or by notice by the insured to the insurer, if there is no clear evidence on the date when the victim claimed against the insured).

### 19 How is insurance coverage allocated across multiple insurance policies?

If there is another insurance that the insured is legally obligated to have, only the exceeding amount beyond the limit of liability under that obligatory insurance will be covered.

If there are more than two insurance policies covering the same risk, with neither being an obligatory policy, there will be a pro rata allocation of damages, in proportion to the ratios of coverage under each of the policies as against the sum of the entire indemnification amounts, when the sum of each indemnification calculated under each policy (on the assumption that there is no other insurance) exceeds the damages.

According to article 672, section 1 of the KCA, in the case of double insurance where the sum of each insurance coverage exceeds the insured value, each of the insurers shall be jointly and severally liable up to the amount of each insurance coverage, and each insurer's liability for indemnification shall be pro rata to each insurance coverage.

## First-party property insurance

### 20 What is the general scope of first-party property coverage?

First-party property insurance policies compensate an insured for damage to the insured's own property. This insurance includes various kinds of cover, such as (house or movables) fire insurance, theft insurance, glass insurance and inland floater insurance, and the scope of coverage differs depending on the kind of insurance policy.

According to article 667 of the KCA, unless specified otherwise in an insurance policy, the insured's loss of business (or earnings) due to an insured accident will not be covered. According to article 680 of the KCA, the suing and labour costs incurred by the insured in preventing or minimising such loss will be covered by the insurer even when they exceeded the limit of liability.

The costs for the assessment of a loss amount will also be paid by the insurer (article 676, section 2 of the KCA).

### 21 How is property valued under first-party insurance policies?

According to the standard fire insurance policy used in Korea, the insurer's liability shall be the loss amount to be determined based on the insured value of the property at the time and place of the loss.

Generally, as regards buildings, machinery and furniture, etc, that are in continuous use, the value for coverage will be the costs of purchasing one of the same structure, use and character as the damaged one (replacement costs) after deducting the depreciation according to the years of use and the degree of wear and tear. If there is a separate, different agreement between the parties, the loss amount can be the costs for purchasing a new product (article 676, section 1 of the KCA).

Meanwhile, as regards exchange goods such as a commodity, raw material or product, etc, the replacement costs (costs for purchasing or reproducing) will be the value for coverage.

### 22 Is insurance available in your jurisdiction for natural disasters and, if so, how does it generally operate?

According to the Korean Storm and Flood Insurance Act (KSFIA), insurance is available to indemnify the insured for damages and losses caused by typhoon, flood, torrential rain, gale, heavy seas, tidal waves, heavy snowfall and earthquakes. The central and local governments of Korea subsidise about 52.5 to 92 per cent of the premiums (for the policy effected in 2018), and there are five insurance companies in Korea that provide a storm and flood insurance policy (DB Insurance Co Ltd, Hyundai Marine & Fire Insurance Co Ltd, Samsung Fire & Marine Insurance Co Ltd, KB Insurance Co Ltd and NH Property & Casualty Insurance Co Ltd).

Under the KSFIA, the subject matter of the insurance policies shall be limited to buildings and agricultural greenhouses (including plastic greenhouses). The period for the insurance shall be one year, which can be extended up to three years by agreement. From 2018, stores or factories owned or operated by small business and enterprises can be subsidised about 34 to 92 per cent of the premiums from the central and local governments. Storm and flood insurance policies can be taken out on the basis of fixed sums indemnification or actual loss pro rata indemnification (average).

## Directors' and officers' insurance

### 23 What is the scope of D&O coverage?

In a standard policy of D&O insurance in Korea, the insurer shall indemnify all the loss (as defined by the policy) suffered by the insured where such loss was caused by a wrongful act of the insured.

Loss is defined under the standard policy to mean the total amount that any insured person becomes legally obligated to pay on account of each claim and for all claims in each policy period and the extended reporting period, if exercised, made against them for wrongful acts for which coverage applies, including, but not limited to, damages, judgments, settlements, costs, defence costs and legal representation expenses.

The loss does not include (i) any amount not indemnified by the insured organisation for which the insured person is absolved from payment by reason of any covenant, agreement or court order, (ii) any amount incurred by the insured organisation (including its board of directors or any committee of the board of directors) in connection with the investigation or evaluation of any claim or potential claim by or on behalf of the insured organisation, (iii) fines or penalties or aggravated or exemplary damages imposed by law or the multiple portion of any multiplied damage award outside Korea, or (iv) matters uninsurable under the law pursuant to which this policy is construed.

Also, the wrongful act is defined under the standard policy to mean any error, misstatement, misleading statement, act, omission, neglect, or breach of duty committed, attempted, or allegedly committed or attempted, by an insured person, individually or otherwise, in his or her insured capacity, or any matter claimed against him or her solely by reason of his or her serving in such insured capacity.

### 24 What issues are commonly litigated in the context of D&O policies?

D&O policies typically provide that defence costs such as suing and labour costs and legal costs (court costs, lawyers' fees, etc) will be covered. However, when policies provide the requirements and scope of coverage narrowly and more strictly than the KCA, a dispute will arise as to whether the terms and conditions of the policy were clearly stated and explained. (If there was a duty to state clearly and explain the policy terms, but this was not abided by, the insurer is unable to rely on that as a part of the insurance contract and should provide coverage.)

A dispute will also arise as to whether an accident falls under an exclusion provided in the policy. In relation to an exclusion based on an intentional violation of laws, a court case held that, where a criminal case is split between a part for which the accused was found guilty and another part for which the accused was found innocent, the defence costs incurred pro rata in respect of the part for which the accused was found guilty would not be covered.

In a case where there was no exclusion based on gross negligence in the D&O policy, a dispute arose as to whether an exclusion would be available based on the general provisions of the KCA regarding the liability.

Also, there were issues in the litigation on the meaning of 'claim'; for example, whether to cover the defence costs incurred without the insurer's prior written consent, whether the relevant terms were subject to the insurer's duty of explanation and the expiry of the time bar period for the policy claim.

## Cyber insurance

### 25 What type of risks may be covered in cyber insurance policies?

A standard policy of cyber insurance covers, inter alia, the insured's risk, such as:

- loss or theft of data;
- liability arising out of breach of privacy protection;
- liability arising out of breach of Payment Card Industry Data Security Standards;
- business interruption;
- cyber extortion;
- reputational risk; and
- third-party liability such as:
  - confidentiality breach liability;
  - privacy breach liability; and
  - network security liability.

### 26 What cyber insurance issues have been litigated?

As at the time of writing, there has been no reported case with regard to cyber insurance issues. However, as there have been many incidents where hackers have stolen customers' personal information (including names, residence registration numbers, mobile phone numbers and email addresses), an issue of criminal or civil liability may arise in relation to the risk coverable by cyber insurance. Also, as there have been several first instance judgments to hold that substantial damages shall be awarded to the victims of cyber crime, it is likely that many issues will be litigated in the near future.

**Terrorism insurance**

**27 Is insurance available in your jurisdiction for injury or damage caused by acts of terrorism and, if so, how does it generally operate?**

In the past, terrorism insurance was operated for a limited period of time in preparation for large international events. Recently, Korea Airports Corporation has taken out a terrorism insurance policy for airports in Korea.

On the other hand, regarding travellers' insurance policies, there was a case in which insurance money was paid for the death of four Korean travellers who had been killed by bombing in a foreign country (there was no disclaimer or exclusion on the terrorism accident in the policy).


**Sung Keuk Cho** **skcho@cholee.co.kr**
**Hanna Park** **hnpark@cholee.co.kr**

10th Floor, Kais System Building
118 Seochojungang-ro, Seocho-gu
06634 Seoul
Korea

Tel: +82 2 592 5790
Fax: +82 2 592 5798
www.cholee.co.kr

# Sweden

**Johan Gregow**
**Wistrand**

## Preliminary and jurisdictional considerations in insurance litigation

### 1 In what fora are insurance disputes litigated?

The Swedish Insurance Contracts Act (ICA) contains no provision regarding disputes and litigation. Instead, litigation related to the determination and settlement of insurance indemnities is governed by the procedural rules for civil law cases laid down in the Swedish Code of Judicial Procedure. For civil law cases, the competent court is in general the court of the place where the defendant resides. A corporation is considered to reside at the place where its board has its seat or, if the board has no permanent seat or there is no board, at the place from which the corporation's administration is carried out.

Moreover, an action regarding tortious acts may be instituted in the court at the place where the act that caused the damage was performed or the damages occurred. When the act was performed or the damages occurred in two or more court districts, legal actions may be instituted in any of those districts.

According to legislation by the European Union, an insurer domiciled in a member state of the EU may be litigated in another member state in the courts of the place where the claimant is domiciled. The insured's right to initiate proceedings before courts in the country where the insured is domiciled is mandatory, and thus cannot be contracted out through the insurance policy. However, the parties may agree that an existing dispute shall be instituted in a certain court. Such agreement is valid and enforceable. Moreover, reinsurance policies may stipulate that an exclusive court is competent, as the mandatory provisions referred to above are not applicable to reinsurance policies.

A losing party can appeal Swedish court judgments in insurance litigations in the same way as other civil proceedings. A court judgment rendered by a Swedish district court (the court of first instance) may be appealed to a court of appeal within three weeks from the judgment being rendered. If a leave to appeal is granted, the court of appeal will try the merits of the case. A judgment rendered by the court of appeal may be appealed to the Supreme Court. The requirements for a leave to appeal to the Supreme Court are high.

Moreover, an insurance policy may stipulate that disputes between the insurer and the insured shall be settled by arbitration, depending on the kind of insurance in question. Merger and acquisition (M&A) insurance and reinsurance policies are primarily referred to arbitration.

Subrogation disputes (ie, when the insurer has indemnified the insured and subrogates against a third party) are sometimes settled through arbitration. This is, inter alia, often the case in disputes between the insurer and the insured's contractor in the field of construction. As a main principle, an arbitration clause between the insured and a contractor is also applicable to the insurer in a matter of subrogation.

### 2 When do insurance-related causes of action accrue?

The obligation of an insurer to indemnify the insured in respect of a claim arises when the insured event occurs and the loss is suffered and, in addition, after notification to the insurer. The insured is obligated to notify the insurer immediately when such an event occurs.

A party seeking insurance indemnification or other insurance coverage must, according to the ICA, commence legal action within 10 years from the date of occurrence of the circumstance or circumstances that form the basis for the right to such coverage under the insurance policy. According to the ICA, an additional time limitation for commencing legal action is six months from the date on which the insurer declares that it has taken a final decision in relation to the claim under the policy. Moreover, an insurance policy may, depending on the kind of insurance in question, provide for other principles of time limitation.

### 3 What preliminary procedural and strategic considerations should be evaluated in insurance litigation?

When an insured event occurs, the first step the insured party should take is to notify the insurer. When the insured is entitled to indemnification but has failed to comply with the terms and conditions of the insurance policy regarding the obligation to report insured events to the insurer within a specific time, and such failure has caused loss to the insurer, the indemnification that otherwise would have been paid to the insured may be reduced in accordance with what is reasonable in regard to the circumstances at hand. There may also be time-limitation provisions in insurance policies related to the duty to notify the insurer (eg, when the insured is a corporate entity).

Moreover, the insured should, to the extent possible, make efforts to limit the damages suffered. Any failure to take reasonable actions to limit the damages suffered may be invoked by the insurer and may be basis for reducing the insured's right to indemnification. This may also be discussed with the insurer, and the insurer may accept to indemnify the insured for the costs associated with such actions.

Insurance litigation is, as mentioned above, subject to the same procedural rules as civil cases in general. This means, essentially, that the same procedural and strategic considerations apply. Obviously, the merits of the case, inter alia, the legal basis for a right to indemnification and the amount of loss that is recoverable under the insurance policy, should be carefully examined before commencing any legal proceedings. It is also important to take necessary steps to obtain and secure evidence for the case. It may, inter alia, be important to obtain technical investigations and expert statements without delay after the damages have occurred, as it may not be possible to conduct the same investigations at a later stage.

In addition, as a main principle the losing party is liable for its own costs, as well as the winning party's costs, for the litigation. The claimant should also take into consideration the length in time of proceedings before the courts. When a party files a statement of claim to the district court, it usually takes up to one to two years before a verdict is given, depending on the complexity of the case. If the claimant wishes to prioritise receiving indemnification as soon as possible and keeping the costs down as well as limiting the risks, the possibilities of a settlement should be considered.

### 4 What remedies or damages may apply?

The insured is entitled to indemnity for the damages suffered, meaning that the insured is to be put in the same financial position as he or she would have been should the insurer have fulfilled its obligation in accordance with the insurance policy. The amount of damages is limited to the contractual indemnity of the insurance policy, and the insurer cannot be liable for additional damages. As such, punitive damages are not available under Swedish law. The insured is, however, entitled to late payment interest at a rate fixed by law, and may potentially also be entitled to reimbursement for actual costs or loss in addition to the coverage indemnity.

**5 Under what circumstances can extracontractual or punitive damages be awarded?**

As mentioned in question 4, punitive damages are not available under Swedish law in relation to a failure to fulfil a contractual obligation. The insured shall be indemnified for the actual damages suffered in accordance with the general principles of tort law and, if applicable, Swedish contracts law.

In personal injury cases, certain principles regarding standard rates for various kinds of injury may apply in accordance with the general principles of tort law and practice within the insurance business. Compensation in relation to personal injury is fairly low in Sweden, especially in comparison with certain common law countries. Loss of income shall be indemnified related to the actual cost or loss, and the same also applies in personal injury cases. Moreover, in the insurance policy there may be certain provisions governing limits of liability, which are legally enforceable as a main principle.

## Interpretation of insurance contracts

**6 What rules govern interpretation of insurance policies?**

In Swedish law, there is no legislation covering the interpretation of insurance policies, or contracts and agreements in general. In the absence of legislation concerning the interpretation of insurance policies, the principles of interpretation have instead evolved through case law and legal doctrine.

**7 When is an insurance policy provision ambiguous and how are such ambiguities resolved?**

Ambiguity ensues, inter alia, when a determined clause is hard to interpret or when two or more clauses of the insurance policy contradict one another. Ambiguity is usually resolved by interpretation of the insurance policy, and may also be based on the parties' intentions or a reasonable conclusion regarding what their intentions must have been. Methods of interpretation include not only the written wording or express provisions of the insurance policy, any evidence in relation to the parties' intentions and the purpose of the insurance policy, but also customs between the parties and customs within a certain line of business (eg, the insurance business). In cases when one party is solely responsible for drafting the contract, an indistinct provision therein may be held against the party who drafted the provision. Such principles could potentially be applied within the field of insurance. It may be stressed that in relation to standard insurance policies, the parties' intentions or expected intentions may not be the main issue in a matter of interpretation. Instead, except for the wording as such, customs on the insurance market and general considerations of a fair and reasonable application of the terms at issue may be more important. However, in cases of, inter alia, a negotiated M&A insurance policy, the parties' intentions or reasonable expectations of their intent may be of higher importance if appropriate. Thus, a matter of interpretation is certainly to a substantive extent dependent on the circumstances at hand.

## Notice to insurance companies

**8 What are the mechanics of providing notice?**

The ICA does not state specific mechanics for providing notice in the event of reporting a loss. This means that notice may be provided in any form the insured prefers. However, the formalities in relation to notice to the insurer may be governed by the insurance policy. The insured should comply with such terms. Moreover, it may be important to secure evidence that a timely notice has been made in accordance with the terms of the insurance policy.

**9 What are a policyholder's notice obligations for a claims-made policy?**

This is not governed by the ICA. Instead, this shall be stipulated in the policy. Under such a policy, the policyholder is usually obligated to provide notice to the insurer within a certain time period from the event when the policyholder was subjected to a claim in written form from a third party. Moreover, in relation to claims from third parties, there are generally other formalities to be complied with by the insured.

**10 When is notice untimely?**

Untimely notice is regulated in the provisions of an insurance policy, and there may be different requirements regarding timeliness of notice.

**11 What are the consequences of late notice?**

If the insurance policy for a consumer includes terms and conditions under which the insured has to report insured events to the insurer within a specific time, a party otherwise entitled to indemnification but that has failed to report such events may see the indemnification that would otherwise have been awarded reduced in accordance with what is reasonable under the circumstances of the failure to report.

If an insurance policy for a company includes terms and conditions under which the insured has to report insured events to the insurance company within a specific time, but the insured has failed to report such events within such period, the right to indemnification may be time-barred according to the policy. Such time period, which may be the basis for time limitation, shall not be shorter than one year from the date of occurrence of the circumstance that forms the basis for the right to insurance coverage under the insurance policy.

## Insurer's duty to defend

**12 What is the scope of an insurer's duty to defend?**

As regards liability insurance, the insurer generally has a duty to defend the insured against certain kinds of claims from third parties. The insurer's obligation should be specified in the insurance policy, especially in complex liability insurance indemnifying corporate entities for liability claims from third parties.

The insurer should generally be under the obligation to pay for any liability towards the third party (ie, which is covered by the policy), to investigate if there is basis for the insured being liable, to negotiate with the third party and to defend the insured in case of legal proceedings. Generally, the duty to defend is wider than the requirements for the insured being liable to a third party. Thus, the insurance company should defend the insured also in cases when the third party seems not to have any real substance for the claim. It should be enough that a third party has made a claim or filed a lawsuit for the insurer to be under the obligation to defend the insured. Generally, insurance policies should provide that the insurer has a right to substantial influence of the pleading of the case and to appoint counsel, etc. If this is not governed by the insurance policy, it is uncertain to what extent the insurer, between the parties, should have the right to decide upon, inter alia, the strategy of the defence or whether any judgment should be appealed. These issues are usually agreed upon by the parties. Case law in relation to the duty to defend is limited.

**13 What are the consequences of an insurer's failure to defend?**

The insurance company should be liable. Such liability may cover the insured's costs for engaging a law firm and other costs in the legal proceedings to the extent reasonable, inter alia, for legal investigations and technical experts.

## Standard commercial general liability policies

**14 What constitutes bodily injury under a standard CGL policy?**

Insurance policies usually do not contain definitions of injuries, etc; the definition of when liability arises is instead covered within Swedish principles of tort law. Swedish principles of tort law attribute all sorts of harm caused by physical means as well as diseases, both physical and psychological, to 'bodily injury'. Psychological shock arising without connection to physical injury may also be considered a bodily injury.

**15 What constitutes property damage under a standard CGL policy?**

The typical definition of property damage in Swedish tort law is damage to, as well as loss of, property. Loss of property and movables may be considered property damage even if the loss is temporary, such as when the stolen object is recovered. Aesthetic changes without loss of functionality to an object may also be considered property damage. Damages to computer systems, such as a virus damaging the system, should also be considered as damage to property under Swedish law.

**16 What constitutes an occurrence under a standard CGL policy?**

In general, an occurrence is the event that is claimed to be covered by the insured and accepted (or not) by the insurer according to the specific policy in question. It may include bodily injury, property damage, or any financial or pecuniary loss to a third party caused by the insured.

**17 How is the number of covered occurrences determined?**

The number of covered occurrences arising from an event is determined by the wording and interpretation of the insurance policy in question, and is determined through several criteria. One fundamental criterion is 'cause'. In order for several events to be subsumed under one occurrence, all of these events must originate from the same cause. Time is also relevant; if two events occur within a short time frame, the chances are higher that these will be considered a single occurrence than if the events take place further apart in time.

**18 What event or events trigger insurance coverage?**

The event triggering insurance coverage depends entirely on the type of insurance and the particular policy. Generally, the insurance coverage is triggered by the damage-causing event. In the case of a claims-made policy, insurance coverage is triggered by the policyholder being notified of the claim by the third party.

**19 How is insurance coverage allocated across multiple insurance policies?**

When the same interest has been insured against the same risk by several insurance companies, each insurance company shall be liable to the insured as if that company alone had issued insurance. However, the insured shall not be entitled to an aggregated amount of indemnification from the companies in excess of the actual indemnification for the damage. Where the amount of liability exceeds the amount of damage, liability shall be allocated among the insurance companies in proportion to the amount of liability.

## First-party property insurance

**20 What is the general scope of first-party property coverage?**

First-party property insurance coverage is common on the Swedish insurance market. For consumers signing a householder's comprehensive insurance, first-party property coverage insurance is usually available as an add-on option to most insurance policies. The objective of first-party property insurance within Swedish law is to cover the interest of the insured rather than a third party in situations where the insured causes damage to his or her own property. First-party property insurance can also be invoked by the insured in cases where damage is caused by a third party to the insured's property.

**21 How is property valued under first-party insurance policies?**

When an event triggering first-party property insurance occurs, the evaluation process commences with the insured notifying the insurer of the lost or damaged property, and providing information in relation to the damaged property. The insurer thereafter values the property on the basis of, inter alia, the information received from the insured and according to certain parameters stipulated in the insurance policy. Parameters taken into account include, first and foremost, the type and age of the property lost or damaged and, in addition, the cost for replacement, but also circumstances such as whether the property has been, will be or will not be replaced. Moreover, the insurer may potentially conduct certain investigations. Such investigations may also be conducted by a third party on behalf of the insurer. In the case of large-scale damages to, inter alia, industrial equipment, the insurer may conduct thorough technical investigations.

**22 Is insurance available in your jurisdiction for natural disasters and, if so, how does it generally operate?**

Insurance covering natural disaster is generally available in Sweden. How it operates varies depending on the type of business (ie, applicable to commercial insurance). Some insurance policies generally include coverage for natural disasters (eg, standard homeowners' insurance policies and most forest insurance policies). Moreover, the insurance may cover investment loss (ie, in addition to expenses and other costs). Coverage may be limited to a certain amount per disaster.

## Directors' and officers' insurance

**23 What is the scope of D&O coverage?**

According to the Swedish Companies Act, inter alia, a member of a board of directors or a managing director who, in the performance of his or her duties, intentionally or negligently causes damage to a company shall compensate such damage. This shall also apply where damage is caused to a shareholder or other person as a consequence of a violation of the Companies Act, the applicable annual reports legislation or the articles of association.

Situations where the managing director or members of a board of directors are held responsible for damages caused to the company due to negligence are usually covered by D&O insurance. The aim of a D&O insurance policy is to protect the management from personal liability in situations where damage has been caused to the company or to a third party. D&O insurance, by nature of the circumstances under which it is usually invoked, usually only covers pure economic loss (ie, excluding bodily injury and property damage).

**24 What issues are commonly litigated in the context of D&O policies?**

Litigation under D&O policies in Swedish courts may concern situations where members of the board of a company, covered under a D&O insurance policy, provide misinformation in the annual report or in a prospectus regarding subscription of shares (ie, in cases where liability in relation to a prospectus is covered by the specific insurance policy). Shareholders or other investors may then sue for damages for which the directors and officers may be held personally responsible, which in turn triggers the D&O policy.

WISTRAND

**Johan Gregow** **johan.gregow@wistrand.se**

Box 11920
404 39 Gothenburg
Sweden

Tel: +46 31 771 21 00/+46 31 771 21 54
Fax: +46 31 771 21 50
www.wistrand.se

Other cases commonly subject to litigation include situations where a company initiates an action against its own directors and officers where they have caused damage to the company through their negligence. Such cases may involve a breach of the company's articles of association or internal policies in relation to, inter alia, investment policies or lending policies in financial institutions.

## Cyber insurance

### 25 What type of risks may be covered in cyber insurance policies?

Cyber insurance policies are a relatively new type of insurance in Sweden. Where it is offered, it generally includes both first-party property coverage and coverage for indemnifying losses caused to third parties.

First-party property coverage may include:

- losses as a result of data loss from property damage, hacker attacks or physical sabotage;
- loss of data access;
- disruption damage resulting from security flaws in IT systems; and
- extortion relating to destruction of data.

Indemnification for losses caused to third parties may include claims arising from hacking attacks resulting in theft or publication of personal data and information, disclosure of business secrets and spreading of computer viruses.

### 26 What cyber insurance issues have been litigated?

To date, there have been no public cases in relation to cyber insurance in Sweden.

## Terrorism insurance

### 27 Is insurance available in your jurisdiction for injury or damage caused by acts of terrorism and, if so, how does it generally operate?

Several of the major insurance companies regulate in their policies for both private and company insurances that damages or injuries due to certain acts of terrorism are excluded from coverage, such as injuries or damages that occur from terrorist acts that involve chemical or nuclear substances. However, insurances for private persons may, inter alia, cover to relocate from an area that is unsafe because of acts or threats of terrorism. Moreover, there are insurers that offer certain insurance coverage for companies related to damages caused by acts of terrorism, for example through special terrorism-insurances. Such insurances may cover damages to property and loss of profit because of acts of terrorism. The insurance companies present their own definitions of acts of terrorism in their policies.

# Switzerland

**Dieter Hofmann and Daniel Staffelbach**
**Walder Wyss Ltd**

## Preliminary and jurisdictional considerations in insurance litigation

### 1 In what fora are insurance disputes litigated?

The fora where insurance disputes are litigated in Switzerland depend mainly on the parties (individuals or legal entities), their domicile and the subject matter of the dispute.

While Switzerland nowadays (as from 1 January 2011) has one unified (Federal) Civil Procedure Code (CPC), the organisation of the courts and to some extent the allocation of matters to these courts is a matter of the law of the cantons (member states), and there are 26 different cantons, each with its own specific court system. In other words, the issue of what court will hear an insurance dispute depends to some extent on the canton in question.

Generally speaking, there is a distinction between claims arising out of insurance contracts based on private law and claims based on public law, in particular social security insurance.

In general there are two civil court levels, a district court and a superior court on the cantonal level. However, in certain cantons (ie, in the cantons of Zurich, Berne, St Gallen and Argovia) there are commercial courts. In the canton of Zurich, it is often the Zurich Commercial Court that hears insurance disputes. In the Zurich Commercial Court, cases are heard by five sitting judges. Two of them are legally trained professional judges, the other three are part-time judges, chosen for their business expertise. In an insurance matter, they would normally come from the insurance industry, in a banking matter from the banking industry and so on. This business background is meant to make sure that the expertise necessary for a case is given (one could refer to them as 'expert judges'). However, it also means that an insured party is up against a panel in which the majority works in the insurance industry. In cases where the claimant has a choice, he or she may prefer to bring the action with the district court. It is a long-standing tradition of the Commercial Court to give a preliminary view on the case after the first exchange of written briefs in order to facilitate a settlement.

On the federal level, it is the Swiss Federal Supreme Court, the highest court in Switzerland, that hears appeals in insurance matters.

Issues with regard to insurance supervisory authorities are dealt with by centralised federal courts.

Reinsurance disputes are primarily dealt with by way of arbitration.

### 2 When do insurance-related causes of action accrue?

By and large, it seems fair to say that the Swiss private insurance market is characterised by a culture of negotiation and amicable settlement. In light of court costs (which are to be advanced by the claimant) and the rather long average duration of litigation, the insured and insurer often prefer to settle their case out of court.

Courts are often involved in cases where there are issues that raise general legal issues that are likely to have an impact on similar cases (in this context, it should be noted that Switzerland does not have a system of binding case law, in contrast to common law jurisdictions) or in cases where the evidence is unclear.

In matters of social security insurance, there are more court cases because the court costs there are fairly low.

### 3 What preliminary procedural and strategic considerations should be evaluated in insurance litigation?

From the point of view of a potential claimant (insured) it is important to realise that he or she will have to embark upon a rather lengthy, time-consuming and costly proceeding. It is therefore crucial for a claimant to make sure that he or she can afford such long and costly proceedings (ie, that there are enough means to finance the proceedings).

Another crucial issue – for both parties, insured claimant and insurer – is to take any and all steps necessary to obtain and secure evidence for the case. This can involve securing an expert early on, given that Switzerland is a relatively small country and that, depending on the field, there may be very few potential experts available.

In the context of securing evidence well in time, one should bear in mind that the new CPC provides for a possibility of taking evidence before bringing a full suit, in summary proceedings, in order to assess the chances of a suit. However, recent court decisions have made it more difficult to take evidence in these summary proceedings, compared to the rather open provision in the CPC. It should also be noted that there is no such thing as US-style discovery in Swiss courts. In recent times, potential claimants have successfully invoked the Swiss Data Protection Act in order to get access to the counterparty's documents; this has so far been primarily done by bank clients against their banks, but this route could be used in other industries as well.

In cases brought by an insured against an insurer, one can often see that the claimant did not sufficiently prepare for the suit and instituted proceedings while ill-prepared. In Switzerland, courts take an active role in facilitating amicable settlements between the parties, normally on the basis of a preliminary, non-binding assessment of the case based on a first exchange of written briefs and documents filed along with the briefs. If the case is not well presented, the court's preliminary assessment is likely to be to the disadvantage of the claimant, and the settlement eventually made will reflect this. It is not uncommon for courts to put quite a lot of pressure on the parties to reach a settlement.

### 4 What remedies or damages may apply?

The types of remedies and damages depend on the specific case. Generally speaking, in Switzerland only actual damages are compensated. Moreover, courts are quite strict and make it difficult for a claimant to meet his or her burden of proof with regard to damages. In this context, it should also be noted that there are no jury trials in Switzerland; cases are heard by professional judges (who normally have full legal training, although there are some lay judges sitting in smaller cases in small courts in rural parts of the country).

### 5 Under what circumstances can extracontractual or punitive damages be awarded?

In principle, there are no punitive damages as such under Swiss law. However, there are certain specific provisions under Swiss law that generate results that may seem similar. In particular, it may be possible to disgorge profits.

## Interpretation of insurance contracts

### 6 What rules govern interpretation of insurance policies?

The rules that govern the interpretation of insurance policies are, by and large, the same rules that apply under Swiss law with regard to contract construction in general.

Primarily relevant are the common intentions of the parties (ie, what the parties really wanted (the 'actual intent' of the parties, called 'subjective construction')). The starting point is always the wording of the contract, but one always has to consider the context and, in particular, the purpose of the contract.

If (and only if) the consenting will of the parties cannot be established (any longer), the contract has to be interpreted according to the 'principle of faith' ('presumed will' of the parties; 'objective construction'). According to this principle, a contract is to be interpreted in an objective manner according to the court's findings on how a contracting party acting in good faith would and should have understood its obligations and rights deriving from the contract.

If the meaning of a contractual provision may not be determined by subjective construction or, if this fails, by objective construction, then, and only then, may rules regarding special cases be applied.

A special rule is in particular the rule of ambiguity. Under this rule, an unclear contractual provision is to be construed to the disadvantage of the party that had formulated the provision ('in dubio contra stipulatorem').

### 7 When is an insurance policy provision ambiguous and how are such ambiguities resolved?

In principle, the rules on construction of an insurance contract also apply to the construction of an insurance policy provision. It is therefore a matter of construction how a policy is to be understood. The primary aim is to determine the common intentions of the parties. If the common intentions of the parties cannot be determined, the contract is to be construed in accordance with the principle of good faith. If this does not lead to a clear result, only then may the rule of ambiguity be applied. This rule means, in essence, that ambiguous wording is to be construed to the disadvantage of the party that had worded this provision. However, this rule may only be applied if and when all other principles of construction have failed or there are at least two different constructions that can seriously be invoked. The rule applies, therefore, if at all only subsidiarily. The rule may in no case be applied simply because the construction of a contractual provision is disputed.

It should also be noted that the rule of ambiguity only relates to determining the content and meaning of a contract, and is not about the application of a (per se clear) contractual provision on the facts.

Even if a contractual provision is objectively unclear, the rule of ambiguity may not be applied if the insurer (or his or her agent) explicitly made the insured aware of the content and scope of the relevant clause at the time the contract was entered into.

The rule of ambiguity may not be misunderstood to mean that it should generally lead to the construction that is the most favourable to the insured. However, if the above-mentioned conditions are met, the construction that is the most favourable to the insured (as the party that normally did not draft the contract) is to be applied.

## Notice to insurance companies

### 8 What are the mechanics of providing notice?

In principle, the insured may make all communications with the insurer orally, or by email, fax or post. There are no statutory provisions in this regard. However, form requirements may be stipulated in the contract. Of course, in order to have proof, one should generally make important communications by registered post.

### 9 What are a policyholder's notice obligations for a claims-made policy?

There are no specific notice obligations for a policyholder with regard to a claims-made policy provided by statutory law. The respective obligations are determined by the insurance contract in question.

### 10 When is notice untimely?

In principle, the insured is obliged to notify the insurer as soon as he or she has knowledge of the occurrence of the insured event and of his or her claim based on the insurance. Notice must be made without delay. The court practice is quite strict in this regard.

Insurers often specify certain deadlines within which notice is to be made with regard to certain events, and they also specify in what form notification is to be made. In contrast, there is no particular form stipulated by statutory law for the notice. In principle, notice may therefore be made orally (eg, over the phone), or by email, fax or post.

It is sufficient if the notice informs the insurer that the insured event has occurred. Therefore, a brief description of the facts is sufficient. It is more important to notify quickly than to provide complete information to the insurer, who may be expected to raise follow-up questions.

### 11 What are the consequences of late notice?

The consequences of late notice depend on whether there is fault on the part of the insured. If the insured infringed his or her duty to notify the insurer without fault, there are, in essence, no legal consequences to the insured's disadvantage.

If there is fault on the part of the insured with regard to giving timely notice, the insured is, in accordance with the Swiss Federal Act on Private Insurance Contracts, entitled to reduce the compensation. In practice, insurance contracts normally stipulate stricter obligations and consequences to the disadvantage of the insured. The most severe consequence is that, after expiry of a deadline, the claim to insurance is forfeited.

## Insurer's duty to defend

### 12 What is the scope of an insurer's duty to defend?

The indemnity insurer is usually under a contractual obligation to defend against unjustified claims brought by the injured party. The contractual terms usually stipulate that the insurer is entitled to decide how the case is dealt with. In other words, the insurer decides whether the claims are to be considered as not justified so that they are to be rejected, or whether they are to be considered as justified and hence to be satisfied. The insurer is also entitled to make payments to the insured party against the will of the insured. It is usually the insurer who negotiates with the injured party in lieu of the insured and enters into a settlement if possible. In the case of a dispute, it is usually the insurer that conducts the proceedings in the name of the insured against the injured party. The indemnity insurer is in control of the proceedings, and it normally also chooses and instructs counsel.

### 13 What are the consequences of an insurer's failure to defend?

The legal consequences if the insurer fails to successfully defend against the claims brought by the injured party depend on the reasons for such failure. In principle, the insurer has to cover the claims brought by the injured party. If the defence failed because the injured party acted in a grossly negligent manner, the insurer may take recourse against the insured or reduce the compensation. If the insurer defended against unjustified claims in a negligent manner, and if this causes damage to the insured party, the insurer might become liable for further damage than what was covered by the insurance in the first instance, depending on the circumstances of the case.

## Standard commercial general liability policies

### 14 What constitutes bodily injury under a standard CGL policy?

Any type of bodily or psychiatric damage may qualify as bodily injury. Bodily injury is determined by medical examination. The economic (financial) effects of a proven bodily injury are to be compensated by the liable party. Accessory immaterial damages that do not reflect a financial value are being compensated by a compensation for personal sufferings. Such compensation for personal sufferings granted by Swiss courts is traditionally very low in comparison to similar compensation granted in other jurisdictions. In this context, it should be borne in mind that there are no jury trials in Switzerland.

### 15 What constitutes property damage under a standard CGL policy?

Damage to property is defined by the reduced value of the property as a consequence of the event insured against. Depending on the item of property (and the damage), the damage to be compensated may consist

of the costs of repair, the costs of replacement or of compensation paid for the reduced market value of the damaged property.

**16 What constitutes an occurrence under a standard CGL policy?**

An occurrence under a standard CGL policy may be defined as bodily injury (death, injury or other damage to health) and damage to property (destruction, damage or loss).

**17 How is the number of covered occurrences determined?**

There is no generally applicable rule in this regard. The determination of the number of covered occurrences depends on the specific insurance contract and also on the industry branch the insured party is active in.

**18 What event or events trigger insurance coverage?**

Insurance coverage is given if the terms and conditions in accordance with the insurance contract are met and if there is no limitation with regard to the scope of coverage.

**19 How is insurance coverage allocated across multiple insurance policies?**

Generally speaking, under the respective contract, the insurer has to grant the unlimited coverage to the insured. The regulation between a number of policies and insurers respectively is dealt with in the framework of compensation payment in order to avoid overcompensation. For insurance coverage based on different legal grounds, there is a mandatory legal sequence to be respected. For the liability of a number of individuals or legal entities for the same damage based on different legal grounds (contract, statutory law or tort), the primary liable party is generally the party that has caused the damage by tort, and lastly the party that is liable in the absence of a contractual obligation and without its own fault based on a statutory provision.

## First-party property insurance

**20 What is the general scope of first-party property coverage?**

First-party property policies are typically named-peril policies. Named-peril policies insure against loss from specifically identified causes of loss. These policies are often issued to account for the particular business of the insured. With regard to insurance coverage for properties (real estate), one should bear in mind that most Swiss cantons provide for mandatory state property insurance, which covers elementary risks such as fire, floods and, in some instances, earthquakes.

**21 How is property valued under first-party insurance policies?**

Depending on the insurance contract, the actual cash value or the reinstatement value is covered.

**22 Is insurance available in your jurisdiction for natural disasters and, if so, how does it generally operate?**

Please see www.gettingthedealthrough.com.

## Directors' and officers' insurance

**23 What is the scope of D&O coverage?**

D&O coverage is meant to protect members of boards of directors and management against claims brought by third parties. The D&O insurance normally covers the costs of the defence against unjustified claims and actions as well as possible compensation payments. Depending on the coverage, costs in order to rehabilitate good reputation are also covered. The type of insurance is typically 'claims-made', providing coverage for claims made during the policy period. Matters excluded from coverage are those that are uninsurable for public policy reasons, such as criminal or fraudulent acts, and acts involving illegal profit or personal advantage.

**24 What issues are commonly litigated in the context of D&O policies?**

Most litigation in the context of D&O relates to bankrupt companies. The claimants usually argue that the board members and management infringed their duties to the detriment of the company's creditors. The creditors often argue that the board members would have been obliged to file for bankruptcy much earlier, and that not doing so and therefore postponing bankruptcy increased the damage.

## Cyber insurance

**25 What type of risks may be covered in cyber insurance policies?**

Cyber insurance is predominantly an issue in business insurance. It would typically provide for coverage against damages claims by third parties if business data is lost or disclosed, and against involuntary infringement of data protection provisions, and would cover the cost of legal proceedings and defence. Insurance may include coverage of external providers of services and goods for which the insured is responsible. Moreover, it is possible to obtain coverage with regard to liability regarding internet media.

**26 What cyber insurance issues have been litigated?**

We have no knowledge of any cyber insurance litigation having taken place in Switzerland to date.

## Terrorism insurance

**27 Is insurance available in your jurisdiction for injury or damage caused by acts of terrorism and, if so, how does it generally operate?**

Please see gettingthedealthrough.com.

*The information contained in this chapter is accurate as of March 2017.*

walderwyss attorneys at law

**Dieter Hofmann** **dieter.hofmann@walderwyss.com**
**Daniel Staffelbach** **daniel.staffelbach@walderwyss.com**

Seefeldstrasse 123
PO Box 1236
8034 Zurich
Switzerland

Tel: +41 58 658 58 58
Fax: +41 58 658 59 59
www.walderwyss.com

# Turkey

**Pelin Baysal and Ilgaz Önder**
**Gün + Partners**

## Preliminary and jurisdictional considerations in insurance litigation

### 1 In what fora are insurance disputes litigated?

In the Turkish judicial system, insurance disputes are resolved by the commercial courts, irrespective of the amount or value of the dispute. On the other hand, insurance disputes arising out of maritime law are heard by the Specialised Maritime Court. If there are no specialised courts (ie, a commercial court in a certain province), disputes are heard by the general competent court, namely a civil court of first instance.

The Code of Civil Procedure provides the claimant with a number of alternative courts having jurisdiction for insurance disputes, including the commercial courts at the domicile of the defendant, and the place of immovable property or risk that is claimed to have triggered the insurance coverage. The Turkish Code of International Private Law numbered 5718 has designated specific jurisdictions for the cases arising from insurance contract disputes, and clearly states that they cannot be contracted otherwise by the parties. Article 46 of the Code provides that the relevant jurisdictional rules shall prevail:

> *The court where the insurer's headquarters, or its branch office or the agent who concluded the contract are located in Turkey, has jurisdiction in the disputes arising from insurance contacts. In the cases to be filed against the insured or the beneficiary, the court of the Turkish domicile of these persons has the jurisdiction.*

As an alternative, the Insurance Arbitration Commission, which is incorporated under the Insurance Union of Turkey, is a feasible dispute-solving mechanism alternative to court proceedings. Only the insured or policyholder is entitled to apply to the Commission to avoid prolonging litigation procedures and obtain a viable solution. No arbitration clause is needed to apply to the tribunal, provided that the insurer is a member of the Commission. Regarding disputes arising out of mandatory insurances, the insured, beneficiary and policyholder are entitled to apply to the arbitral tribunal even if the insurer is not a member of the Commission. It is also possible to initiate international or domestic arbitration proceedings.

### 2 When do insurance-related causes of action accrue?

As per the general insurance rules stipulated in the Turkish Commercial Code (TCC) numbered 6102 and dated 14 February 2011, the insured's cause of action against the insurer accrues when the insurer's obligation to indemnify the insured commences; in any event, this is within 45 days of the date of notification of the policyholder (in life insurance, this period is 15 days) provided that the insurer's right to examine the risk in question is not prejudiced by the insured or any external hindrance.

However, there is a prescription period that should always be kept in mind. As per the general insurance rules under the TCC, all claims arising from insurance contracts shall be prescribed after a period of two years as of the date when payment falls due. In any event, all claims relating to an insurance indemnity or insurance sum shall be prescribed after a period of six years from the date of materialisation of the risk. In liability insurance, indemnity shall be prescribed within 10 years of the event constituting the subject of the insurance: for example, negligence of the insured.

### 3 What preliminary procedural and strategic considerations should be evaluated in insurance litigation?

In general, the following must be taken into account before initiating insurance litigation:

- the scope of the law governing the insurance contract and duties imposed on the insured or policyholder imposed by the governing law and policy conditions;
- the competency of the courts or arbitral tribunal;
- costs that will arise from litigation (in the Turkish litigation system, although the costs are not sky-high, the claimant should bear the costs during the litigation and the losing party should bear the costs after the litigation period is completed, together with the claimant's attorney fee up to the amount prescribed by the tariff of the Turkish Bar Association); and
- the prescription period of the claim.

In practice, the culture of settlement or mediation is not yet firmly established in Turkey; in most cases, therefore, disputes are resolved by actions before the courts.

Regarding insurance disputes, identifying the damage, determination of the material facts in relation to loss and whether the insured has increased the risk of occurrence is particularly important. Similarly, these also have an immense effect on the recourse action between jointly liable parties.

To identify and determine the damage or loss accrued and the material facts as of the date of the loss, it is advisable to take immediate action to record the evidence. In practice, this action is preferably taken right after the occurrence of the risk. Obtaining an adjuster's report or filing a determination action before the court is also advisable, as these offer safer claims to initiate an action. It is also important for the insurer to detect whether there are other insurances covering the risk.

Last but not least, in liability insurance, the recourse actions must be considered carefully as there are conditions to be met to initiate litigation for recourse claims. The following should be noted: to be entitled to the right of subrogation, first the insurer must pay the indemnity to its insured or, depending on the circumstances, the beneficiary; and the right of subrogation only covers the amount that is paid by the insurer to the insured or beneficiary and the interest applied to such amount starting from when the payment was made. The insured or beneficiary remains the rightful owner of the amount that is not covered by the insurer.

### 4 What remedies or damages may apply?

Monetary damages are claimed in a typical litigation case.

Monetary damages in insurance disputes would cover the indemnity foreseen under the policy and the default interest, provided that the claim for the interest is stated within the initial claim. The commercial interest rate to be accrued is set every year; in 2018 it was 19.5 per cent per year. With respect to foreign currency, the legal interest rate will be the highest interest rate applied to deposit accounts with a one-year maturity, unless a higher rate is stipulated in the contract.

Regarding non-life insurance, the main principle is the prohibition of enrichment. Therefore, in non-life insurance such as property and liability insurance, it is not possible to claim for a higher amount than the incurred damages. The ultimate purpose of the damages to be awarded by the court would be to reinstate the insured or policyholder

to the position it would have been in had the risk covered under the policy not occurred.

If the policy stipulates a fixed sum for all damages, it may not be possible for the insured to be in the position it would have been in before it suffered damage. However, if the policy covers the total property valued under the contract, provided that all duties of the insured are satisfied, it may be possible for the insured to claim and obtain the sum of all its damages.

It is also possible to include a revaluation clause in the insurance contract and pay the current value of the property. This is usually preferred in motor vehicle insurance, where the value of the motor vehicle is revalued at the time of the occurrence.

### 5 Under what circumstances can extracontractual or punitive damages be awarded?

Under Turkish law, it is not possible to award punitive damages because of the principle of prohibition of enrichment. It is, however, possible to insert penalty clauses in agreements where one or more of the parties agree to pay a certain sum of money or perform an action if they fails to fulfil their obligations under a contract. Under penalty clauses, loss does not need to be proved. However, it is not common to insert penalty provisions in insurance policies in Turkey.

In reinsurance, extracontractual obligations refer to damages awarded by a court against an insurer that are outside the provisions of the insurance policy, owing to fraud, bad faith or negligence of the insurer in handling a claim. Turkish law precedents and practice are scarce in this respect; however, courts are inclined to deal with this issue from the point of the insurer's burdens of proving the scope of the insurance coverage and enlightening the insurer regarding fundamental aspects of the policy. If the insurer fails to fulfil these burdens, the court may either conclude that the disputed matter is within the scope of the insurance policy regardless of the written agreement or may order the insurer to compensate the insured for any loss caused as a result of the insurer's failure. The reinsurer, on the other hand, would be responsible only to the extent of the reinsurance agreement with the insurer and may avoid any compensation for such court judgments unless a particular clause holds the reinsurer responsible.

## Interpretation of insurance contracts

### 6 What rules govern interpretation of insurance policies?

Although the general approach of Turkish legislation is towards protecting the relatively weak party in a legal transaction, there are no explicit rules regarding the interpretation of insurance policies. However, under the reasoning of the TCC, it is highlighted that the founding principle of insurance contracts is the protection of the insured.

As a general principle of Turkish law, the terms of a contract are construed to the detriment of the author of such term. Since insurance policies are considered to contain the standardised terms of contract imposed by the insurer, they will be interpreted to the detriment of the party that formulated the provision, who is usually the insurer.

Other than this, the basic principle of the contract remaining in force and the consensus of the parties are also dominant in the interpretation of insurance policies. In this respect, the TCC upholds the terms and conditions negotiated between the parties or contained in the proposal form communicated by and between the parties if the policy or endorsement thereof contradicts such documents.

### 7 When is an insurance policy provision ambiguous and how are such ambiguities resolved?

As per article 1,425 of the TCC, insurance policies shall be drafted in an intelligible and easily readable manner. Indeed, the primary duty of providing proper wording is on the insurer. In this respect, article 11 of the Insurance Act also requires insurance contracts to be written in Turkish and stipulates that any wording not in Turkish would be construed by taking into account the meaning provided by the Turkish Language Association. Although we observe dissenting opinions in some court precedents, which go a step further by arguing that insurance clauses not written in Turkish should be deemed voidable, this opinion has not gained any ground so far.

During the conclusion and the term of the insurance contract, there may be some points that are not clear or have more than one meaning that may create ambiguity in the insurance contract. These points may cover everything related to the insurance contract – for example, relating to the obligations of the parties, coverage, exclusions and deductibles.

During the negotiation or the conclusion of the insurance contract, if there are any provisions that are questioned by the insured, the insurer and its agents are under the obligation to inform and clarify these points, principally in writing. The burden of proving that the pre-contractual information duty has been duly fulfilled shall lie with the insurer. It is seen in practice that the Court of Appeals gives utmost importance to the positive duty of information of the insurer. For example, in one of its decisions, the Court of Appeals ruled a decision of reversal where it determines that the indemnification requested by the insured should have been identified depending on whether the insurer can prove that it has accomplished its informative duty.

## Notice to insurance companies

### 8 What are the mechanics of providing notice?

The TCC introduces a positive duty for notification on the insured. Notice should also be made by a third party as far as it is aware of the insurance coverage and entitled to the right to obtain compensation. As a general rule, the notification should be made as soon as the incident giving rise to the insurance claim has occurred.

The procedure for such notification is not clearly defined in the TCC. This may vary depending on the policy. In some policies, usually in property insurance, notifying the occurrence to the insurer may be made by leaving a notice of claim by electronic means, whereas in other policies, notification may be sent through a notary public. However, for the sake of proof, it is advisable for the insured to send a written notification, preferably via registered post or notary public, to avoid any uncertainty regarding when the indemnification duty of the insured becomes due.

### 9 What are a policyholder's notice obligations for a claims-made policy?

The TCC does not explicitly regulate notice obligation in claims-made policies, but provides general rules for the notification duty of the policyholder. In general, the policyholder shall notify the insurer without delay when it becomes aware of the occurrence of the risk.

In liability insurance, the insured shall notify the insurer within 10 days of those events that may give rise to its liability. Moreover, the insured shall notify the insurer of any claim made against it immediately, unless otherwise agreed. This provision cannot be altered to the detriment of the insured in an insurance contract. When there is such an alteration, the rules provided in the TCC will directly apply.

The scope of this notification is not clearly set in the TCC. However, in accordance with the contract or at the insurer's request, the insured shall provide all information and documents necessary for determining the extent of the risk and indemnity and that might be expected from the policyholder to the insurer within a reasonable period of time.

### 10 When is notice untimely?

If the notice is not provided within the periods stated in question 9, notice is considered to be untimely. The TCC does not provide any strict time limit but leaves it to the discretion of the judge to determine whether the notice is timely in consideration of the particularities of the case.

### 11 What are the consequences of late notice?

The TCC gives utmost importance to the causal link between the negligence of the policyholder in its notification duties and the magnitude of the insurer's indemnity obligation.

If the insurance indemnity or the fixed sum to be paid increased as a result of the failure or delay in giving notice of the occurrence of the risk, the indemnity or the fixed sum shall be reduced by taking into consideration the degree of the negligence of the policyholder. This provision cannot be altered to the detriment of the insured in an insurance contract.

## Insurer's duty to defend

### 12 What is the scope of an insurer's duty to defend?

The insurer's duty to defend is only possible in liability insurance. It is not a duty but more of a right granted by the TCC to insurers. In other words, insurers are not obliged to defend the insured in a possible litigation.

If the insurer desires to defend the insured, the insurer shall declare its intent to defend the insured within five days of the date of notification of those events that may give rise to its liability.

When the insurer defends, it acts on behalf of the insured but for its own account and under its own responsibility, and assists in the defence of the insured with regard to the claims of the third persons. If the insurer considers its right to defend, it should also give due consideration to the rights and interests of the insured.

This provision cannot be altered to the detriment of the insured in the insurance contract. In the case of detrimental alteration, the provisions of the TCC shall apply.

It is common for an insurer to choose to take over defence for its own account, as it is to the benefit of the insurer with regard to coverage matters.

### 13 What are the consequences of an insurer's failure to defend?

If the insurer remains silent and does not choose to defend the insured, it shall pay the indemnity that would become final and binding on the insured. Any settlement agreed by the insured without the consent of the insurer is not binding on the insurer if it did not approve such settlement within 15 days of notification. It should be noted that the insurer shall not refrain from approving the settlement for unjust causes.

## Standard commercial general liability policies

### 14 What constitutes bodily injury under a standard CGL policy?

In the Turkish insurance framework, such a standard CGL insurance does not exist. Instead, the Undersecreteriat of the Treasury provides alternative general conditions for the different needs of business organisations.

As per the General Conditions determined by the Undersecreteriat of the Treasury, third-party liability insurance covers both bodily injury and property damage claims of third parties. Apart from the above, there are different kinds of financial liability policies, including professional liability insurance, independent auditors' professional liability insurance, motor vehicles liability insurance, financial liability insurance, employers' liability insurance and medical injury liability insurance.

In liability insurance against third persons, bodily injury covers death, loss of limb and other harm to the human body, including sickness or disease.

### 15 What constitutes property damage under a standard CGL policy?

Property damage covers all kinds of physical and visible injury to tangible property, such as total or partial loss of the property, including all injury resulting in the loss of use of that property.

### 16 What constitutes an occurrence under a standard CGL policy?

Under general liability insurance, the materialisation of the decrease in the assets of the policyholder arising out of either property damage or bodily injury constitutes an occurrence.

### 17 How is the number of covered occurrences determined?

The number of covered occurrences is not explicitly determined in Turkish legislation.

Likewise, neither the TCC nor the General Conditions of liability insurance specifically stipulate how serial damages must be evaluated.

However, contracts tend to include a serial damages clause that considers continuous or continual occurrences as one, and stipulates that the insurer shall indemnify the insured once, up to the value of the insurance coverage.

Including a serial damages clause in a contract also has an effect on the deductible attributable to the insured. Together with the serial damages clause, the risk remaining with the insured shall be covered once, which is in some cases having a high amount of deductible preferred by the insured.

### 18 What event or events trigger insurance coverage?

As per the TCC, insurance coverage is triggered by the occurrence – or in other words, the materialisation – of the risk, provided that the occurrence is insured under the insurance policy and the notifications are duly made by the insured, irrespective of whether it is a claims-made or occurrence-based policy.

### 19 How is insurance coverage allocated across multiple insurance policies?

In principle, if the same interest is insured against the same risk for the same term by more than one insurer at the same date or at different dates, the policyholder shall not be paid in excess of the insurance value. There are two different kinds of multiple insurance policies stipulated under the TCC.

**Double insurance**

In respect of an interest covered for its full value, the same person or other persons can only subsequently take out insurance against the same risks for the same periods, provided that the following circumstances and conditions are present:

- the double insurance is approved by the subsequent and previous insurers;
- the policyholder transferred its rights arising out of the previous insurance contract to the subsequent insurer or waived its rights under the previous insurance contract. In this case, the transfer or the waiver must be written on the insurance policy, failing which the subsequent insurance shall be deemed to be invalid; and
- the liability of the subsequent insurer is restricted to the part of the loss that is not paid by the previous insurer. In this case, the previous insurance must be annotated on the subsequent insurance policy, failing which the subsequent insurance shall be deemed to be invalid.

**Joint insurance**

If the same interest is insured with more than one insurer at the same date, against the same risk and for the same period, all of the co-insurance contracts shall be deemed valid only up to the value of the insured interest. In other words, in joint insurance, there are different insurance policies for a part of the value of the property.

In such a case, each insurer shall be liable for the proportion that its insured sum bears to the total of the insurance sums. If the insurers are jointly liable according to their contracts, the insured shall not have the right to claim more than its loss. Moreover, each of the insurers shall be liable up to the sum it has to pay according to its contract. In that case, the insurer who has made the payment shall have recourse to the remaining insurers for the proportion of the insurance sums that the insurers have to pay to the insured under their contracts.

## First-party property insurance

### 20 What is the general scope of first-party property coverage?

Under Turkish law, first-party property coverage includes all kinds of risks that would create physical damage to the property of the insured (fire, flood, etc). Some typical examples of first-party property insurance would be motor vehicle insurance, construction insurance and theft insurance.

### 21 How is property valued under first-party insurance policies?

As per the TCC, depending on the nature of the property, the procedure for valuation of the property subject to the policy may vary. For example, in fire policies, it is usually the case that, after obtaining the information from the policyholder, the insurer appoints a private expert to value the asset. In case of a disagreement, the parties may appoint a referee expert as well. When determining the value of the commercial assets, the expert should take into account the assets' current value or purchase price of the day before the occurrence. The value of the machines and equipment, on the other hand, should be calculated taking into account the price of a new asset of the same quality. The value of the negotiable instruments should be determined according to their market value in the stock exchange.

The value of the insurance is set in the contract and constitutes a binding value for the property at the time of the occurrence. The insurer, however, is entitled to request a reduction of the value of the

property, provided that the set value is excessive in relation to the real property value.

It is also possible to include a revaluation clause, which is widely seen in motor vehicle property insurance, in which the property is revalued at the time of the occurrence.

As a side note, the insurer is entitled to examine the value of the property during the term of the contract.

**22 Is insurance available in your jurisdiction for natural disasters and, if so, how does it generally operate?**

Insurance for earthquakes is compulsory in Turkish jurisdiction for those who own real estate that is used for anything other than commercial and industrial purposes. According to the General Conditions of Compulsory Earthquake Insurance, this insurance also covers losses arising out of fire, explosion, tsunami and landslide triggered by earthquake.

Other than the above, any policyholder can extend its facultative fire insurance wide enough to cover:

- its commercial and industrial buildings against earthquake;
- other natural disasters such as volcanic eruption, flood and fire;
- environment pollution that is directly or indirectly caused by one of the natural disasters within the scope of the insurance; and
- terrorism, strikes and civil commotions.

## Directors' and officers' insurance

**23 What is the scope of D&O coverage?**

As per Turkish legislation, there is no standard D&O insurance coverage, as this type of insurance is not specifically regulated under Turkish law and the General Conditions of professional liability insurance do not shed adequate light on the matter.

In practice, the scope of the D&O insurance policy covers third-party claims against the insured that are caused by faults or improper performance of his or her professional services. Third parties would typically mean the shareholders of the company, regulatory authorities, creditors, competitors and employees.

Insurance companies in Turkey tend to provide D&O insurance coverage that includes cover for administrative monetary fines issued by the regulatory authorities and litigation costs, provided that there is a deductable stipulated in the contract and excluding any wilful misconduct and misrepresentation of the D&O.

**24 What issues are commonly litigated in the context of D&O policies?**

Although it is difficult to provide statistical information in terms of the most severe and frequent claims because circumstances may vary significantly, it can be said that claims against D&O policies are frequently based on an allegation of a breach of the general duty of care and a breach of the duties in the company law provisions of the TCC.

While not frequent, D&O liability in antitrust infringements can be quite severe, amounting to an administrative fine of up to 5 per cent of the fine imposed on the company (up to 10 per cent of the annual turnover in Turkey).

It can also be said that frequent claims also arise from administrative proceedings for non-compliance with various legislation such as capital markets, tax and customs-related legislation.

## Cyber insurance

**25 What type of risks may be covered in cyber insurance policies?**

Cyber insurance is a new concept in Turkey, and mainly offers cover for the risks related to threats to companies' networks and IT infrastructure. Coverage includes expenses incurred and payments made by a company:

- for the destruction or theft of its assets through any unauthorised access to or use of such company's systems, including its risk management systems;
- in communicating with affected customers about such data breach or loss;
- for the recovery of lost or breached data;
- in identifying how a breach to its systems or how a network failure has occurred; and
- in monitoring complaints raised by data subjects.

It is also possible to include digital media risks, such as:

- defamation of trade reputation, or of the character of any person or organisation;
- unintentional infringement of a copyright, title, slogan, trademark, trade name, trade dress mark, service mark, service name, domain name or licence agreement;
- invasion and infringement of, or interference with, the rights of privacy, publicity, morality and not being presented in a false light;
- theft of ideas or information, plagiarism, piracy or misappropriation;
- public disclosure of private facts;
- personal intrusion and commercial appropriation of a name;
- material interruption to a company's network systems; and
- data restoration.

**26 What cyber insurance issues have been litigated?**

Cyber risks become one of the newly emerging risks in Turkey. Reportedly, the number of those who are victimised by cyber attacks is 10 million per year and the total cost of the attacks is up to US$550 million. One of the biggest and most serious cyber attacks in Turkey to date involved one of the most reputable banks in 2016. According to the bank's official statements, the loss incurred by the bank was then remedied as per the lower limit of the Banker's Blanket Bond without seeking any separate insurance coverage particularly concerning cyber risk.

In a recent court decision, it was shown once more that hackers are targeting corporations' electronic data, compelling the victims to seek settlement negotiations with the hackers to recover this data. In a case that came before the Supreme Court in October 2017, the court stated that lawsuits filed by the victims for a declaratory award with respect to

loss of account records should not be dismissed owing to lapse of statute of limitation because the statute of limitation should be deemed to have commenced as of the date when the settlement negotiation is understood to yield no positive outcome.

With a fast-growing Turkish e-commerce market, new legislation and administrative measures are expected in the near future.

## Terrorism insurance

### 27 Is insurance available in your jurisdiction for injury or damage caused by acts of terrorism and, if so, how does it generally operate?

Anti-Terror Law No. 3713 dated 12 April 1991 defines terror as 'all types of criminal offence committed by means of duress, violence, oppression, threat, menace or intimidation by members of an organisation for the purposes of changing the constitutional qualifications of the Republic, political, judicial, social, secular, economic order of the country, impeding the state's inseparable integrity with her realm and nation, endangering the existence of the state and the republic, debilitating, overthrowing or occupying the state's authority, dissipating fundamental rights and freedom, distorting domestic and international security, public order or public health'.

The Act Concerning Compensation of Terror-Originated Losses No. 5233 dated 17 July 2004 regulates procedure and principles for compensation by means of amicable manners for the losses suffered by real persons and legal entities. Accordingly, the state compensates the losses arising from terror activities that cause:

- damage to livestock, trees, crops, and other movable and immovable assets;
- bodily injuries, disability, casualties, and relevant treatment or funeral expenses; and
- deprivation resulting from being unable to reach the owned assets.

These losses are principally compensated in kind, if possible. For example, the state gives priority to giving a house instead of cash to an aggrieved citizen who lost his or her house as a result of a terror attack.

When evaluating the amount of loss, however, the commission takes into account collateral benefits that the aggrieved may have enjoyed. Insurance payments are one of these possible benefits. The commission, upon an application for compensation claim, researches and determines the amount the aggrieved may have received from his or her insurance policy because of the loss. This amount would be deducted from the suffered loss to determine the compensation to be made by the state. Insurance companies cannot recourse against the state for the insurance payments to indemnify the terror losses.

Turkish insurance law does not provide any restriction with regard to coverage for losses caused by acts of terrorism. Even though General Conditions of an insurance type such as fire insurance do not include terror by default, the insured may request to include this risk in return for an additional premium.

# Ukraine

**Oleg Kachmar and Oleksandra Bortman**
Vasil Kisil and Partners

## Preliminary and jurisdictional considerations in insurance litigation

### 1 In what fora are insurance disputes litigated?

Depending on the parties to the case, insurance disputes are usually litigated in commercial or general courts. If the insured is an individual, the case should be considered by the general court, while all other types of disputes, including disputes between legal entities, will come under the jurisdiction of the commercial court.

Also, administrative courts adjudicate the disputes between an insurer and the regulatory authority (the National Commission for Regulation of Financial Services Markets) as to the decisions on application of measures for violation of legislation on financial services.

### 2 When do insurance-related causes of action accrue?

Primarily, insurance-related disputes often arise from the breach of obligations under the insurance contract or regulatory acts relating to the procedure for concluding, fulfilling or terminating such agreements.

Apart from that, disputes often arise as to validity of the insurance contracts (eg, owing to failure of the insured to provide accurate information on the object of the insurance contract or refund of insurance premiums owing to invalidation or termination of the insurance contract).

The most common breach of obligations is the refusal of an insurer to pay an insurance indemnity to the insured person fully or partially.

Sometimes disputes arise because of late investigation of the insured event (or late calculation of damages) by the insurer. Although there are legislative and contractual requirements as for the period of payment of insurance indemnity, the insurer may delay its decision upon recognition of a certain event as insured, which is often interpreted by the insured as a refusal to pay insurance indemnity.

Subrogation and recourse are two other sources of insurance-related disputes.

### 3 What preliminary procedural and strategic considerations should be evaluated in insurance litigation?

From the procedural standpoint, the Ukrainian law provides for a preliminary dispute settlement procedure if a dispute between two legal entities arises. Although technically such procedure is not obligatory, the courts in Ukraine tend to request the evidence that the claimant attempted the preliminary dispute settlement procedure. Such procedure includes the following steps:

- an injured party sends a written complaint to another party;
- a party that received a written complaint usually has one month to consider and react upon it; or
- a party that received a written complaint notifies an injured party as to the results of the consideration of the complaint.

If the preliminary dispute settlement procedure proves to be ineffective, the injured party refers the matter to the court.

Importantly, sometimes the insured (usually an individual) submit complaints on refusal to pay insurance indemnity to the regulatory authority, which may oblige the insurer to stop the breach of contract and make the prescribed payments.

As regards strategic considerations in insurance litigation, commercial courts are usually rather swift in consideration of cases. It usually takes two to three weeks for the first court hearing to be held and the court renders its decision in around two to three months on average. Depending on the complexity of the particular case, the insurance dispute may be considered by the court of first instance, the appellate court, and the court of cassation within the period of 10 to 12 months.

If the case requires appointment of forensic examination in order for the court to determine valid causes of property damage or destruction (fire, crop shortfall) or disability, as well as the amount of damages, the consideration of the case may be delayed up to one-and-half to two years.

Also, the court usually obliges a losing party to pay the winning party's costs, even though the percentage of the costs of the winning party rarely exceeds 10 to 30 per cent of the actual costs. Nevertheless, recent legislative amendments in the area of judicial reform in Ukraine provides regulatory means for courts to award the costs of the winning party in full amount. Apart from that, the parties are now obliged to submit a preliminary estimation of litigation costs while submitting the first document on the merits of the case. The court may also oblige the parties to deposit the funds in the amount of the preliminary estimated costs to a deposit account of the court.

### 4 What remedies or damages may apply?

For non-performance or undue performance of the terms of the contract the parties bear the civil liability, prescribed by contract or by law. In case of delay in paying an insurance indemnity, an insurer is required to perform its contractual obligation and pay an insurance indemnity taking into account inflationary losses and 3 per cent interest rate.

Apart from that, an insurer will be subject to a penalty in the form of forfeit or fine. The amount of such penalty could be envisaged by contract or by law. For example, as to the insurance of civil liability of owners of vehicles, for each day of delay in paying an insurance indemnity, the insurer shall pay the forfeit that is calculated according to relevant (doubled) discount rate set out by the National Bank of Ukraine.

As regards the breach of the insurance contract by the insured, the insurer may claim the refusal to pay an insurance indemnity payment or the termination of the insurance contract.

The parties to the insurance contract may agree in the contract on other legal effects of failure to perform the contractual obligations and grounds of liability.

If the insurer systematically violates the insurance rules, the regulator may suspend or deprive such an insurer of its insurance licence.

### 5 Under what circumstances can extracontractual or punitive damages be awarded?

Extracontractual damages apply if either insurer or insured failed to perform monetary obligation (eg, payment of the insurance indemnity). In such case, insurance indemnity should be paid considering inflationary losses and 3 per cent interest rate.

In terms of punitive damages, the payment of forfeit or fine may be envisaged in contract.

## Interpretation of insurance contracts

### 6 What rules govern interpretation of insurance policies?

Since insurance policies constitute contracts, the rules regarding interpretation of contracts apply. Ukrainian law provides that the content of

a contract may be interpreted by parties themselves or by the court with rendering a decision on the issue afterwards.

Insurance agreements concluded in accordance with international insurance systems that require the use of unified insurance conditions (for instance, international aviation insurance market) are interpreted in the light of the conditions used in contemporary international insurance system accordingly.

Also, typical conditions (typical agreements) may be taken to account even if there is no reference to typical conditions in the specific insurance agreement.

If insurance rules contradict the insurance agreement, the latter will have a priority. If the insurance agreement refers to the insurance rules, then such rules are obligatory to both parties. But if there is no reference in the insurance agreement, the court may not rely upon such insurance rules.

### 7 When is an insurance policy provision ambiguous and how are such ambiguities resolved?

Generally, an insurance policy provision is ambiguous if it is impossible to establish its content. Such ambiguities are resolved through interpretation of the provisions of the insurance policy and the rules regarding the interpretation of contracts apply.

First, while interpreting a contract, the meaning of words and expressions uniform for the whole content of the contract and the meaning of terms generally accepted in the particular area shall be taken into account.

Second, if such efforts are ineffective, then the content of a contract may be established by comparing the relevant provision of a contract with the content of other provisions of such contract, its whole content, as well as intentions of the parties.

Finally, should the measures above prove to be of no assistance, then the purpose of the contract, the content of the previous agreements, the established practice of relationships between the parties, business customs, subsequent conduct of the parties, the content of the typical policy and other relevant circumstances should be considered.

## Notice to insurance companies

### 8 What are the mechanics of providing notice?

Ukrainian law, while obliging an insured party to provide a notice to the insurer, does not specify the manner of doing so. Usually, the mechanics are stipulated in an insurance contract or policy, whereas the most common means are email, telephone and via post.

As a rule, insurance contracts prescribe that the insured is required to inform the insurer of the insured event in any manner available and provide a written statement afterwards too.

### 9 What are a policyholder's notice obligations for a claims-made policy?

Ukrainian law does not provide for specific notice obligations for a policyholder regarding a claims-made policy. The respective obligations are determined by the insurance contract in question. Wording such as 'beforehand', 'immediately' 'at the nearest time', 'upon first opportunity' or 'the reasonable time' is commonly used. Parties are also free to agree on any particular time frame, such as one day, three days or one week.

### 10 When is notice untimely?

As mentioned above, the laws of Ukraine do not prescribe general conditions on the notice period. If the policy does not stipulate a specific period, then it will depend on the way that court interprets the wording 'beforehand', 'reasonable', 'upon first opportunity' or 'immediate' period. In any event, the late notice cannot create obstacles for an insurer in establishing the circumstances, character and the amount of damages.

Thus, if the notice was not made in the prescribed period and there were no objective reasons for delay, such notice would be considered untimely.

### 11 What are the consequences of late notice?

Late notice may result in creation of obstacles for the insurer to investigate the circumstances, character and amount of damages in relation to the insured event. Thus, a failure by the insured to fulfil its obligation to notify the insurer on time may be interpreted as a ground for refusal to pay an insurance indemnity.

Nevertheless, late notice as such does not suffice as a ground for refusal to pay insurance indemnity, but only if the insurer is precluded from the chance to obtain enough information as to whether a certain event amounts to the insured event.

## Insurer's duty to defend

### 12 What is the scope of an insurer's duty to defend?

Under Ukrainian law, the insurer bears no duty to defend. However, there are different ways in which the insurer can defend against the insurance-based claims.

First, the insurer may take a stand that the insured event did not occur. Second, the insurer may argue that the occurred event does not qualify as an insured event within the meaning of policy or contract. Finally, the insurer may rely on legislatively prescribed grounds of refusal to pay an insurance indemnity, which, among others, are the following:

- intentional actions undertaken by an insured aimed at the occurrence of an insured event, except for the actions related to the fulfilment of civil or office duties committed in the state of necessary self-defence (without exceeding its limits) or with regard to protection of the property, life, health, honour or business reputation;
- intentional crime committed by an insured that resulted in the insured event;
- submitting by an insured of false information about the fact of insurance event occurrence;
- making the full payment of indemnification by the person who caused such damage under the property insurance contract; and
- delay in notification of the insurer about the occurrence of the insured event, unless there are objective reasons for such a delay.

### 13 What are the consequences of an insurer's failure to defend?

If the insurer fails to defend against the claim of the insured, then it will be obliged to fulfil the terms of the court decision, which can set forth the obligation of the insurer to pay an insurance indemnity and financial penalties, prescribed by the law or by the contract. The financial penalty may take the form of forfeit or a fine for breach of the contractual obligation.

Also, the insurer may be forced to cover the litigation costs of a winning party.

## Standard commercial general liability policies

### 14 What constitutes bodily injury under a standard CGL policy?

Any violation of anatomical integrity of flesh, organs and their functions that occur as a result of effect of one or several external damaging factors (physical, chemical, biological, psychological) should be qualified as a bodily injury.

### 15 What constitutes property damage under a standard CGL policy?

Property damage is understood as loss, shortage of or damage to certain property.

For example, with regard to agricultural insurance, property damage may be understood as loss or shortfall of crop owing to, for instance, frosts, droughts, hailstones in certain percentage of the expected amount of crop.

### 16 What constitutes an occurrence under a standard CGL policy?

An occurrence is an event causing liability (obligation to pay indemnity) and is envisaged by the insurance agreement or by law. It may take form of a bodily injury, damage to property or incurrence of liability.

### 17 How is the number of covered occurrences determined?

There is no generally applicable rule in this regard. The determination of the number of covered occurrences depends on type of insurance and the specific insurance contract. In practice the number of covered occurrences is defined by the type of insurance (eg, insurance of health, civil liability of the owners of the means of transport), nature of the occurrence of insured event, insured sum and terms of agreement.

For instance, if the property that was the object of the insurance contract is destroyed, the insured will have only one indemnity payment under this policy. If the property was damaged several times, the insured have a possibility to get several indemnity payments not exceeding the value of such a property, agreed between parties to the contract. In addition, there are some types of insurance policies that provide for one payment only, such as life insurance.

**18 What event or events trigger insurance coverage?**

The occurrence of the insured event under the insurance policy triggers insurance coverage. The insured event is an event prescribed by insurance contract or by law that has already occurred, and after the occurrence of which the insurer's obligation to pay an insurance indemnity arises.

The insured event varies for different types of insurance. For example, as regards health insurance, the insured event would be the bodily injury or sickness. As to the civil liability insurance, the insured event will be the occurrence of tort.

In any event, the insured event will be defined according to the type of insurance, terms of insurance contract and rules of law concerning this type of insurance.

**19 How is insurance coverage allocated across multiple insurance policies?**

Ukrainian law provides for the institute of co-insurance when the object of the insurance contract is insured by several insurers by concluding a single insurance contract.

Such a contract must contain the terms that determine the rights and obligations of each insurer. Under such contract, if agreed by the parties, one of the co-insurers may represent all other co-insurers in the relations with the insured, albeit remaining liable within the scope of its share.

In such case, the liability of each co-insurer depends on several factors, such as the terms of the contract between the co-insurers and the insured, the terms of the contract between co-insurers, and the share of property that is insured by the co-insurer.

## First-party property insurance

**20 What is the general scope of first-party property coverage?**

Within the scope of a property insurance agreement, the risk is insured for loss (destruction), shortage of or damage to specific property. Usually, the definition of property includes the specific items, goods, vehicles, as well as the groups of these items. While concluding the insurance contract the parties should agree on the insured coverage that is determined within the scope of value of the insured property and cannot exceed its true market value.

**21 How is property valued under first-party insurance policies?**

The value of the property under insurance contract should be agreed between parties while concluding the contract according to the provisions of law and according to the rates and tariffs that are in force at the moment of conclusion of the contract. The insurer has a right to value the insured property itself or appoint an expert examination to this end.

Still, the parties to the contract may agree on other ways of calculating the value of the insured property. For example, for the purpose of valuating the parties can agree on using the market price of the property instead of the actual (contract) price.

**22 Is insurance available in your jurisdiction for natural disasters and, if so, how does it generally operate?**

The Ukrainian laws provide for insurance for natural disasters. Relevant provisions are usually included into the property insurance policies. There are no limits as to the type of natural disasters.

## Directors' and officers' insurance

**23 What is the scope of D&O coverage?**

The scope of D&O coverage includes the following elements:

- compensation of damages to other persons or their property within the course of carrying out employment duties by officers (property interests of officers); or
- compensation of damages occurred owing to improper performance of the duties by officers (property interests of companies).

**24 What issues are commonly litigated in the context of D&O policies?**

D&O coverage is rather uncommon for the Ukrainian market. Thus, no commonly litigated issues may be named.

## Cyber insurance

**25 What type of risks may be covered in cyber insurance policies?**

Cyber insurance policies may cover the following risks:

- DDos attacks;
- 'fishing' (type of e-fraud aimed at obtaining users' confidential data, such as logins and passwords);
- cyber-extortion; and
- infection with malware.

**26 What cyber insurance issues have been litigated?**

D&O coverage is rather uncommon for the Ukrainian market. Thus, no commonly litigated issues may be named.

## Terrorism insurance

**27 Is insurance available in your jurisdiction for injury or damage caused by acts of terrorism and, if so, how does it generally operate?**

Generally, acts of terrorism are usually included in the list of events that preclude the occurrence of the insured event. However, such insurance for injury or damage caused by acts of terrorism is not prohibited by Ukrainian law.

VASIL KISII

**Oleg Kachmar** **kachmar@vkp.ua**
**Oleksandra Bortman** **bortman@vkp.ua**

17/52A Bohdan Khmelnytsky Street
Kyiv 01030
Ukraine

Tel: +380 44 581 7777
http://vkp.ua

# United Arab Emirates

**Sam Wakerley and John Barlow**

**HFW**

## Preliminary and jurisdictional considerations in insurance litigation

### 1 In what fora are insurance disputes litigated?

In the UAE, the general rule is that parties are free to agree upon the forum for disputes, subject to the following conditions.

First, UAE law provides that the UAE courts (as opposed to a foreign court) have jurisdiction over claims brought against UAE nationals (ie, a UAE individual or legal entity) or foreign legal entities with a domicile or place of residence in the UAE (Federal Law No. 11 of 1992 (the Civil Procedures Law), article 20). Any agreement to the contrary is void under UAE law (article 24).

Second, articles 31 to 41 of the Civil Procedures Law include a series of circumstances that will determine which court within the UAE has jurisdiction over, for example, the conclusion of a contract or the performance of a contract. Article 37 relates specifically to insurance: where a dispute relates to insurance, jurisdiction is vested in the court where the beneficiary has its residence or of the location of the property. On a broad reading, this clause gives jurisdiction to any UAE court where the beneficiary of the policy or the insured property is located.

Third, arbitration clauses are recognised by UAE law. In June 2018, Federal Law No. 6 of 2018 on Arbitration (the Arbitration Law) came into force, which repealed and replaced articles 203 to 218 of the Civil Procedure Law. The Arbitration Law respects the rights of parties to arbitrate. Article 8 states that the court before which an action was commenced regarding a dispute in respect of which an arbitration agreement exists shall dismiss the action, unless the court finds that the arbitration agreement is void or unenforceable. In addition, article 7(6) of the Insurance Authority Code of Conduct and Ethics (as set out in Board Resolution No. 3 of 2010) (the IA Resolution) states that non-compulsory insurance policies may incorporate an arbitration clause as a means to settle any dispute arising between the parties subject to the arbitration clause being printed as a separate agreement from the general terms and conditions incorporated in the policy (IA Resolution article 7(2)(b)).

Fourth, the UAE also has a series of free zones, including the Dubai International Financial Centre (DIFC) and the Abu Dhabi Global Market (ADGM), which have their own civil (ie, non-criminal) laws and their own courts to administer those laws. Both the DIFC and ADGM operate as a common law legal system, predominantly based on English common law and substantive civil law and procedure. Parties are free to choose DIFC or ADGM law to govern their contracts.

As a result of Dubai Law No. 16 of 2011, article 5(A)(2), parties situated outside the DIFC can now opt into the DIFC courts' jurisdiction to hear disputes, exclusively or non-exclusively, either before the conclusion of their contract (ie, before any potential dispute arises) or after the dispute has arisen by jointly agreeing in writing to refer a dispute to the DIFC courts. Parties contracting with a DIFC entity may fall within the DIFC courts' jurisdiction (rather than the local (non-DIFC) courts) even without a choice of court clause in favour of the DIFC courts, if their dispute falls within one of the exclusive jurisdictional gateways laid down by article 5(A) of Dubai Law No.12 of 2004. This generally includes tort and contract claims partly or wholly connected with the DIFC. If parties wish to opt out of the jurisdiction of the DIFC courts in favour of the local courts, they are entitled to do so under article 13(1) of DIFC Law No. 10 of 2005, but in light of recent cases, this requires careful wording.

In relation to the ADGM, Section 16(2)(e) of the ADGM Courts, Civil Evidence, Judgments, Enforcement and Judicial Appointments Regulations 2015 (the ADGM Courts Regulations), states that the ADGM Court of First Instance shall have jurisdiction as is conferred on it by any request, in writing, by the parties to have the ADGM Court of First Instance determine the claim or dispute.

### 2 When do insurance-related causes of action accrue?

The cause of action in respect of insurance contracts arises when the risk or event materialises (Federal Law No. 5 of 1985 (the Civil Code), article 1026(1)).

In respect of liability claims, the cause of action arises when a third party makes a claim against the insured (Civil Code article 1035) or when a judgment is awarded against the insured.

The limitation period for claims under insurance contracts is three years from the occurrence of the incident, or from the date of the insured having knowledge of that occurrence (Civil Code article 1036).

The rule in respect of marine insurance claims is different. The limitation period in respect of marine insurance is generally two years from the date of the incident or where a third party makes a claim against the insured (Federal Law No. 26 of 1981 (the Commercial Maritime Code), article 399(1)). Further, limitation is suspended under marine insurance by 'registered letter or delivery of other documents relating to the claim' (article 399(3)), or a 'legal excuse' (article 399(1) and (2)).

### 3 What preliminary procedural and strategic considerations should be evaluated in insurance litigation?

The UAE legal system is a civil law system and the primary source of law is a statutory code. This means there is no system of binding precedent (although previous court decisions may be indicative and persuasive).

In insurance disputes, the court will typically appoint an expert to investigate the facts, meet with the parties, gather evidence and prepare a report. While the opinion of the expert is not binding on the court (Federal Law No. 10 of 1992 on the Issuance of Evidence in Civil and Commercial Transactions (Issuance of Evidence), article 90(i)), the court will usually follow the recommendations in the expert's report.

In civil cases, evidence is provided by way of documentary rather than witness evidence. Significantly, the factual findings of an official document (which are those in which a public official or person employed in public service certifies what has taken place before him or her, or what he or she has been informed of by the parties concerned within the limit of his or her authority and jurisdiction, such as a police report) are binding upon a UAE court (Issuance of Evidence articles 7 and 8).

There are no mandatory disclosure obligations before the UAE courts. A party will therefore only disclose those documents on which he or she relies. Although the court-appointed expert may request that a party produce documents, there are no sanctions for failing to do so, although a negative inference may be drawn from a failure to provide them. Importantly, privilege is not a recognised concept under UAE law but, even if it was, it would most likely never need to be invoked in circumstances where disclosure does not form part of a regular litigation procedure before the local UAE courts.

Where causes of action are based on documentary evidence and there is a dispute about the validity of a document, the original documents must be produced (Civil Procedure Law article 45).

Other than nominal costs (such as court fees, expert's fees and a small amount in respect of legal fees), UAE courts do not award costs.

In terms of pre-action protocol and procedure, article 110(1) of Federal Law No. 3 of 2018 on the Amendment of Certain Provisions of Federal Law No. 6 of 2007 sets out the process by which insurance claims are to be handled internally by insurers. Insurers are obliged to adhere to the following procedures, in accordance with applicable legislation and the provisions of insurance policies:

- insurers must issue a decision in relation to all insurance claims in accordance with the IA Resolution;
- if a claim is refused, insurers must provide written reasons for the rejection of the claim to the insured;
- in the event of a dispute between the insurer and the insured, an insured may submit a written complaint to the Insurance Authority, which may request further clarification from the insured; and
- in the case of an objection by the insured to the clarifications provided by the insurer, the insured may seek to refer the matter to a specialised insurance committee.

The Dubai Court of First Instance has confirmed that, in accordance with article 110(3) of Federal Law No. 3 of 2018, insurance-related disputes will not be accepted by the local UAE courts unless such disputes have first been considered by the specialised committees set up in accordance with article 110(2). However, the Insurance Authority Disputes Committee has yet to be launched (see 'Update and trends'). Article 110(2) empowers the Insurance Authority to form specialised dispute resolution committees that will settle disputes arising out of insurance contracts. Either party may appeal the decision of the Insurance Authority committee to the Court of First Instance within 30 days. However, once this period has elapsed, the decision of the committee becomes final and binding (article 110(4)).

### 4 What remedies or damages may apply?

Article 1034 of the Civil Code requires insurers to pay the indemnity or sum due to the assured or beneficiary 'in the manner agreed upon when the risk materialises or when the time specified in the contract comes'.

Insurers must be mindful that it is, in theory, possible for insureds to bring a damages claim as compensation for a civil wrong or for breach of contract against insurers if they consider that a claim has been mishandled, or possibly incorrectly or wrongfully declined.

In relation to the late payment of claims, article 9(2) of the Insurance Authority Code of Conduct and Ethics, as set out in the IA Resolution, states that insurers must '[s]ettle the claims without undue delay in accordance with the provisions of the law and the terms and conditions of the Policy'. However, 'undue delay' is not further defined and, of course, arguments can be made as to whether delays are justified. Article 9 goes on to state that insurers must make a decision within 15 days of receiving a full set of documents, although again whether a set of documents is 'full' may vary case to case.

In addition, interest may also be applicable to the late payment of insurance claims. Where the insurer delays payment of a claim, it shall be bound to pay to the insured compensation for the delay, unless otherwise agreed (Federal Law No. 18 of 1993 (the Commercial Transactions Law), article 88). Where a policy stipulates the rate of interest and the debtor delays payment, the delay interest shall be calculated on the basis of the agreed rate until full settlement (the Commercial Transactions Law article 77).

In relation to pre-contract disclosure, article 1032(b) of the Civil Code makes it clear that an insured must disclose all information that insurers would wish to know when evaluating the risk. An insured's duties do not end there: article 1032(c) also provides that an insured has an ongoing duty of disclosure, post-contract, to notify insurers of any matters occurring during the policy period that would lead to an increase in risk. If an insured does not act in good faith and fails to disclose relevant information, or provides incorrect information, insurers can require that the policy be cancelled from the date of the insured's failure to disclose the relevant information (absent express wording in the Policy, cancellation likely requires an application to court) (article 1033(1) of the Civil Code).

### 5 Under what circumstances can extracontractual or punitive damages be awarded?

The insurer is obliged to exercise good faith in paying claims (Civil Code articles 246 and 1034, and article 3(2) of the IA Resolution).

It follows that it may theoretically be possible for the insured to claim extra damages for breach of this duty of good faith when adjusting and settling claims (ie, this would be similar to the punitive 'bad faith' claims) or to claim damages for consequential losses flowing from the insurer's breach, or both, in addition to the insured's primary claim under the policy.

However, punitive damages are not generally awarded in the local courts and so we are not aware of any cases where a court has awarded damages for breaching the duty of good faith under UAE law.

## Interpretation of insurance contracts

### 6 What rules govern interpretation of insurance policies?

Parties to contracts (including insurance contracts) governed by UAE law are subject to the obligation to perform the contract in 'good faith' (Civil Code article 246; see also article 3 of the IA Resolution). A party's obligations under the contract extend beyond what is expressly contained in the contract to include an obligation to embrace that which is appurtenant to it by virtue of the law, custom, and the nature of the transaction (Civil Code article 246).

The primary rule of interpretation is that clear words will be given their direct literal meaning with no scope for any other interpretation (Civil Code articles 258(2) and 259).

Where there is doubt as to the meaning of a term, the court may give effect to the intentions of the parties over the words in the contract (Civil Code article 258(1)).

Policies issued in the UAE are to be issued in Arabic (Federal Law No. 6 of 2007 (the Insurance Law), article 28), and may be translated into any other language. If there is a difference in interpretation between the two languages, the Arabic version will prevail.

Any clause in an insurance contract that tries to give the insurer the opportunity to avoid the contract of insurance or avoid the claim must be displayed 'conspicuously' (Civil Code article 1028(c)). According to the IA Resolution article 7(2), such clause should be clearly displayed (eg, in a different font or colour) while article 28 of the Insurance Law stipulates that it should be highlighted in a prominent manner (eg, in a different colour or in bold characters) and must be initialled by the insured. This means that the insurer should require the insured to initial or sign next to any term discharging the insurer from liability under the policy.

This definition covers warranties, exclusion clauses and conditions precedent, although UAE law does not expressly recognise the differences between contractual terms in contracts of insurance. To the extent that a warranty, exclusion or a condition precedent is drafted in general terms and seeks to deny cover for any breach of the law, insurers will not be permitted by the UAE courts to rely on the general provision unless it seeks to exclude cover for a felony or a deliberate misdemeanour pursuant to the Civil Code article 1028(1)(a).

Any such clause where the breach is not causative of the loss is potentially invalid (Civil Code article 1028(e)).

### 7 When is an insurance policy provision ambiguous and how are such ambiguities resolved?

As per article 265(1) of the Civil Code, where the wording of a policy is clear, it may not be departed from by way of interpretation to ascertain the intention of the parties. However, should there be scope for interpretation of the policy, the court will make enquiries into the 'mutual intentions of the parties', as well as the nature of the transaction, and the trust and confidence that should exist between the parties (Civil Code article 265(2)).

Where there is doubt as to the meaning of a policy term, it will be construed by the court in favour of the obligor (Civil Code article 266(1)). Nevertheless, it is permissible to construe ambiguous wording in policies in a manner detrimental to the party that put it forward or the party that benefits from it if they are deemed to be contracts of adhesion (Civil Code article 266(2)).

**Update and trends**

HFW forecast that 2019 will see the UAE finalise and implement the long-awaited life insurance regulations, promulgated by the Insurance Authority. While the regulations were originally proposed in 2016, they are due to come into effect in 2019. The regulations place significant focus on regulating indemnity commission and implementing mandatory disclosure obligations. In 2017, the Insurance Authority issued draft reinsurance regulations, which included requirements for reinsurer classifications and provisions relating to the reinsurance of takaful insurers. We understand that this is still under consultation but these may come into force in 2019. Not only will the regulatory environment become more robust, but regulators are set to become increasingly rigorous in enforcing regulations, with a focus on solvency requirements at the forefront of their regulatory agenda. This year alone, the Insurance Authority has introduced regulations concerning the financial solvency requirements of branches of foreign insurance companies (Insurance Authority Board of Directors Chairman Resolutions No. 14 of 2018) and for insurance consultants to obtain a licence they must provide a professional indemnity insurance policy (Resolution of the Insurance Authority Board Chairman No. 12 of 2018).

The proposed introduction of the Insurance Authority Disputes Resolution Committee in 2019 will see the powers of the Insurance Authority grow even further, whereby the committee will have powers to settle disputes arising out of insurance contracts. The Court of First Instance has also confirmed that in accordance with article 110(3) of Federal Law No. 3 of 2018, insurance-related disputes will not be accepted by the local UAE courts unless such disputes have first been considered by the specialised committee.

Finally, technology will be firmly at the forefront of the insurance market in 2019, dominating all aspects of the insurance industry, from operational efficiency, cyber insurance and product innovation. Paired with the introduction of business technology (ie, fintech, the increase in digitisation and the risks posed by cybersecurity), insurers will need to stay ahead of these trends, customising innovative products and services to meet the evolving demands of the modern digital economy.

## Notice to insurance companies

### 8 What are the mechanics of providing notice?

The procedure for providing notice of a claim will usually be set out in the insurance policy itself, which will typically require notice to be given in writing. Article 7(5) of the IA Resolution states that insurers must explain the procedures the insured must follow in the event the insured risk has occurred to receive the entitled compensation. The content of the notice will typically require a summary of the claim or circumstance, quantum information sufficient for insurers to assess coverage and any supporting documents.

### 9 What are a policyholder's notice obligations for a claims-made policy?

There are no specific provisions under UAE law regarding a policyholder's notice obligations for a claims-made policy. This will be set out in the insurance policy and will normally require notice to be provided as soon as possible.

### 10 When is notice untimely?

UAE law does not specify a time frame for notification of an occurrence, claim or circumstances under an insurance policy. However, there may be provisions in the policy with regard to notification by the insured to the insurer. If the insured has a reasonable excuse for the delay, any term that provides that late notification means an insured's rights shall lapse under the insurance policy shall be void under UAE law (Civil Code article 1028(b)) (see question 11).

### 11 What are the consequences of late notice?

Under UAE law, there are no specific consequences for late notification in insurance contracts; rather, the general position on breach of contract will apply. In the event of a breach of contract, the insurer may seek damages or refuse to pay a claim under the policy (depending on the insurance policy itself).

Further, 'arbitrary' clauses are void (ie, a clause, breach of which is not connected to the occurrence of the insured risk, is potentially invalid); this could include breach of a notification provision (Civil Code article 1028(e); see question 6).

It should be noted that if an insured fails to provide all information requested by insurers following notification, this can amount to a reason to deny the claim in circumstances where such information is required to ascertain the incident or the extent of the loss (IA Resolution article 9(6)) and where the insured has no reasonable excuse for the delay (Civil Code article 1028(b)).

## Insurer's duty to defend

### 12 What is the scope of an insurer's duty to defend?

According to UAE law, an insurer is entitled to pursue any claims that the insured can bring against third parties for the losses indemnified by the insurer. Article 9(5) of the IA Resolution states that should the insurer pay the insured the payable amount without delay, the insured shall sign a document to discharge the insurer, a subrogation or a transfer of rights when the amount of indemnity is paid.

However, there is no requirement under UAE law in respect of an insurer's duty to defend. The insurance policy will often set out these duties. Commonly, an insurer will agree to cover the costs of the insured to defend the claim, and there are likely to be claims control clauses enabling the insurer's involvement in the defence of the claim.

### 13 What are the consequences of an insurer's failure to defend?

See question 12. There are no express consequences for the failure of an insurer to defend an insured's claim under UAE law.

Where the insurer fails to defend in breach of the insurance policy, the insurer may be liable for damages. A duty to defend under an insurance policy will normally be subject to caveats such as there being no reasonable chance of success.

## Standard commercial general liability policies

### 14 What constitutes bodily injury under a standard CGL policy?

Physical damage in the context of medical injuries is expressed under UAE law as 'bodily injury'. Bodily injury is broadly defined to be anything whatsoever that affects the health of a human being. Compensation is payable under UAE law for 'any harm caused to a person' (Civil Code article 299). Compensation for bodily injury, pain and suffering (ie, moral damages) is recoverable under UAE law (Civil Code article 293).

### 15 What constitutes property damage under a standard CGL policy?

Articles 95 to 103 of the Civil Code defines property as any thing or right having a material value in dealing. The term includes both land and chattels. Article 97 of the Civil Code adds that property is anything 'which can be possessed whether physically or constructively, or which may be lawfully enjoyed, and which does not by its nature or by operation of law fall outside the scope of dealing (transactions)'.

Article 300 of the Civil Code refers to the obligation of a person who 'causes damage to or renders defective' another property to either make such property good or pay compensation.

### 16 What constitutes an occurrence under a standard CGL policy?

These are largely market wordings that have not been 'domesticated' – that is, these policies have not been standardised, and coverage differs from one policy to the next.

There has been no law or case law on this issue in the UAE (unlike under English or other common law, where the meaning of 'occurrence' and other aggregating language has been considered in some detail).

### 17 How is the number of covered occurrences determined?

UAE law does not deal in detail with the concepts of causation and occurrences.

**18 What event or events trigger insurance coverage?**

This will often be defined in the insurance policy. In the absence of specific wording, under Civil Code article 1026(1), the insurance is triggered if the risk or the event specified in the policy 'materialises', which provision has also been translated to state that the insurer's obligations are triggered 'upon the occurrence of the risk or event specified in the contract'.

**19 How is insurance coverage allocated across multiple insurance policies?**

As per article 1042 of the Civil Code, any person who insures property or an interest with more than one insurer must notify all of them of the other contracts of insurance, the amount of each of them and the names of the other insurers. If there are several insurers, the amount of the insurance must not exceed the value of the property or interest insured.

An insurer (specifically in respect of a fire loss) is entitled to a contribution from other insurers if there is double insurance (Civil Code article 1043). For a non-fire loss, UAE law does not provide an express right to an equitable contribution.

## First-party property insurance

**20 What is the general scope of first-party property coverage?**

First-party property insurance policies in the UAE generally provide coverage for a specific event or on an all-risk basis, and include cover for business interruption, property damage and fire claims. For a named peril policy, in the first instance the insured must prove that an insured peril has occurred, within the currency of the policy, leading to loss or damage. If the policy is an all-risks policy, the insured must prove that the insured property has suffered loss or damage, arising out of fortuity, within the policy period. Thereafter, the burden will shift to insurers to prove that the loss falls outside the scope of the relevant policy or that it is excluded (along with any other applicable defences).

**21 How is property valued under first-party insurance policies?**

The policy often expressly sets out a mechanism for valuation. Under the Civil Code, insurance is defined as a contract whereby the insurer, upon the risk materialising, pays the insured the sum (ie, an indemnity). The insured cannot recover more than its loss, in accordance with the principle of good faith under UAE law (Civil Code article 246).

**22 Is insurance available in your jurisdiction for natural disasters and, if so, how does it generally operate?**

Insuring against damage to property and person by reason of a natural disaster is a permitted insurable risk in the UAE. The coverage of natural disasters generally relates to civil liability under the Civil Code (article 1027) and there is no positive exclusion of these as insurable matters. Thus, there is no legal bar to their inclusion. An insured in the UAE is generally offered any or all of three common types of disaster insurance: property insurance, business interruption insurance and third-party liability insurance. As there are no specific regulations governing disaster insurance coverage, the insurer's chosen market practice generally dictates what policy benefits are conferred.

The content of an insurance policy as it relates to fire damage is informed by the requirements of the Civil Code (article 1037). Under this article, the insurer is liable to make good all insured claims for fire damage arising out of earthquakes, lightning, storms, winds, hurricanes, household explosions and falling aeroplanes, and all other matters that are customarily regarded as within scope. The insurer is liable to cover damage that is considered a 'certain result of the fire', including damage sustained in salvage, or during steps taken to prevent the spread of the fire, and for the loss or disappearance of any property insured during the fire (article 1037).

Perhaps the most burdensome requirement is for the insurer to honour policies in relation to fire damage arising through any error of the insured (article 1038) or those working under the insured (article 1040), although there are arguments that the fire insurance provisions of UAE law should not apply in all instances.

## Directors' and officers' insurance

**23 What is the scope of D&O coverage?**

D&O insurance is available in the UAE. There are no specific regulations governing D&O insurance coverage. D&O policies in the UAE are largely based on London market wordings.

As a result of the widening duties and liabilities of directors and officers under Federal Law No. 2 of 2015 (the Commercial Companies Law), it is unclear whether a company can legally indemnify a director or officer (such that it could claim under a Side B (corporate reimbursement) cover). In the light of this uncertainty, any director or officer should look carefully at their Side A Cover (indemnification of the director), which is likely to be the responsive cover.

**24 What issues are commonly litigated in the context of D&O policies?**

There have not, to our knowledge, been any reported claims before the UAE courts under D&O insurance policies.

However, we expect that the following issues will arise (and have arisen) in the UAE in respect of D&O policies:

- the question of allocation: that is, whether certain elements can be allocated to cover under the D&O policy, and where other elements are not covered (as well as allocation between different policies; eg, D&O and professional indemnity policies);
- whether Side A (indemnification of the director) or Side B (corporate reimbursement) cover should respond to a claim; and
- what triggers the policy cover: where the allegations are systemic (but no claims have been intimated against the directors) and whether this is a claim that should be (or can be) notified under a D&O policy.

HFW

**Sam Wakerley** **sam.wakerley@hfw.com**
**John Barlow** **john.barlow@hfw.com**

Level 8, Building 6
Emaar Square, Sheikh Zayed Road
PO Box 53934
Dubai
United Arab Emirates

Tel: +971 4 423 0555
Fax: +971 4 425 7941
www.hfw.com

## Cyber insurance

### 25 What type of risks may be covered in cyber insurance policies?

Cyber insurance risks will either fall to be covered by first-party or third-party insurance policies, which are freely available in the UAE. While there are no regulations governing cyber insurance coverage under UAE law, the UAE has issued Federal Law No. 5 of 2012 (as amended by Federal Decree-Law No. 2 of 2018) on Combating Cyber Crimes.

Those cyber insurance policies that are available in the UAE are largely based on London market wordings.

### 26 What cyber insurance issues have been litigated?

To our knowledge, there have been no reported claims before the UAE courts under cyber insurance policies.

## Terrorism insurance

### 27 Is insurance available in your jurisdiction for injury or damage caused by acts of terrorism and, if so, how does it generally operate?

Specific insurance for injury and damage caused by acts of terrorism is available in the UAE. Products offered include property terrorism and sabotage insurance, terrorism and political risk insurance, and, recently, high-risk travel insurance with terrorism cover. Coverage can be extended to include interruption to business following physical loss or damage to businesses from terrorism. In relation to general property insurance cover, there is limited terrorism cover available in respect of physical loss or damage caused by or resulting from terrorism at specified locations, but there are a number of exclusions. These include exclusions for terrorism caused by nuclear materials or radiation, as well as loss resulting from actions to defend or respond against terrorism. In addition, there are also exclusions for any loss resulting from the actual cash value portion of direct physical loss or damage by fire caused by or resulting from terrorism.

# United Kingdom

**Hermes Marangos, Tom Rotherham, Lucy Alexander, Nicholas Barnard and Adriano Stagni**

**Signature Litigation LLP**

## Preliminary and jurisdictional considerations in insurance litigation

### 1 In what fora are insurance disputes litigated?

In England and Wales, insurance disputes are litigated in the following fora of the civil courts:

- county courts;
- High Courts;
- the Court of Appeal; and
- the UK Supreme Court (although only on appeal from either the High Court or the Court of Appeal).

Claims with a value of more than £100,000 can generally be issued in the High Court in the first instance, otherwise appeals may be heard here from the relevant county court. If the dispute in question involves particularly complex insurance or reinsurance issues, then it may be heard in the Commercial Court (a specialist part of the Queen's Bench Division). Judges in the Commercial Court have extensive experience specific to the disputes over which they preside. Disputes that require financial market expertise will likely be heard in the Financial List of the Commercial Court.

It is commonplace for a reinsurance contract to contain an arbitration clause. If correctly drafted (and therefore enforceable), the parties will have to resolve their dispute via arbitration, which may be conducted under ad hoc rules or those of a particular arbitral institution.

It is important to note that a reinsurance contract may also require the parties to submit their dispute to another dispute resolution mechanism before litigation or arbitration; for example, submission to a reinsurance mediator. The English court will also encourage parties to attempt alternative dispute resolution (most often mediation) before litigating; failure to do so may result in costs penalties.

### 2 When do insurance-related causes of action accrue?

The general rule is that a claim for breach of contract must be brought within six years of the accrual of the cause of action. This will in most cases be six years from the breach, but this is obviously harder to ascertain with insurance policies.

With regard to liability policies, the right to indemnity is triggered when the liability is ascertained, which may be in the form of an agreement, an award or a judgment. With property, marine or life policies, the cause of action will be deemed to be when the event occurs.

### 3 What preliminary procedural and strategic considerations should be evaluated in insurance litigation?

The following should be considered at the outset of an insurance dispute:

- limitation: you should ensure that, if acting for the claimant, that the claim is within the limitation period (see question 2);
- the dispute resolution clause and choice of law: it is very important to consult the policy wording, to see what method of dispute resolution is provided for, and under which law. It is common for insurance disputes to be arbitrated, and for this to be reflected in the policy;
- pre-action steps such as protocol compliance and mediation: insurance disputes rarely call for onerous pre-action steps, but it is worth checking to avoid being penalised. The court will certainly want to see evidence that the parties have first attempted mediation;
- time and cost: the English court system requires a certain level of front loading of court costs, which should be considered at the outset of a dispute. There will likely be at least a year between commencing a claim and the trial. The winning party may be able to redeem most of their costs from the other side after judgment;
- disclosure: disclosure is quite an onerous obligation in the English legal system, as parties must disclose documents that both help, and are adverse to, their case. As a result, this can be quite a timely and expensive process;
- appeals: the right to appeal a decision is not automatic in every venue in the English court, and can be at the judge's discretion. In addition to this, an appeal can take up to a year to execute, which usually has serious cost implications for both parties. Arbitration typically carries little scope of appeal;
- confidentiality: it's important to bear in mind that, unlike arbitration, litigation in the English courts is public (unless there is very good reason for it not to be);
- mitigation: the party seeking to prove they have suffered a loss is under a duty to mitigate said loss. If this is not done, then any compensation awarded may be reduced as a result; and
- commercial relationships: it's important to consider at the outset of a dispute whether litigation is the best course of action. It can irrevocably damage any continuing business relationship between parties, and so negotiation or mediation may sometimes be a better way forward.

### 4 What remedies or damages may apply?

**For the insured**

The insured will most likely want a fully and timely indemnity as allowed for by the policy. In a departure from historical treatment of late payment, the Enterprise Act 2016 introduced an implied term in insurance contracts whereby insurers must pay sums 'within a reasonable time' (although this can be contracted out of in non-consumer contracts). A breach of this implied term will give rise to a claim for damages. The insured must bring a claim for late payment within one year of payment by the insurer.

**For the insurer**

The insurer will most likely want a declaration of non-liability for the claim in question. Before the Insurance Act 2015 (the Act) came into effect, the main remedy for an insured's breach was avoidance of the claim (if the breach was of a warranty or a condition precedent, or in the case of material non-disclosure). Since August 2016 (when the Act came into force), however, the remedies available to the insurer have been altered. The Act applies to consumer contracts (save for Part A). It will also apply to non-consumer contracts, to the extent that its provisions (all but the section prohibiting basis clauses, which will apply regardless) are not contracted out of by the parties. The new remedies are as follows:

- a breach of warranty will now suspend the policy, rather than avoiding it, and so the insurer will continue to be liable if the breach is remedied before the loss occurs. This is because, under the Act, all warranties have become 'suspensive conditions'. It is also worth noting that all basis of contract clauses (where pre-contractual

representations are converted into warranties) are now prohibited, and parties are not able to contract out of this position; and
- the duty of disclosure now falls within a wider duty on the insured to provide insurers with a fair representation of the risk. If a breach is not deliberate or reckless, then the aim will be to put the insurer in the position that it would have been in had there been fair disclosure as follows:
  - where the insurer would have declined the risk, the policy can be avoided;
  - where the insurer would have accepted the risk but with additional contractual terms, the contract will be treated as if such terms were included; and
  - where the insurer would have charged a greater premium, the claim will be scaled down proportionately.

### 5 Under what circumstances can extracontractual or punitive damages be awarded?

The general rule is that extracontractual or punitive damages will almost certainly not be awarded for breach of contract under English law. The court may award simple interest as provided for by the Supreme Court Act 1981.

## Interpretation of insurance contracts

### 6 What rules govern interpretation of insurance policies?

Insurance policies are interpreted in accordance with the general principles of contractual construction. This means that the court will take an objective and commercial approach in trying to decipher the intentions of the parties at the time of agreeing the policy in question. This will be achieved by reference to what a reasonable person, having all the background knowledge that would have been available to the parties, would have understood them to be using the language in the contract.

The Consumer Rights Act 2015 serves to protect the insured against terms in policies that are deemed unfair. If a term is not deemed transparent or prominent within the policy, then it can be assessed for unfairness and can in turn be challenged.

### 7 When is an insurance policy provision ambiguous and how are such ambiguities resolved?

An insurance policy provision will be deemed ambiguous if there is more than one credible interpretation. This ambiguity will be resolved by applying the following principles, to fulfil the objective set out in question 6:
- natural meaning of words: the starting point will be the natural meaning of the words used, although in an insurance context it's important to note that words in a policy, specifically loss-causing events, can have multiple natural meanings;
- precedent: the court will consider previous decisions to help decide an ambiguous provision, but they will not be bound by these;
- contra proferentem: any ambiguity will be decided against the person who drafted the policy, which will usually be the insurer, but may sometimes be the broker (as agent to the insured);
- extrinsic evidence: the court takes an objective approach to ambiguous provisions, and so extrinsic evidence will not be considered;
- business common sense: if a provision is ambiguous and there is more than one possible construction, the court will choose the one that makes the most commercial sense, but they will not reject the meaning simply because one party made a bad bargain;
- implied terms: the court is reluctant to move away from express wording, but they may be willing to imply certain terms if they still cannot ascertain the meaning; and
- Consumer Rights Act 2015: if a term in a consumer contract, or a consumer notice, could have different meanings, the meaning that is most favourable to the consumer will prevail.

## Notice to insurance companies

### 8 What are the mechanics of providing notice?

Typically, the insurance policy will specify how and when a notification should be made (in addition to what needs to be notified). Any notice requirements should be strictly complied with, so that cover cannot be denied. The insured must give the insurer the details of the loss, including time and place, to enable the insurer to obtain sufficient evidence to meet the claim. There is likely to be a time limit to give notice of a claim, after which cover may be refused (see question 11). As of 4 May 2017, indemnity insurers are also under a time limit, whereby they have a legal obligation to pay valid insurance claims within a reasonable time. This duty applies to all insurance and reinsurance policies taken out, varied or renewed from 4 May 2017.

It is important to remember that blanket notifications, covering unknown losses or events, may well be rejected by the insurer. It is therefore prudent for the insured to be as specific as possible about the facts giving rise to the claim.

### 9 What are a policyholder's notice obligations for a claims-made policy?

Under a claims-made policy, the policyholder must notify a claim during the period agreed under the policy, but the liability on the insured may have occurred before the policy.

The policyholder is also under a duty of fair representation, which means that they will have to disclose every material circumstance that he or she knows or ought to know, or sufficient information to put a prudent insurer on notice that it needs to make further enquiries into the identified material circumstances.

### 10 When is notice untimely?

Notice of a loss or a claim must be given within the time specified by the policy itself, or upon the occurrence of the event giving rise to the loss or claim.

Giving notice of circumstances, which may give rise to a loss or claim, must be done as soon as reasonably practical or possible. It is best to be prudent to avoid denial of coverage, although it can be difficult to predict whether a claim will emerge. See question 8 regarding the dangers of blanket notifications.

### 11 What are the consequences of late notice?

The consequences of late notice will vary depending on the wording of the policy, and whether the notice provision is a condition precedent to indemnity or a condition. If notice is considered to be just a bare condition of the contract, then the insurer will have to prove harm in order to avoid the policy.

Before the Act came into force, conditions precedent had to be fully complied with on a very strict basis. If the insured breached one of these then the insurer could refuse cover, regardless of whether they had suffered any material harm or prejudice as a result. Now breach of conditions precedent do not allow the insurer to deny cover, provided that the insured can prove that non-compliance could not have increased the risk of the loss that occurred. This protection is only available in consumer contracts, and, more importantly, only if the term does not 'define the risk as a whole'.

If a notice provision is deemed to be caught by this protection, in practice the insurer will likely deal with a breach by claiming that they have been prejudiced by the late notice. They will argue that, as a result, they have been unable to properly investigate and deal with the claim, and so will reduce compensation available to the insured (potentially by up to 100 per cent depending on the harm caused by the breach).

The Court of Appeal has recently stressed that conditions precedents will only be deemed as such if they are set out in very clear terms, and any ambiguity will be decided in favour of the insured. In addition, *Denso Manufacturing v Great Lakes Reinsurance* [2017] EWHC 391 (Comm) considered that claims cooperation conditions and conditions requiring the provision of information were more than capable of being conditions precedent, as the 'commercial purpose of [these] conditions is obvious', and in this case they related to a liability that had already arisen.

## Insurer's duty to defend

### 12 What is the scope of an insurer's duty to defend?

As a general rule, under English law, an insurer is not under any duty to defend a claim made against an insured. The policy may, however, provide that the insurer will do so (usually subject to the insurer's view on whether a defence has a reasonable chance of success). Insurers may agree to this obligation in a bid to make their policies more attractive. In this situation, a contractual duty to defend will materialise, and any

breach of this will give rise to a claim for damages and other remedies for breach of contract.

The more common practice is to have subrogation and assignment clauses contained in the policies. A subrogation clause gives the insurer the right, once it has paid the insured under the policy, to 'step into their shoes' and recoup some if not all of their losses from a third party. This secondary claim would be in the name of the insured, from whom the insured would then claim any sums received by way of compensation. An insurer may also be subrogated to any benefits that a court may award, for example, interest and costs. An assignment of the rights under the policy required agreement of the parties, and will enable the insured to pursue the claim in their own name.

### 13 What are the consequences of an insurer's failure to defend?

As discussed in question 12, the insurer may agree to a contractual duty to defend a claim, but this will usually have a caveat of only arising where there is a reasonable chance of a defence succeeding. A dispute may arise between the parties as to what constitutes a 'reasonable chance', in which case the parties would follow the dispute resolution mechanism outlined in the policy itself.

## Standard commercial general liability policies

### 14 What constitutes bodily injury under a standard CGL policy?

'Commercial General Liability' is now used in the insurance market to describe some insurance policies in England and Wales. These policies are more widely described as being public and product liability policies, which provide cover in respect of an insured's liability to third parties in respect of personal injury or property damage caused by the insured. It is normal for 'personal injury' to be defined by the policy and such definitions usually cover injury, sickness, disease and death resulting from such an injury.

### 15 What constitutes property damage under a standard CGL policy?

Property damage in a public and product liability policy is typically defined as being loss or physical damage to the property of a third party.

### 16 What constitutes an occurrence under a standard CGL policy?

Public liability policies are 'occurrence' based, where the policy is triggered on the occurrence of the insured event – usually bodily injury or property damage specified in the policy. In contrast, product liability policies can be occurrence or 'claims-made' policies. Under a claims-made policy, indemnity is triggered by notification of a claim or circumstance to the insurer.

### 17 How is the number of covered occurrences determined?

Typically, a policy will specify a certain level of cover per claim, and that the total cover provided will be subject to an aggregation of claims, whereby all claims arising out of the same occurrence are treated by the insurer as a single claim. Whether or not different claims 'aggregate' for the purpose of cover has been the subject of a great deal of litigation and its outcome is usually sensitive to the relevant facts and policy wording. Nevertheless, analysis of what is an occurrence is considered by reference to a number of factors including time and location.

In March 2017 the Supreme Court handed down one of the most important judgments related to aggregation provisions in recent years, in *AIG Europe Limited v Woodman and others* [2017] UKSC 18. The decision provided useful guidance on the meaning of the phrase 'a series of related matters or transactions' when used in an aggregation clause, namely that this requires some 'real connection' between the transactions. The judgment also serves as a reminder that the application of any aggregation clause is a fact-sensitive exercise.

### 18 What event or events trigger insurance coverage?

As set out in the answer to question 16, there are crucial differences between occurrence-based and claims-made policies. Policies written on a loss-occurring basis are triggered by the occurrence of bodily injury or relevant damage (as specified by the policy). Claims-made policies are triggered by notification of a claim or circumstance to the insurer. For this reason, compliance with notification provisions is essential to ensuring cover is provided under a claims-made policy.

**Update and trends**

In *Dalamd Ltd v Butterworth Spengler Commercial Ltd* [2018] EWHC 2558 (Comm), the High Court gave new guidance to brokers on their duties when advising an insured on taking out a policy, as well as the placement of the risk. In *Dalamd*, it was held that it was possible for an insured to claim damages for negligence against its broker, but that to do so the insured has to show that a claim on its policy would fail because of the broker's negligence.

In terms of emerging trends, 2019 will likely see a rise in international disputes, with England the chosen jurisdiction, in arbitration as well as litigation, including but not limited to Bermuda Form cases. In addition, we will see a continued focus on cyber and data privacy breaches owing to the implementation of GDPR and the Data Protection Act 2018, and the types of cover sought by insureds to mitigate their risk in these areas. This will also include professional negligence and D&O cases for actions or omissions by individuals found responsible for data losses; in fact, numerous policies will likely be impacted.

### 19 How is insurance coverage allocated across multiple insurance policies?

One insurer may pay the claim and then seek recovery from the other insurers, however insurers will often include wording to exclude cover where there is more than one policy.

## First-party property insurance

### 20 What is the general scope of first-party property coverage?

First-party property insurance provides cover for loss or damage to an insured's goods or buildings, or both, following the occurrence of an insured event. Policies can either specify an event that is insured against or operate as an 'all risks' policy.

The goods covered by such insurance are usually listed in the policy and are only covered if they are stored in a specified location (eg, artwork kept in a secure gallery or a car kept in a garage). Typically, first-party property policies will include a number of exclusion clauses covering normal wear and tear that occurs during normal use of the specified goods, arson and fraud.

Policies also usually include an 'excess' (or 'deductible'), which is the amount of loss the insured is responsible for before it is entitled to be indemnified by insurers.

### 21 How is property valued under first-party insurance policies?

Under an 'unvalued' policy, the insured property is valued as at the date of the reported loss with the principal that an insured is barred from recovering more than this amount (ie, the actual loss suffered).

As the name would suggest, a 'valued' policy allows the insured to fix the value of an insured item as at the date of the policy. The insured can therefore recover the full value insured if a total loss of the property is sustained. Typically, valued policies are purchased for high-value single items such as jewellery or artwork.

### 22 Is insurance available in your jurisdiction for natural disasters and, if so, how does it generally operate?

Insurance against losses arising from natural disasters is widely available in England and Wales. Policies will usually specify the location of the insured risk, with most polices having extraterritorial effect given that natural disasters such as hurricanes, wildfires and earthquakes do not occur in England. Insureds should always carefully consider governing law and jurisdiction clauses in policies that operate with extraterritorial effect, as well as stating the currency in which claims will be paid.

Natural disaster policies are occurrence-based policies and therefore issues of aggregating numerous occurrences into a single claim (establishing the cause of occurrence of a particular loss can be particularly challenging in the wake of a natural disaster) can lead to litigation between insurer and insured.

## Directors' and officers' insurance

### 23 What is the scope of D&O coverage?

D&O policies are 'claims-made' polices that protect the insured from loss suffered as a result of a third-party claim following an alleged wrongful act by the insured. Policies normally define 'wrongful act' as an actual or alleged breach of a director's duties, the making of misleading statements, misrepresentations, or other errors or omissions that give rise to a claim. As is the case with other claims-made policies, a claim notified in 2018 that is still ongoing in 2020 is covered under the 2018/19 policy and will be excluded from the 2020/21 policy.

Coverage under D&O policies is usually broken down into three 'sides' of the policy wording:

- side A cover – covers losses suffered as a result of a claim against a director or office that cannot be indemnified by the company;
- side B cover – covers indemnifications made by the company to a director or officer in respect of a claim made by a third party; and
- side C cover – covers claims brought against the company by its shareholders.

In addition to the cover above, the policy will also specify if there is a deductible to be retained by the insured, as well as any exclusions or exceptions to cover. Typical exclusions are fraud and for 'insured v insured' claims where a director who is also a shareholder makes a claim under the policy, or the company brings a claim against one of its directors.

### 24 What issues are commonly litigated in the context of D&O policies?

Common issues that arise between insurer and insured in respect of D&O policies include disagreements over the definition of 'director' and 'wrongful act' in the policy, whether a claim was notified in time and in accordance with the notification provisions set out in the policy and whether any pre-existing exposure to claims were properly disclosed to the insurer before the inception of the policy.

## Cyber insurance

### 25 What type of risks may be covered in cyber insurance policies?

The main heads of cover under a standard cyber policy are typically:

- network security and privacy liability;
- privacy breach response costs and security event costs;
- regulatory defence costs;
- cyber BI cover;
- data and software restoration; and
- cyber extortion.

In some cases, reputational risk cover can also be added, although this is difficult to quantify and capacity in this area is limited.

The definition of security breach will generally include denial of service attacks, transmission or receipt of malware and viruses and unauthorised access or use.

However, the more comprehensive the insurance cover is, and therefore the more risks covered, the greater the cost (potentially to both parties). The decision as to which risks to cover will require significant consideration when an insured takes out a policy.

### 26 What cyber insurance issues have been litigated?

While cyber policies are too recent to have produced any substantive case law, there have been multiple disputes between insurer and insured in respect of cyber policies. In the United States a number of insureds have made claims under cyber policies where funds have been voluntarily sent to a fraudster as a result of an email scam. Insurers usually deny coverage under a cyber policy in these instances because funds were sent voluntarily rather than hacked or stolen. Conversely, insurers have tended to cover the payment of Ransomware attacks, but disputes have arisen in respect of quantifying the resulting business interruption loss to the business while IT services are suspended.

In addition there have been a number of claims resulting from data breaches, both against private companies and government bodies illustrated by *Vidal-Hall v Google Inc* [2015] EWCA Civ 311 and *TLT and others v The Secretary of State for the Home Department and the Home Office* [2016] EWHC 2217 (QB).

The best practice is for all insureds to remain aware of the fundamental aspects of coverage when looking to a cyber policy. Ensuring quick and proper notification of a claim or circumstance (particularly in the case of a ransomware attack, which is often an indicator of further attacks), making a full disclosure of all risks and exposures to insurers or brokers before inception of the policy, and being sure to note the different limits and sublimits of coverage for first and third-party claims are all advised.

A major issue of concern is the interplay between cyber attacks and failure by companies to take protective action either by disgruntled employees and ex-employees or outsiders misusing information or hacking into companies' systems. It is presently considered that most companies do not have proper systems in place, which will likely lead to clams against D&Os that are cyber-related.

## Terrorism insurance

### 27 Is insurance available in your jurisdiction for injury or damage caused by acts of terrorism and, if so, how does it generally operate?

Historically, losses caused by terrorist attacks have been excluded in most types of commercial insurance policies in England and Wales. In response, the UK government established Pool Re, a reinsurance scheme ultimately backed by the UK government that provides reinsurance cover to insurers who are member of the Pool Re scheme for property of business interruption losses caused by terrorism. All insurers who are members of the Pool Re scheme must offer terrorism cover to insureds that request commercial property cover; some insurers will include terrorism cover as standard, while some will charge an additional premium.

SIGNATURE

**Hermes Marangos** **hermes.marangos@signaturelitigation.com**
**Tom Rotherham** **tom.rotherham@signaturelitigation.com**
**Lucy Alexander** **lucy.alexander@signaturelitigation.com**
**Nicholas Barnard** **nicholas.barnard@signaturelitigation.com**
**Adriano Stagni** **adriano.stagni@signaturelitigation.com**

138 Fetter Lane
London EC4A 1BT
United Kingdom

Tel: +44 20 3818 3500
Fax: +44 20 3818 3501
www.signaturelitigation.com

The scope of terrorism cover available from insurers therefore depends to a large extent on the reinsurance cover available to insurers from Pool Re. As such, terrorism cover in the United Kingdom tends to be limited to commercial property and business interruption policies where terrorism is the proximate causes of any losses. For example, if an act of terrorism caused a dam to burst, any third-party commercial property damage would be covered. As a general rule, policies do not cover personal injury caused by terrorism.

The scope of cover is limited to terrorist acts that take place within the United Kingdom, but excluding Northern Ireland, the Channel Islands or nuclear sites. The act that triggers cover must constitute an act of terrorism as defined by the Reinsurance (Acts of Terrorism) Act 1993, although insurers are at liberty to provide their own definition of terrorism in policy wordings, with many opting to use the definition in the Terrorism Act 2000.

As of April 2018, Pool Re has extended its cover to include material damage and business interruption caused by acts of cyber terrorism (remote digital interference). The scope of the cover available is designed primarily to protect commercial property and will be offered as standard to policyholders buying terrorism insurance from a Pool Re member. Business interruption cover is designed to apply only to events occurring at a policyholder's premises. It is likely that more and more areas of business interruption will be covered to deal with the new form of measures and countermeasures against terrorism, which lead to business losses.

# United States

**Mary Beth Forshaw and Elisa Alcabes***

**Simpson Thacher & Bartlett LLP**

## Preliminary and jurisdictional considerations in insurance litigation

### 1 In what fora are insurance disputes litigated?

Most insurance disputes are litigated in state or federal trial courts. An insurance action may be subject to original federal court jurisdiction by virtue of the federal diversity statute, 28 USC section 1332(a). In this context, an insurance company, like any other corporation, is deemed to be a citizen of both the state in which it is incorporated and the state in which it has its principal place of business.

If an insurance action is originally filed in state court, it may be removed to federal court on the basis of diversity. Absent diversity of parties or some other basis for federal court jurisdiction, insurance disputes are litigated in state trial courts. The venue is typically determined by the place of injury or residence of the parties, or may be dictated by a forum selection clause in the governing insurance contract.

Some insurance contracts contain arbitration clauses, which are usually strictly enforced. If an insurance contract requires arbitration, virtually every dispute related to or arising out of the contract typically will be resolved by an arbitration panel rather than a court of law. Even procedural issues, such as the availability of class arbitration and the possibility of consolidating multiple arbitrations, are typically resolved by the arbitration panel.

Practitioners handling insurance disputes governed by arbitration clauses should diligently comply with the procedural requirements of the arbitration process. Arbitration provisions in insurance contracts may set forth specific methods for invoking the right to arbitrate and selecting arbitrators. Careful attention to detail is advised, as challenges to the arbitration process are commonplace. An insurance dispute that originates in arbitration may ultimately end up in the judicial system as a result of challenges to the fact or process of arbitration.

### 2 When do insurance-related causes of action accrue?

Insurance litigation frequently involves a request for declaratory judgment or breach of contract claims, based on allegations that an insurer breached its defence or indemnity obligations under the governing insurance policy. Insurance-based litigation may also include contribution, negligence or statutory claims. In order for any insurance-related claim to be viable, it must be brought within the applicable statute of limitations period, which is governed by state law. In determining whether a claim has been brought within the limitations period, courts address when the claim accrued. For breach of contract claims, the timing of claim accrual may depend on whether the claim is based on an insurer's refusal to defend or failure to indemnify. When a claim arises from an insurer's failure to defend, courts typically endorse one of the following positions:

- the limitations period begins to run when the insurer initially refuses to defend;
- the limitations period begins to run when the insurer refuses to defend, but is equitably tolled until the underlying action reaches final judgment; or
- the limitations period begins to run once the insurer issues a written denial of coverage.

When a claim arises from an insurer's refusal to indemnify a policyholder, courts have held that the claim accrues either when the underlying covered loss occurred or when the insurer issues a written denial of coverage.

A legal finding that a policyholder's claim is time-barred is equivalent to a dismissal on the merits.

### 3 What preliminary procedural and strategic considerations should be evaluated in insurance litigation?

At the outset of insurance litigation, practitioners must conduct a careful evaluation of possible causes of action in light of the available factual record in order to assess procedural and substantive strategies. When an insurance dispute turns on a clear-cut question of law and could appropriately be resolved on a motion to dismiss or a motion for summary judgment, dispositive motion practice should be considered. For example, if an underlying claim for which coverage is sought alleges an occurrence that arose after the insurance policy at issue expired or alleges facts that fall squarely within the terms of a pollution exclusion, the insurer may file a dispositive motion to seek swift resolution of its coverage obligations. In contrast, where an insurance dispute presents contested issues of fact, practitioners should be vigilant about formulating case management orders and discovery schedules. Insurance-related discovery is often contentious, expensive and time-consuming, and may give rise to disputes regarding privilege or work product protection. In this respect, document retention policies must be implemented and in some cases, confidentiality stipulations may be appropriate. Finally, a preliminary assessment of any insurance matter should involve consideration of whether it is appropriate to request trial by jury or whether to implead third parties, including entities such as co-insurers, third-party tortfeasors or insurance brokers.

### 4 What remedies or damages may apply?

Many insurance coverage lawsuits seek relief in the form of a judicial declaration that articulates the scope of coverage under the insurance policies in dispute. In essence, one or more parties requests that the court enter a ruling that coverage is available or unavailable before addressing the appropriate remedy or damages. If the court issues a ruling declaring coverage to be exhausted or otherwise unavailable, the appropriate remedy or damages may be dismissal of the action with or without costs imposed on the insured.

Where courts find coverage to be available, they often go on to address the issue of remedy or damages in a separate phase of the case. The most common measure of damages in insurance litigation is contractual damages, which may be awarded in connection with a breach of contract claim. The amount of contractual damages is typically based on the coverage due under the relevant policies (or, for a claim of rescission, the amount of premiums to be refunded). In complex insurance litigation, such as that involving multiple layers of coverage with injuries or damage spanning an extended period of time, the damages calculation may be more involved, often requiring expert testimony.

Aside from basic contractual damages, additional amounts may be recovered in certain insurance disputes. For example, some jurisdictions may allow consequential damages based on economic losses that flow directly from the breach of contract or that are reasonably contemplated by the parties. Additionally, some jurisdictions permit attorneys' fee awards under certain circumstances.

Whether attorneys' fees awards are available may be governed by state statute, relevant case law or, in some cases, the insurance

agreements themselves. Arbitration clauses, in particular, may provide for the payment of the prevailing party's attorneys' fees and costs. While attorneys' fees may be difficult to recover, the threat of an attorneys' fees award may affect the dynamics of settlement negotiations.

Infrequently, the possibility of tort-based or punitive damages can arise in insurance litigation. These damages may come into play in the context of claims alleging that an insurer acted in bad faith or violated state unfair or deceptive practices statutes.

Where monetary damages are awarded in an insurance action, a corollary issue is the imposition of pre-judgment (or post-judgment) interest. The imposition and rate of interest may be determined by the parties via explicit contractual language. Absent governing language, the question of whether a prevailing party is entitled to pre-judgment or post-judgment interest and, if so, the applicable interest rate, is typically governed by state law. When pre-judgment interest is allowed, determination of the accrual date is paramount because opposing positions can differ by many years, and resolution can have a significant impact on the total damages award. Courts have utilised different events for determining the interest accrual date, including when payment was demanded, when payments are deemed due under the applicable policy and when the complaint was filed.

### 5 Under what circumstances can extracontractual or punitive damages be awarded?

Certain states permit policyholders to seek extracontractual or punitive damages when an insurer allegedly has acted in bath faith or violated unfair or deceptive practices statutes. Bad faith allegations frequently relate to an insurer's refusal to defend or settle an underlying matter, but can also stem from other conduct, such as claims-handling practices. Some jurisdictions do not recognise tort claims arising out of an insurer's breach of contract. In those jurisdictions, a policyholder's recovery typically is limited to contractual damages, with no opportunity for a punitive damage award. Some courts in such jurisdictions, however, may allow recovery of extracontractual damages (eg, lost income or related economic losses) against an insurer if the losses were foreseeable and arose directly out of the breach of contract.

In jurisdictions that recognise bad faith tort claims against an insurer, policyholders face several obstacles when seeking punitive damages. In most but not all cases, a punitive damages claim is not actionable without an adjudication that the insurer has breached the insurance contract. Even where an insurer is held to have breached a contract, and a policyholder has established bad faith or statutory violations, punitive damages are extremely difficult to recover. Most jurisdictions strictly require the party seeking punitive damages to meet a high burden and to prove 'wilful or malicious' conduct, 'malice, oppression or fraud', or 'gross or wanton behaviour' by the insurer. Furthermore, some jurisdictions impose an elevated burden of proof, requiring a bad faith showing to be made by 'clear and convincing evidence'.

## Interpretation of insurance contracts

### 6 What rules govern interpretation of insurance policies?

All jurisdictions in the United States interpret insurance contracts in accordance with the plain meaning of policy language in order to effectuate the intent of the parties at the time the contract was made. The preliminary inquiry in insurance contract interpretation is whether the insuring agreement or insuring clause provides coverage for the loss at issue.

If coverage does not exist under the insurance policy, the inquiry ends, and there is no need to look to policy exclusions or other provisions.

If coverage potentially exists (ie, if a loss falls within the scope of coverage set forth in the insuring clause), the second inquiry is whether the policy contains any exclusions from or limitations on that coverage. While exclusions may be narrowly construed, courts will enforce exclusions and other coverage limitations when their clear and unambiguous terms bar or restrict coverage.

Insurance policies frequently contain endorsements, which are contractual amendments that must be read as part of the policy. Valid endorsements supersede and control conflicting policy terms.

### 7 When is an insurance policy provision ambiguous and how are such ambiguities resolved?

An insurance policy provision may be deemed ambiguous if a word or phrase is reasonably susceptible to more than one construction.

A split in jurisdictional authority may be a basis for finding ambiguity. However, an ambiguity does not exist by virtue of the parties' differing interpretations or simply because a clause is complex and requires judicial analysis. Similarly, the absence of a definition for a policy term, or the existence of multiple meanings for a term or phrase does not, without more, render it ambiguous.

Once it is determined that an insurance policy contains an ambiguity, courts employ several methods for resolving the ambiguity.

First, extrinsic evidence regarding the mutual intent of the parties at the time of contract formation may be considered to interpret the policy. Such extrinsic evidence may include testimony as to the circumstances surrounding contract formation, premium amounts, course of dealing and industry custom and practice. Second, many jurisdictions in the United States will, under certain circumstances, employ the 'reasonable expectations' doctrine, under which the policyholder's objectively reasonable expectations as to coverage are relevant to the interpretation of an ambiguous policy term. A minority of jurisdictions have rejected formulations of the reasonable expectations doctrine in favour of traditional contract interpretation principles.

When all other principles of contract interpretation have failed to resolve an insurance policy ambiguity, some courts in the United States apply a contra-insurer rule of construction. Under the contra-insurer rule, ambiguous policy provisions are interpreted strictly against the insurer (as drafter of the policy) in favour of policy coverage.

The contra-insurer rule has been applied to interpret ambiguous policy exclusions in situations where the insurer exercised significant control over the drafting of the language at issue. Notably, however, the facts of a particular case may render the rule inapplicable. In particular, courts have declined to apply the contra-insurer rule when the parties to the insurance contract possess equivalent bargaining power.

Therefore, the contra-insurer rule may not be applied under the following circumstances:

- when the policyholder is a large, sophisticated business or corporate entity;
- when counsel or specialised insurance brokers have acted on behalf of the policyholder in the negotiation of the insurance policy;
- when the ambiguous provision or policy has been drafted by the policyholder or an agent of the policyholder;
- when the policy is a customised, individually negotiated 'manuscript' policy; or
- when it is established that the parties share equal bargaining power.

## Notice to insurance companies

### 8 What are the mechanics of providing notice?

Although the language of notice provisions varies among policies, all notice provisions serve a similar purpose: to enable an insurer to adequately investigate and respond to claims. Most general liability policies require a policyholder to provide notice as soon as practicable to the insurer of all claims brought against the policyholder or of occurrences that may give rise to a covered claim. Many general liability policies also require a policyholder to provide the insurer with copies of court papers and demands.

Most policy provisions require notice to be in writing, and to contain information necessary to enable the insurer to determine whether coverage may be implicated. In addition, notice should be provided by the policyholder (rather than a third party) to the insurer or an authorised agent of the insurer.

### 9 What are a policyholder's notice obligations for a claims-made policy?

Claims-made policies typically provide coverage only if a claim is made during the policy period and reported to the insurer during the policy period or any applicable extended reporting period. Timely notice is an essential element of a claims-made policy. Accordingly, a policyholder's failure to give notice in good time under a claims-made policy may result in a forfeiture of coverage.

Therefore, a critical issue in insurance litigation relates to what events constitute a 'claim' for the purposes of notice under a

claims-made policy. Most courts have held that a 'claim' contemplates the assertion of a legal right by a third party against the policyholder.

However, under certain circumstances, an agency subpoena or administrative proceeding might satisfy the 'claim' requirement for the purposes of a triggering notice under a claims-made policy. In contrast, a mere request for information or communication alleging wrongdoing will not typically rise to the level of a 'claim' in this context.

Certain provisions in claims-made policies may operate to extend or otherwise affect a policyholder's notice obligations. First, an extended reporting period (often mandated by state statutory law, which varies by jurisdiction) may provide a reasonable period of time following the policy's expiry date in which the policyholder may provide notice. Second, a 'savings' clause may provide that claims made during a limited period after the expiry of the policy will be deemed to have been made during the policy period, so long as the policyholder gives notice to the insurer of facts or circumstances giving rise to the claim. Similarly, an 'awareness' provision might extend coverage beyond the policy period where facts giving rise to a claim were known and reported to the insurer during the policy period, but no formal claim was asserted until after the policy's expiry.

### 10 When is notice untimely?

Notice of a claim under a claims-made policy will be deemed untimely if it is provided after termination of the policy period or any extended reporting period and has not been the subject of a timely notice of circumstances within the applicable reporting period. Notice provisions in occurrence-based policies typically do not set forth a specific time period for notice, but rather contain language requiring notice to be given 'promptly' or 'as soon as practicable'. The timeliness of notice under these and similar provisions is generally judged by a reasonableness standard.

Typically, whether notice is timely presents a question of fact to be resolved in light of the specific circumstances in any given case. In some cases, however, a court may rule on reasonableness as a matter of law. For example, when the delay in providing notice is lengthy (ie, months or years), or when the policyholder has offered no legitimate excuse for the delay, a court may deem notice unreasonable as a matter of law.

Several factors may affect the reasonableness determination. First, a policyholder's lack of knowledge of an occurrence may excuse a delay in notice where the policyholder has otherwise acted with due diligence. Second, a policyholder's reasonable belief that liability would not be imposed or that a claim would not arise has, in some circumstances, militated against a finding of late notice. Courts across United States jurisdictions are split as to whether a policyholder's lack of knowledge of coverage or of a policy's existence may excuse or otherwise affect the late notice analysis.

### 11 What are the consequences of late notice?

As noted above, late notice under a claims-made policy may result in forfeiture of coverage. The consequences of untimely notice under occurrence-based policies differ across jurisdictions in the United States. A minority of jurisdictions hold that notice is a condition precedent to coverage, such that untimely notice results in an automatic forfeiture of rights under the policy. Under this approach, prejudice is presumed to flow from the insurer's delay in receiving notice. A majority of jurisdictions require the insurer to demonstrate prejudice as a result of untimely notice in order to deny coverage on this basis. However, jurisdictions in this category have held that late notice bars coverage where the applicable policy language explicitly makes prompt notice a condition precedent to coverage. Several jurisdictions have endorsed a middle-of-the-road approach to late notice, under which the presence or absence of prejudice to the insurer is just one factor to be considered in deciding whether untimely notice should result in a forfeiture of coverage.

Insurers can establish prejudice by several means. Prejudice has been found where late notice has prevented the insurer from being able to investigate claims, to interview witnesses, to participate in settlement negotiations, or to collect reinsurance. Similarly, prejudice exists where an insurer has lost its ability to enforce contractual rights, such as the right to defend claims against the policyholder. Decisions relating to prejudice are highly fact-specific, and courts frequently employ flexible analyses based on the particular factual record presented.

## Insurer's duty to defend

### 12 What is the scope of an insurer's duty to defend?

Some liability insurance policies require an insurer to provide a defence for a policyholder when it is named as a defendant in underlying litigation. An insurer's duty to defend claims against a policyholder is determined by reference to the allegations in the underlying complaint.

If the allegations articulate a claim that potentially falls within the policy's coverage, courts generally require the insurer to provide a defence. However, courts have found no duty to defend under the following circumstances:

- when the insured is not sued in its insured capacity;
- when the complaint alleges intentional or inherently wrongful acts;
- when the allegations in the complaint fall exclusively within policy exclusions; and
- when factual issues conclusively negate the possibility of coverage.

Courts have issued conflicting rulings as to whether extrinsic evidence, outside of the 'four corners' of the underlying complaint, may be considered in evaluating an insurer's defence obligations.

Although an insurer's duty to defend frequently extends through the duration of the underlying litigation against the policyholder, there are certain circumstances under which courts have deemed it appropriate for an insurer to withdraw its defence. If, for example, the underlying claims have been limited to claims that fall outside the scope of policy coverage, an insurer may be allowed to terminate its defence. Additionally, some courts have ruled that an insurer's defence obligations terminate upon exhaustion of policy limits, although many courts reject the notion that an insurer can terminate its defence simply by tendering policy limits.

### 13 What are the consequences of an insurer's failure to defend?

When a court determines that an insurer has breached its duty to defend, it may be responsible for all reasonable defence costs incurred in the underlying litigation. In addition, an insurer that has refused to defend might, in some jurisdictions, be held responsible for the legal costs incurred in a declaratory judgment action brought to enforce that duty. Courts are split as to whether other, more severe consequences result from a breach of an insurer's defence obligations. For example, under certain circumstances, courts have held that an insurer that breaches its duty to defend should be held responsible for indemnity costs as well. To the extent that indemnity costs may be awarded as a result of the breach of the duty to defend, courts have imposed a requirement that such indemnity costs be reasonable in light of the claims and factual record. Similarly, an insurer that unreasonably denies a defence might, under certain circumstances, be held to have waived certain defences to coverage.

## Standard commercial general liability policies

### 14 What constitutes bodily injury under a standard CGL policy?

CGL policies generally provide coverage for bodily injury or property damage sustained by third parties (rather than the policyholder) as a result of an occurrence.

Insurance coverage litigation frequently centres on whether the underlying claims against the policyholder allege bodily injury or property damage within the meaning of the applicable insurance policy, and whether the events giving rise to the injury or damage were caused by an occurrence.

The phrase 'bodily injury' in insurance contracts generally connotes a physical problem. However, a number of courts have ruled that the term also encompasses non-physical or emotional distress, either standing alone or accompanied by physical manifestations.

The question of whether bodily injury exists may also arise where an underlying complaint alleges non-traditional or quasi-physical harm, such as biological or cellular level injury or medical monitoring claims. Courts addressing these and other analogous bodily injury questions have arrived at mixed decisions. Bodily injury determinations are often case-specific, turning on the particular factual record presented.

### 15 What constitutes property damage under a standard CGL policy?

Property damage typically requires injury to or loss of use of tangible property. Therefore, the mere risk of future damage is generally insufficient to constitute property damage. Similarly, it is generally held that the inclusion of a defective component in a product, standing alone, does not constitute property damage. Numerous other allegations of harm or potential harm to property have generally been deemed to fall outside the scope of covered property damage, including the following:

- injury to intangible property (such as computer data);
- injury to goodwill or reputation;
- pure economic loss; and
- diminished property value.

However, it should be noted that although economic loss is not equated with property damage, courts may use a policyholder's economic loss as a measure of damages for property damage where physical damage is found to exist.

### 16 What constitutes an occurrence under a standard CGL policy?

Virtually all modern-day general liability insurance policies provide coverage for an occurrence that takes place during the policy period. The insurance term 'occurrence' is typically equated with or defined as an accident or an event that results in damage or injury that was unexpected and unintended by the policyholder.

Insurance litigation frequently involves several issues relating to the occurrence requirement:

- whether intentional conduct that results in unexpected or unintended harm constitutes an occurrence;
- whether negligent conduct that results in expected or intended harm constitutes an occurrence;
- whether an event or series of events constitutes a single occurrence or multiple occurrences;
- whether the occurrence falls within a given policy period (ie, what is the operative event that triggers a policy?); and
- how insurance obligations should be divided among multiple insurers (or the policyholder) when an occurrence spans multiple policy periods (ie, allocation).

Although it is a widely accepted principle that insurance policies provide coverage only for fortuitous events, and cannot insure against intentional or wilful conduct, it is less clear whether (and under what circumstances) intentional conduct that results in unexpected and unforeseen damage can constitute a covered occurrence. This question has arisen in a multitude of factual contexts, including claims arising out of faulty workmanship, pollution and fax blasting in violation of federal statutes. In evaluating the occurrence issue, some courts focus on the initial conduct of the policyholder, while other courts look to whether the resulting harm was unexpected or unintended.

### 17 How is the number of covered occurrences determined?

The determination of whether damage or injury is caused by a single occurrence or by multiple occurrences has significant implications for available coverage. The number of occurrences may impact both the policyholder's responsibility for deductible payments and the per occurrence policy limits that are available. Thus, it is a hotly contested issue in insurance litigation. Most courts utilise a cause-based analysis to determine the number of occurrences. Under the cause-oriented approach, if there is one proximate cause of the injury, there is one occurrence, regardless of the number of claims or incidents of harm.

In contrast, under an effects-oriented analysis, the focus is on the number of discrete injury-causing events.

Number of occurrences disputes arise in virtually all substantive areas of insurance litigation, including claims arising out of asbestos, environmental harm, natural disasters, and the manufacture or distribution of harmful products.

### 18 What event or events trigger insurance coverage?

Litigation that centres on whether a given policy period has been implicated by an occurrence is generally referred to as a 'trigger of coverage' dispute. 'Trigger' describes what must happen within the policy period in order for an insurer's coverage obligations to be implicated. In cases involving ongoing or continuous property damage or personal injury, the question of what triggers policy coverage may be complex. From a legal perspective, courts employ several different methods to resolve trigger disputes. For bodily injury claims, the operative trigger event has been held to be:

- at the time of exposure to a harmful substance;
- at the time the injury manifests itself;
- at the time of actual 'injury in fact'; or
- a combination or inclusion of all of the above.

Property damage claims have also given rise to multiple trigger approaches, some of which focus on the initial event that set the property damage into motion, while others look to the time that physical damage became evident. From a factual perspective, parties are often required to submit voluminous evidence in support of their position as to when property damage or bodily injury actually occurred. Expert witnesses are often retained to address trigger issues.

### 19 How is insurance coverage allocated across multiple insurance policies?

When an occurrence triggers multiple policy periods, disputes frequently arise as to how indemnity costs should be allocated among various insurers. The emerging trend in courts in the United States is a pro rata approach, which apportions loss among triggered policies based on insurers' proportionate responsibilities. In applying pro rata allocation, courts have considered:

- the time that each insurer is on the risk;
- the policy limits of each triggered policy;
- the proportion of injuries during each policy; or
- a combination of these and other factors.

Pro rata allocation also typically contemplates policyholder responsibility for periods of no coverage or insufficient coverage. The pro rata allocation approach stems from policy language that limits insurers' obligations to damage 'during the policy period'. A minority of courts endorse a joint and several liability approach, under which a policyholder is entitled to select a single policy from multiple triggered policies from which to seek indemnification. This approach stems from common policy language requiring an insurer to pay 'all sums' that the policyholder becomes legally obligated to pay. Notably, even courts that endorse all sums allocation typically allow a targeted insurer to pursue contributions from other triggered insurers.

## First-party property insurance

### 20 What is the general scope of first-party property coverage?

First-party property insurance policies, unlike third-party liability policies, compensate a policyholder for damage to the policyholder's own property. Therefore, although first-party insurance litigation can give rise to some of the same issues presented in third-party liability coverage cases, first-party insurance disputes may turn on issues specific to first-party insurance policies, and courts in the United States have become increasingly cognisant of the distinction between the two types of policies.

As a preliminary matter, first-party policies often impose certain obligations on the part of the policyholder as condition precedents to coverage. The policyholder is typically required to set aside damaged property to allow the insurer to conduct an inspection.

Policyholders are also obligated to provide a sworn statement or proof of loss within a certain time period. Failure to fulfil either of these obligations may result in a forfeiture of coverage. Furthermore, first-party policies frequently contain suit limitation clauses, which provide that coverage litigation against the insurer must be brought within a certain time frame after the date of the loss (often one or two years). In some cases, the suit limitations clause in the policy may be shorter than the applicable statute of limitations.

If a property insurance claim has been properly preserved and asserted against an insurer, insurance disputes frequently turn on causation-related issues (ie, whether the loss at issue was caused by a covered peril). Causation issues may become complicated where a covered peril and an excluded peril combine to cause a loss. Under such circumstances, many courts employ the efficient proximate causation rule, which holds that when a loss is caused by both covered and

excluded perils, there is coverage only if the covered peril is the dominant cause of the damage. Therefore, where an insured risk was only a remote cause of the loss, there is typically no coverage.

Courts have also utilised a concurrent causation doctrine to allow for coverage when a loss is caused by both excluded and covered events. Under this approach, a court may award a percentage of coverage under the policy based on the portion of damage caused by covered risks. Importantly, the proximate or concurrent cause doctrines may not be used to create coverage where the policy has clearly excluded certain perils by virtue of explicit policy language.

Similarly, first-party policies may contain anti-concurrent causation clauses that operate to exclude coverage where loss is caused by a combination of covered and uncovered perils.

### 21 How is property valued under first-party insurance policies?

First-party property insurance disputes often involve questions relating to the proper valuation of covered property. The basic types of coverage for property damage are 'replacement cost' coverage and actual cash value (ACV). Policy language controls the application of each type of coverage. Replacement cost coverage is usually defined to allow replacement of 'like kind and quality' property (ie, the functional equivalent of the lost or damaged property). Therefore, courts often limit replacement cost damages to the amount of money it would take to reconstruct the property as it stood prior to the loss, and may be unwilling to allow a policyholder to recoup costs necessary to comply with newly enacted code or safety regulations. In contrast, ACV coverage typically allows a policyholder to recover the depreciated value of the lost or damaged property. Some policies may provide that a policyholder can recover the ACV of destroyed property and subsequently make a claim for replacement costs. Such policies generally require the policyholder to provide notice (within a certain period of time) of its intent to seek replacement costs. In addition, such policies invariably include as a condition precedent to supplemental replacement costs a requirement that the policyholder first complete restoration of its property. Many states have passed legislation that sets forth certain statutory minimum coverage requirements for first-party property policies.

### 22 Is insurance available in your jurisdiction for natural disasters and, if so, how does it generally operate?

The potentially catastrophic losses associated with natural disasters present significant challenges for both insurers and policyholders. In the United States, insurance is available for certain risks associated with natural disasters through a combination of private insurance and governmental programmes. Some risks associated with natural disasters are uninsurable.

**Hurricane**

Hurricane damage may be covered under first-party property insurance policies, depending upon the cause of the damage. Hurricanes typically involve one or more different perils, including wind, rain, storm surge, flooding, mould and power outages. Some perils, such as wind and windstorm, are routinely covered under property insurance policies. Others, such as flooding, generally are excluded. Thus, the underlying cause of the damage for which coverage is sought is critical. Identification of the cause is a fact-intensive inquiry and may require the use of experts. Moreover, specific policy provisions may come into play in assessing hurricane damage coverage under a property insurance policy. An 'anti-concurrent causation clause', for example, may limit coverage for hurricane damage arising from multiple perils, if one of the perils is excluded. Specific exclusions, for example, for wind, flooding or mould, may bar coverage.

In addition to seeking coverage for property damage, policyholders impacted by hurricane damage frequently invoke 'business interruption' coverage, which provides reimbursement for lost income when business is interrupted by the loss of property owing to an insured peril. Business interruption coverage typically extends to the period of restoration, or the reasonable amount of time it takes for business operations to return to normal following physical damage to property or equipment. Litigation often revolves around the date on which the insured could have repaired, rebuilt or replaced its property to resume operations, which may precede the date on which the policyholder actually did return to business. Litigation also frequently involves the correct measure of recovery for business interruption losses. Courts have typically found that recovery should reflect what the insured business would have earned had no interruption occurred, using the earnings minus expenses of the business before the interruption to determine lost income recovery.

**Flood**

Property insurance policies typically exclude coverage for floods. Courts in the United States enforce flood exclusions to bar coverage for damage caused by naturally occurring floods, burst dams and other natural flood events. By contrast, courts consistently refuse to apply the flood exclusion to bar coverage for damage caused by human negligence, for example, a burst water main or pipe. Conflicting conclusions may arise with respect to flood damage that arises, in part, from human conduct. After Hurricane Katrina, for example, a flood exclusion was held to bar coverage for damage caused by breaches in the levees surrounding New Orleans, despite the involvement of human negligence in that flood.

Flood insurance is available from insurers in the United States through the National Flood Insurance Program (NFIP) together with a recently expanded private insurance market. Federal courts have exclusive jurisdiction to hear actions under the NFIP. Under the NFIP, the Federal Emergency Management Administration subsidises and administers flood insurance at affordable rates to homeowners and business owners in participating communities. Various coverage limits exist for homes, businesses and personal property. Additionally, coverage is subject to a number of exclusions, including losses: 'substantially confined to the insured premises' (as opposed to widespread), caused by 'earth movement' (except where such losses arise from mudslides proximately caused by flooding), resulting from the policyholder's neglect to use reasonable protective measures, caused by normal erosion, and caused by a flood in progress at the time of purchase of the insurance policy.

The future of the NFIP is uncertain. Following Hurricanes Katrina, Sandy and Harvey, the programme has been heavily in debt. The government is continuing to debate reforms that include requiring greater participation by the private market and restricting coverage for severe repetitive-loss properties. The government recently removed a non-compete clause from the NFIP to encourage private insurers to enter the flood insurance market. As a result, private insurers are now able to service NFIP flood policies and offer primary flood insurance.

**Wildfire**

Most first-party property insurance policies cover fire damage, including losses resulting from catastrophic wildfires. Coverage traditionally also extends to losses resulting from smoke, soot and ash. In some high-risk areas, however, insurers will exclude coverage for wildfires, requiring policyholders to purchase a rider or separate policy for such coverage. As with any policy, coverage is determined based on the applicable policy language and the facts of the case. Among other issues, courts have grappled with whether wildfire losses caused by smoke, soot or ash are excluded under common exclusions for damages caused by smog or pollution, with inconsistent results.

**Earthquake**

First-party property insurance policies typically exclude coverage for earthquakes. Instead, policyholders may purchase a separate policy or an endorsement from their private insurer or, in California, the California Earthquake Authority. Notably, first-party property insurance and earthquake insurance policies are not intended to overlap. Accordingly, earthquake policies typically do not cover fire or water damage initially caused by an earthquake. Furthermore, most earthquake policies contain an exclusion for earthquakes that are 'not naturally occurring' or 'human-made'. Recently, insurers and regulators have disputed coverage for earthquake losses in areas adjacent to natural gas extraction, or 'fracking', which has been shown to cause or contribute to an increase in seismic activity.

## Directors' and officers' insurance

### 23 What is the scope of D&O coverage?

Directors and officers liability insurance policies, commonly referred to as 'D&O' policies, provide coverage for claims against a company or its officers and directors. D&O coverage is typically limited to 'losses' incurred owing to 'claims' against the company or its directors and

officers. Thus, the initial determinations must be whether the underlying action against the company or individuals qualifies as a 'claim' under the policy and whether the alleged 'losses' are insured.

In most contemporary D&O policies, the term 'claim' includes civil, criminal and administrative proceedings, and demands for damages or relief. Therefore, D&O policies often do not provide coverage for expenses arising out of investigations (such as subpoenas and other preliminary investigative measures) unless a proceeding has been initiated. Nonetheless, some courts have ruled, based on applicable policy language and the particular factual record, that D&O coverage is implicated as a result of a regulatory investigation, even absent formal proceedings. In recent years, the trend has been for D&O insurers to offer policies that provide coverage for regulatory investigations directed against individual insureds when they are clearly identified as the targets of such investigations. In addition, many D&O policies cover costs associated with an interview of an insured person in connection with an investigation of the insured entity. By contrast, if an investigation appears to target only the insured entity, without identifying any individuals, coverage typically remains limited. The term 'loss' is generally defined to include settlements, damages, judgments and defence costs. Litigation as to the scope of covered 'loss' may arise where the policyholder's payments are deemed restitutionary (ie, disgorgement payments) rather than compensatory, or where the policyholder's payments are essentially a redistribution of assets within a corporation, rather than a compensable loss. A court's 'loss' evaluation will turn on the applicable policy language as well as the nature of the payments for which the policyholder seeks indemnification.

### 24 What issues are commonly litigated in the context of D&O policies?

Commonly litigated issues include the scope of coverage for investigations commenced by government agencies and the insurability of fee awards granted to class action plaintiffs' counsel in the context of securities class actions. Other issues involve the timeliness of notice and the question of whether certain claims arising at different times are related to one another so as to trigger D&O coverage in the earliest policy during which the claim arose or whether such claims are unrelated so as to trigger two separate policy years.

In addition, D&O policies may be subject to rescission by insurers where it is established that the application for insurance contained material misrepresentations or omissions. Litigation relating to rescission claims turns on several issues. First, courts will evaluate whether the misrepresentation or omission was material. In many jurisdictions, materiality relates to whether the insurer would have issued the policy or offered the same terms had it known the truth. Second, the success of a rescission claim may, in some jurisdictions, depend on whether the policyholder had an intent to deceive in connection with the misrepresentation. Third, the identity of the party that made the misrepresentations may be relevant, particularly where coverage is sought by an 'innocent' director or officer who had no involvement in the application process. Some courts have held that once a material misrepresentation is established, the policy is void as to all directors and officers. In response, many D&O policies now contain non-imputation language precluding rescission as against any innocent directors or officers.

If there is a potential for D&O coverage, many policies contain provisions that require the insurer to advance defence costs for covered claims. Such provisions vary, and issues may arise as to whether an insurer is obligated to advance defence costs contemporaneously as they are incurred or whether the insurer is allowed to wait until the claim is resolved before providing reimbursement of defence costs. There is no judicial consensus on this issue, and rulings turn primarily on the specific language presented. In certain cases, an insurer may be entitled to an allocation of defence costs for covered versus non-covered claims.

Defence costs aside, substantive disputes in D&O insurance litigation often relate to interpretation of several common policy exclusions, such as the 'insured versus insured' exclusion, which excludes coverage for claims against insured directors and officers brought by, or with the assistance or solicitation of, an insured organisation or insured person. Courts have issued conflicting rulings as to whether claims asserted by an entity that acts on behalf of the corporation (such as bank regulators, receivers, bankruptcy trustees or other litigation entities) should be considered an 'insured' for purposes of the exclusion. Rulings in this context are driven primarily by applicable policy language, including carve-backs from the exclusion that preserve coverage for derivative and shareholder claims. In recent litigation, courts have addressed whether the 'insured versus insured' exclusion applies to actions in which claims are asserted by both insureds and non-insureds. In these 'mixed' claim situations, courts have found that claims brought by non-insured persons with the assistance or solicitation of insured persons are barred from coverage by the insured v insured exclusion. In contrast, where a non-insured person is found to have brought a claim without such assistance or solicitation, courts have applied allocation clauses in the D&O policies to extend coverage to claims brought by non-insureds, while excluding coverage for claims brought by insureds.

Other litigated exclusions include what are known as 'conduct' exclusions, which bar coverage for claims arising from a director or officer's deliberately wrongful or fraudulent acts, or the improper gaining of personal profit. Here, issues may arise regarding whether the alleged conduct has been finally adjudicated so as to trigger the exclusions. Issues can also arise regarding whether or not the director is alleged to have acted beyond his or her capacity as a director. If so, courts will find coverage is excluded. Also frequently litigated is the 'professional services' exclusion. Most D&O policies exclude coverage for claims alleging a failure to provide professional services or a breach of an obligation to provide professional services. Typically, such claims would be covered under an errors and omissions (E&O) policy. At times, however, policyholders may discover a gap, such as a situation in which a claim for professional services is not covered under the policyholder's E&O policy and is excluded under its D&O policy. This has led to disputes over the scope of the 'professional services' exclusion in D&O policies, with outcomes typically highly fact-driven.

## Cyber insurance

### 25 What type of risks may be covered in cyber insurance policies?

Cyber insurance policies may provide coverage for various types of 'cyber risks', such as liabilities arising from security breaches or first-party losses arising from network failures. Thus, a cyber policy may offer third-party liability coverage for claims against the insured alleging failure to protect 'confidential information', which is usually defined to include information in the insured's custody or control from which an individual may be uniquely and reliably identified or contacted (eg, name, address, telephone number, social security number or health-related information). A cyber policy also may provide first-party coverage for network interruption loss arising from a breach or failure of an insured's computer system, including where such a breach or failure results in receipt of malicious code or other unauthorised access to secure information. The insured's loss is typically measured by the amounts paid to remedy a 'material interruption' plus any net income that the insured would have earned but for the interruption. Further, a cyber policy may provide event management coverage for loss sustained in managing a security failure or privacy breach, as well as cyber extortion coverage for losses incurred in addressing threats to the insured's computer network. Since cyber insurance is a relatively new insurance product, the law regarding the interpretation of such policies is not developed. Issues may arise relating to the nature and amount of technological detail that the insured must provide to support a claim under a cyber insurance policy and the calculation of loss arising from a cyber event. Issues may also arise regarding how exclusions such as those based on lightning, wind, water, flood or other natural causes, and the identity of the person or persons causing a network breach (eg, former employees) will impact the coverage that is available.

### 26 What cyber insurance issues have been litigated?

While not yet widespread, litigation has begun to develop regarding the scope of cyber insurance coverage for data breaches, hacking incidents, accidental loss or disclosure of personal data, network failures and other cyber-related events. To date, decisions that have addressed such claims suggest that courts will apply fundamental insurance principles to the interpretation of cyber insurance policies and will uphold insurers' denials of coverage where policy language supports such a result. For example, a restaurant chain sought coverage under its cyber insurance policy for all costs arising from a data breach in which its customers' credit card information was stolen. The cyber insurer covered

**Update and trends**

Punitive damages can be a significant potential exposure to defendants in any type of litigation in the United States. Whether such damages are insurable may vary depending on policy language and applicable state law. A recent wave of mass tort litigation against manufacturers and distributors of talc products and opioids raises the question whether punitive damages awarded in these cases are covered by insurance. Whether or not punitive damages are covered typically depends on two factors: (i) the language of the insurance policy; and (ii) the public policy of the state whose law applies to the policy. With respect to the first factor, a majority of courts have found that punitive damages fall within the scope of coverage if the policy covers 'all damages' and does not exclude punitive damages. If policy language is unclear, disputes may arise. In certain states, public policy concerns have resulted in statutes or case law explicitly precluding insurer indemnification of punitive damages because the purpose of such damages is punishment to deter future wrongdoing. For this reason, some states have found that the wrongdoer, not an insurer, should pay the costs imposed through punitive damage awards. Some states, however, have adopted exceptions to this rule, including, for example, where the policyholder is held liable for punitive damages on a vicarious liability theory. Ultimately, in assessing the availability of coverage for punitive damages under any insurance policy, it is important to be mindful of the specific policy language that may trigger or exclude such coverage and whether the state law that governs the policy addresses the insurability of punitive damages.

the costs of conducting a forensic investigation into the data breach and of defending litigation filed by customers. The insurer denied coverage, however, for nearly US$2 million in fees assessed by the restaurant chain's banks pursuant to contract. An Arizona federal court upheld the insurer's coverage denial. First, the court found the fees fell outside the policy's coverage for 'privacy injury' claims because the banks did not sustain any unauthorised disclosure of private information. The court then found that while the fees potentially constituted 'privacy notification expenses' under the policy, coverage was barred by the policy's definition of loss and a contract exclusion. By way of further example, an electronic data processing and storage company sought a determination from a federal court that its cyber insurer owed a duty to defend a suit by an insured's customer seeking damages for the insured's refusal to turn over electronic billing data. The court denied the policyholder's motion for summary judgment, finding that the underlying action did not trigger the cyber insurer's duty to defend. The court found the complaint did not allege damages arising from an 'error or omission' but, rather, from the policyholder's alleged knowledge, wilfulness, and malice. Notably, demonstrating that courts apply fundamental insurance principles when interpreting cyber policies, the court looked to traditional insurance law to preclude consideration of extrinsic evidence in determining the scope of the cyber policy's duty to defend.

A potentially recurring issue in the context of cyber insurance litigation is the extent to which the policyholder has undertaken appropriate measures and procedures to prevent hacking and data breaches. For example, an insurer sought a declaratory judgment that it had no duty to defend and indemnify claims against its insured arising from a data breach in which electronic healthcare patient information was released. The insurer alleged that coverage was precluded by the Failure to Follow Minimum Required Practices exclusion, requiring that the insured continuously implement procedures and risk controls identified in the policy application, or risk losing coverage. The court dismissed the lawsuit based on an alternative dispute resolution agreement. Nonetheless, the complaint suggests a defence upon which cyber insurers may seek to rely as disputes arise.

With respect to general liability policies, policyholders have attempted to obtain coverage for cyber losses pursuant to 'personal and advertising injury' provisions, which typically provide coverage for losses arising out of the publication of material that violates an individual's right to privacy. In some instances, courts have concluded that personal and advertising injury provisions do not encompass cyber-related claims. For example, where a policyholder accidentally lost computer data containing employees' personal information, an insurer's coverage denial was upheld because there had been no 'publication' of the material to third parties. Personal and advertising injury coverage has also been rejected for losses caused by computer hacking. In one instance, a court found that there was no coverage because a hacker, and not the policyholder, had committed the privacy violation. By contrast, a court found that a general liability insurer was required to defend a class action alleging the policyholder's online release of confidential medical records. Because the information was posted on the internet, the court found it constituted publication and, thus, the class members' claims potentially triggered coverage. The availability of general liability coverage for hacking incidents and cyber-related losses under other policy provisions will depend on the particular policy language and the nature of the underlying claims. Thus, for example, where a policy limits 'forgery' to include only fraudulent written instruments, courts have denied coverage for claims arising out of hackers' online bank transfers. Similarly, where a policy explicitly states that the 'fraudulent entry' of data is limited to losses caused by unauthorised access into the policyholder's computer system, losses caused by an authorised user's entry of fraudulent information into the computer system may fall outside coverage.

In the first-party property context, parties have litigated whether computer data constitutes 'physical' property, such that lost computer data could be covered property. In addition, litigation has arisen concerning the extent to which computer fraud insurance covers loss incurred as a result of wire transfers initiated by fraudulent emails. Where courts have found a sufficient causal connection between an unauthorised entry into a computer system and the loss-causing wire transfer – for example, an employee's transfer of funds outside the company in response to a fraudulent email – coverage may apply. As with general liability coverage, outcomes in the first-party context vary, and depend largely on applicable policy language and the factual record presented. For example, where a policy includes coverage for 'loss of use', courts may be more inclined to find that expenses associated with lost data are within the scope of coverage. However, a federal court has reiterated the fundamental principle that first-party insurance coverage does not impose a duty to defend or indemnify against legal claims for harm suffered by third parties because of a data breach.

## Terrorism insurance

**27 Is insurance available in your jurisdiction for injury or damage caused by acts of terrorism and, if so, how does it generally operate?**

Recent terrorist attacks serve as a reminder that the threat of terrorism remains a permanent feature of modern life. While terrorism insurance is available in the United States, it is subject to a number of limitations and the extent to which it may provide coverage in the wake of a terrorist attack remains unclear.

In 2002, following the 9/11 attack in the United States, Congress passed the Terrorism Risk Insurance Act (TRIA), which sought to ensure the continued availability of commercial property and casualty insurance for terrorism risk. Conceived as a temporary programme to allow private markets to stabilise and build insurance capacity to absorb future losses for terrorism events, the TRIA has been extended until 31 December 2020. It requires that insurers make available terrorism risk insurance for commercial property and casualty losses resulting from certified acts of terrorism, and provides for shared public and private compensation for insured losses. The Act also requires insurers to offer coverage for terrorism on the same terms and conditions as non-terrorism-related losses. The TRIA does not regulate premium rates, which remain within the authority of each state insurance regulator.

Under the TRIA programme, the federal government will reimburse insurers for 85 per cent of terrorism-related losses that exceed a certain threshold, subject to a premium-based deductible. The threshold for reimbursement was originally set at US$100 million in aggregate losses. As of 2015, the threshold increases by US$20 million each year, reaching US$200 million by 2020. Notably, the TRIA's backstop is not available unless the Treasury Secretary certifies that the act was 'part of an effort to coerce the civilian population of the US or to influence the policy or affect the conduct of the US Government by coercion'. To date, no act has been so certified, despite several recent incidents having been described as terrorist acts in the press and by law enforcement.

While the TRIA has increased the availability of coverage, there are significant uncertainties and limitations as to its scope. For example,

the TRIA does not address coverage for nuclear, chemical, biological or radiological attacks. Because policies have long included nuclear exclusions, insurers are not required to offer coverage for these type of attacks. On the other hand, the Department of Treasury recently clarified that stand-alone cyber liability policies covering acts of cyber terrorism are also backstopped by and must comply with the TRIA. Additionally, the TRIA only applies to losses that occur on US soil, or to US flagged vessels, carriers or US missions, and does not address the lack of available coverage for terrorism-related risks that result in losses outside the United States. Furthermore, as mentioned above, the TRIA only covers loss resulting from terrorism certified by the Treasury Secretary. Other acts or 'non-certified' acts of terrorism are generally excluded. However, owing to the infrequency of certification, some insurers have begun to offer endorsements covering losses resulting from non-certified terrorism.

Exclusions for terrorism-related risks are a recent and evolving innovation, and remain largely untested in the courts.

* *The authors would like to thank Karen Cestari of Simpson Thacher & Bartlett LLP for her contribution to this chapter.*

Simpson Thacher

**Mary Beth Forshaw** **mforshaw@stblaw.com**
**Elisa Alcabes** **ealcabes@stblaw.com**

425 Lexington Avenue
New York, NY 10017
United States

Tel: +1 212 455 2846/+1 212 455 3133
Fax: +1 212 455 2502/+1 212 455 2502
www.stblaw.com

*Getting the Deal Through*

Acquisition Finance
Advertising & Marketing
Agribusiness
Air Transport
Anti-Corruption Regulation
Anti-Money Laundering
Appeals
Arbitration
Art Law
Asset Recovery
Automotive
Aviation Finance & Leasing
Aviation Liability
Banking Regulation
Cartel Regulation
Class Actions
Cloud Computing
Commercial Contracts
Competition Compliance
Complex Commercial Litigation
Construction
Copyright
Corporate Governance
Corporate Immigration
Corporate Reorganisations
Cybersecurity
Data Protection & Privacy
Debt Capital Markets
Defence & Security Procurement
Dispute Resolution
Distribution & Agency
Domains & Domain Names
Dominance
e-Commerce
Electricity Regulation
Energy Disputes
Enforcement of Foreign Judgments
Environment & Climate Regulation
Equity Derivatives
Executive Compensation & Employee Benefits
Financial Services Compliance
Financial Services Litigation
Fintech
Foreign Investment Review
Franchise
Fund Management
Gaming
Gas Regulation
Government Investigations
Government Relations
Healthcare Enforcement & Litigation
High-Yield Debt
Initial Public Offerings
Insurance & Reinsurance
Insurance Litigation
Intellectual Property & Antitrust
Investment Treaty Arbitration
Islamic Finance & Markets
Joint Ventures
Labour & Employment
Legal Privilege & Professional Secrecy
Licensing
Life Sciences
Loans & Secured Financing
Mediation
Merger Control
Mining
Oil Regulation
Outsourcing
Patents
Pensions & Retirement Plans
Pharmaceutical Antitrust
Ports & Terminals
Private Antitrust Litigation
Private Banking & Wealth Management
Private Client
Private Equity
Private M&A
Product Liability
Product Recall
Project Finance
Public M&A
Public-Private Partnerships
Public Procurement
Rail Transport
Real Estate
Real Estate M&A
Renewable Energy
Restructuring & Insolvency
Right of Publicity
Risk & Compliance Management
Securities Finance
Securities Litigation
Shareholder Activism & Engagement
Ship Finance
Shipbuilding
Shipping
Sovereign Immunity
State Aid
Structured Finance & Securitisation
Tax Controversy
Tax on Inbound Investment
Technology M&A
Telecoms & Media
Trade & Customs
Trademarks
Transfer Pricing
Vertical Agreements

*Also available digitally*

# Online

www.gettingthedealthrough.com

ISBN 978-1-912228-89-8