Insurance Litigation

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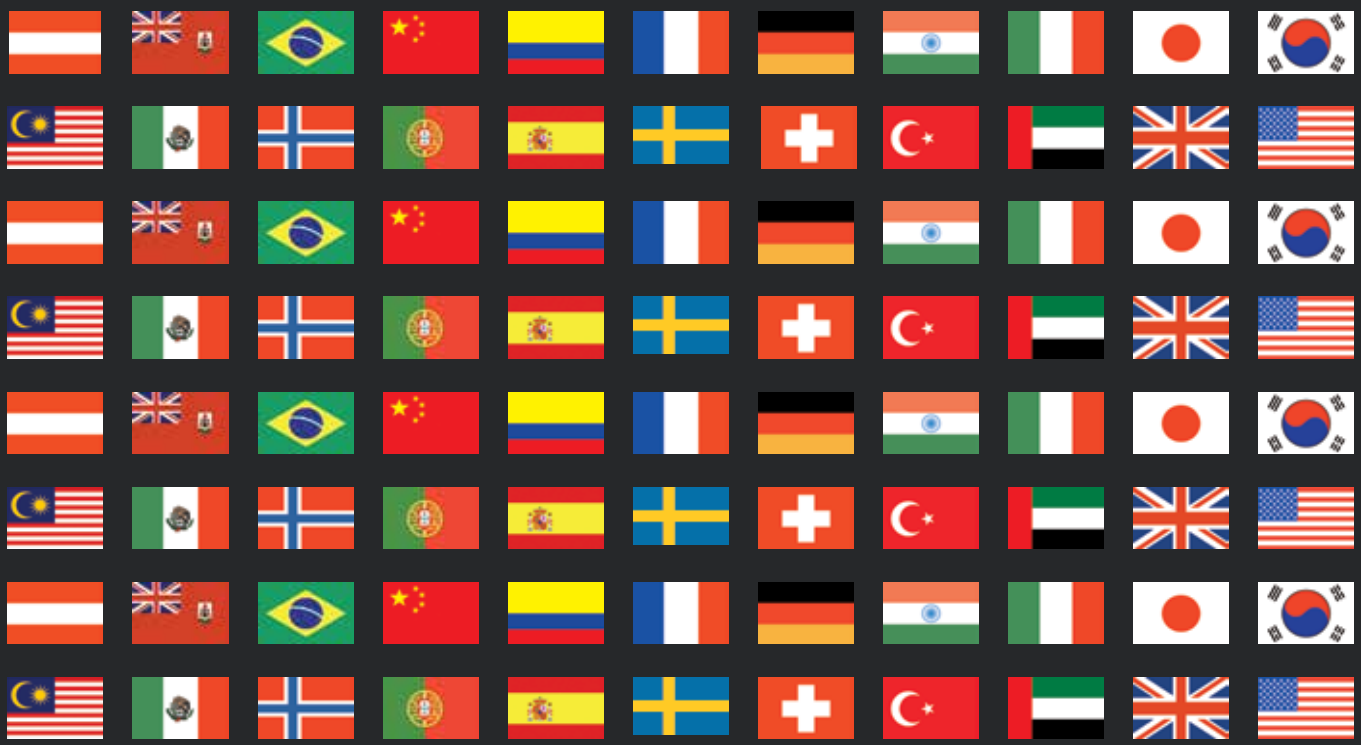

2016

GETTING THE DEAL THROUGH

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Insurance Litigation 2016

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Insurance Litigation 2016

Third edition

Getting the Deal Through is delighted to publish the third 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 Austria, Colombia, Germany, Malaysia, Sweden and the United Arab Emirates.

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 would like to extend special thanks to Barry R Ostrager, the contributing editor on the first two editions, who contributed the original format from which the current questionnaire has been derived, and who helped to shape the publication to date. We would also like to acknowledge the contributing editors, Mary Beth Forshaw and Elisa Alcabes of Simpson Thacher & Bartlett LLP, and thank them for their assistance with this edition.

GETTING THE DEAL THROUGH

London
March 2016

Austria

Therese Frank and Christian Klausegger
Binder Grösswang Rechtsanwälte GmbH

Preliminary and jurisdictional considerations in insurance litigation

1 In what fora are insurance disputes litigated?

Insurance disputes are generally litigated in civil courts. Depending on the amount in dispute, either the district courts (amount in dispute under €15,000) or the regional courts (amount in dispute above €15,000) will act as court of first instance.

In cases where the insurer is the defendant or the insurer files suit against an insured company, the above-mentioned courts will act as commercial courts.

Insurance disputes can also be tried in arbitral proceedings. However, arbitration clauses between insurers and consumers are only valid if the parties agreed on settling the dispute in arbitral proceedings after the dispute has arisen. Hence, arbitration clauses cannot be included in insurance contracts with consumers or in the applicable terms and conditions.

Out-of-court dispute settlements are becoming increasingly important. Conciliation bodies for insurance disputes have been created to support parties in reaching out-of-court settlements.

2 When do insurance-related causes of action accrue?

Insurance-related causes of action mostly accrue upon denial of coverage by the insurer. The insurer has to inform the insured in writing about the denial of coverage by naming the grounds for its decision. If the insured wants to challenge the insurer's decision, he or she has to file a lawsuit with the competent court within one year upon the receipt of the insurer's letter.

Disputes often arise out of deviating interpretations of the terms of the policy by the insurer and the insured in relation to the occurrence and the actual or alleged failure to comply with duties under the policy. During recent years, coverage disputes relating to the insurance of persons, such as life, health and personal accident insurance as well as disability insurance, accounted for the majority of insurance cases tried before Austrian courts. Moreover, coverage disputes regarding legal expenses policies have increased also recently.

In addition, class actions brought by public associations challenging standard clauses of terms and conditions are regularly litigated in front of Austrian courts.

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

Both the insurer and the insured should thoroughly assess their case and collect appropriate evidence. The insured should always make sure that he or she has complied with all duties provided for in the insurance policy, such as the duty to notify in a timely manner.

The Code on Insurance Contracts stipulates a time limit of one year upon receipt of a written denial of coverage to commence coverage litigation against an insurer. After the lapse of this period, the insured's claims become time-barred. Austrian courts apply this rule rigorously. Hence, if the insured fails to file a complaint within this period, he or she loses his or her claims against the insurer even if he or she were to win the case on the merits. During ongoing settlement negotiations between the insurer and the insured, this time limit is, however, suspended. Should settlement negotiations end in failure, the complaint against the insurer has to be filed promptly, taking into consideration the time necessary to prepare such complaint, in order to avoid the claims becoming time-barred.

4 What remedies or damages may apply?

Complex rules exist as to when an insurer can refuse coverage, rescind the contract or increase the premium. Generally speaking, if the insured fails to comply with his or her duty to provide the insurer with accurate information prior to the conclusion of the insurance contract, the insurer will have the possibility – depending on the importance of the information and the degree of negligence of the insured – to rescind contract or increase the premium. In general, the insurer can also deny coverage if the insured caused the occurrence at fault or was grossly negligent.

Regarding claims for damages under general tort law principles, see question 5.

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

Theoretically, both the insurer and the insured can claim damages based on general tort law principles if a contractual breach leads to damage and the damaging party is at fault. Depending on the actual circumstances, the damaged party can not only claim compensation for its loss but also for loss of profits (if any). However, other than with regard to recourse claims, such awards are rare in insurance litigation. Moreover, interest falls due for late payment.

There is no concept of punitive damages under Austrian tort law.

Interpretation of insurance contracts

6 What rules govern interpretation of insurance policies?

The Code on Insurance Contracts does not contain any specific rules on the interpretation of insurance contracts and insurance terms and conditions. Rather, it is settled case law of the Austrian Supreme Court that insurance contracts and insurance terms and conditions (if in each case governed by Austrian law) have to be interpreted following the same rules as contracts in general.

As a first step, the usual meaning of the wording is assessed by taking into consideration the intention of both parties. If the meaning of a clause in dispute still is not clear, the customary practice will be taken into consideration as a second step. For this purpose, all circumstances leading to the contract and all usual business habits and customs shall be considered.

Regarding the interpretation of insurance terms and conditions, the Austrian Supreme Court has established some rules specifying these general principles:

- insurance terms and conditions are to be interpreted objectively by taking into consideration only their wording. The benchmark for interpreting the wording is the understanding of a reasonably circumspect policy holder. However, in cases where the wording is a result of negotiations between the parties, the terms and conditions shall have the meaning intended by those parties;
- legal terms must be interpreted pursuant to their meaning in a legal context should they not be otherwise defined; and
- provisions restricting coverage should not have a broader meaning than necessary when considering their economic aim, the chosen wording and the context of the provision.

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

A policy provision is deemed to be ambiguous if its meaning is not clear pursuant to objective criteria. Such ambiguous clauses have to be interpreted

at first by taking into consideration the meaning that they would have for the average insured. If this step does not resolve the ambiguity, the general rule on ambiguous contracts pursuant to the Austrian Civil Code is applicable, according to which any unclear expression is interpreted to the detriment of the party that used the expression. This will usually be the insurer with regard to insurance contracts and the applicable terms and conditions.

An additional rule is applicable if the insured is a consumer: clauses included in general terms and conditions or contractual standard forms are invalid if they are ambiguous or incomprehensible.

Notice to insurance companies

8 What are the mechanics of providing notice?

The Code on Insurance Contracts stipulates the general duty of the insured to promptly notify the insurer about the occurrence. In cases where several policyholders exist, the notification by one policyholder will usually suffice. With regard to insurances for third-party account, the duty to notify timely in general also extends to the insured person or persons. In practice, the insured person will inform the policyholder who in turn will notify the insurer.

In addition, specific rules substantiating this general rule apply for various types of insurance. For example, occurrences covered by fire insurance have to be notified within three days, and occurrences covered by hail insurance within four days. With regard to third party liability insurance, the insured has to notify the insurer within one week of all the facts that could trigger a liability in relation to a third party. The insurer cannot provide in the policy or the terms and conditions for shorter periods than the ones specifically provided for in the Code on Insurance Contracts to the detriment of the insured.

The Code on Insurance Contracts does not provide for a mandatory notification in writing. However, it is common practice to include in the terms and conditions the duty to notify in writing.

Further, upon request of the insurer, the insured has the duty to provide all information necessary to investigate the occurrence and the liability of the insurer. Documents have to be provided only to a degree that can be reasonably expected. For some types of insurance, the Code on Insurance Contracts stipulates specific rules. Within the scope of compulsory third-party liability insurance, such as liability car insurance, the rule to provide all necessary information (including documents to the degree it can be reasonably expected) extends to the damaged third party.

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

There are no specific statutory rules for claims-made policies. Hence, the principles set out in question 8 apply in addition to the terms and conditions of the respective policy. In general, the policyholder should notify the insurer promptly after the claim against the insured person comes to his or her attention.

10 When is notice untimely?

Notice is deemed to be untimely in cases where the insured:

- does not notify the insurer at all;
- does not notify the insurer in a correct manner; or
- does not notify the insurer promptly or within the time limits stipulated for certain types of insurance (see question 8), or within the time limits set forth in the terms and conditions, or both.

However, where specific time limits are provided for in the Code on Insurance Contracts, these cannot be amended to the detriment of the insured in the terms and conditions of the insurance contract.

11 What are the consequences of late notice?

The Code on Insurance Contracts does not stipulate the consequences of late notice. Rather, the terms and conditions generally provide for an exclusion of coverage in cases of late notice. The Code on Insurance Contracts stipulates an acceptable range of consequences depending on the type of breach of a contractual duty. The consequences set forth in the terms and conditions must be in line with these stipulations.

For example, it is permissible to stipulate in the terms and conditions the exclusion of coverage and the right to terminate the insurance contract in cases of late notice. However, such clause will not apply in the event that the insured was not at fault. Moreover, the insurer may not rely upon a clause providing for exclusion of coverage in cases of late notice if the occurrence came to its attention through other means.

Moreover, the insurer could claim indemnification from the insured based on general tort law for damage caused by the late notice. The burden of proof for late notification of the insured and for the fact that the late notice caused damage to the insurer lies with the insurer. Hence, the insurer has to prove that the insured was aware of the occurrence and did not notify within the applicable time limit. However, the insurer does not have to prove that the insured acted in fault. Rather, the burden of proof that he or she was not at fault lies with the insured.

Still, the insurer's duty to cover the losses will be upheld provided the insured is excused (eg, if he or she was too sick to notify) or acted only slightly negligently. Pursuant to settled case law, the insurer will also not be released from its duty to cover the losses if the insured can prove that he or she did not breach his or her duty to notify in bad faith but only grossly negligently, insofar as the late notice could not influence the insurer's investigation or the extent of coverage. Austrian courts have ruled, for example, that an insured acts with gross negligence if he or she ignores the general terms and conditions and is, as a consequence, not familiar with his or her duty to notify in a timely manner.

Insurer's duty to defend

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

Pursuant to the Code on Insurance Contracts, third-party liability policies consist of two separate spheres: coverage of the third-party claim on one hand and the insurer's duty to defend against this claim on the other. The scope of the insurer's duty to defend includes all necessary costs for the defence of the insured in court proceedings as well as the costs arising in connection with the out-of-court defence of the third-party claims. The costs have to be deemed as objectively 'necessary'. Subjective considerations are not taken into account. Moreover, the insurer has to cover the costs incurred in connection with the insured's general duty to mitigate the damage.

If the insured prevails in civil proceedings against the third party, the third party will have to reimburse the insured for the costs of the court proceedings. However, in cases where the third party is unable to pay, the insurer has to cover the insured's costs. In cases where the insurer requests that the insured shall be defended in criminal proceedings initiated against him or her (if the prosecuted crime could lead to a liability of the insured in relation to a third party) or in disciplinary proceedings, the costs for this defence are also covered.

The insurer's duty to defend also applies if the third-party claim is without merit. Hence, the insured does not have to substantiate the merits of the third-party claim. Rather, the duty to defend is triggered when a third party is alleging facts that could lead to an occurrence covered under the policy.

The terms and conditions usually stipulate additional duties for the insured and rights for the insurer. For example, the insured is not free to choose counsel in the civil proceedings against the allegedly damaged third party, but is obliged to mandate an attorney named by the insurer. Moreover, the insured may not admit the third party's claim or agree on a settlement without the insurer's consent. In addition, the insurer has the right to make statements on behalf of the insured, even in an out-of-court setting.

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

If the insurer unjustly refuses to honour its duty to defend, the rights of the insurer in connection with the defence of the claim, such as the right to choose counsel or to consent to a settlement, are transferred to the insured. Pursuant to settled case law, the unjust denial of coverage is deemed to be a waiver of the insured's duty to get the insurer's consent to a settlement or to the admission of the third-party claim. Hence, the insurer cannot argue that the insured breached his or her duty in this regard. Rather, the insurer has to cover the indemnification agreed upon with the third party together with the insured's defence costs. The insurer will only be free from liability to bear the defence costs in the event that the insured acted grossly negligently when defending a claim against a third party.

Standard commercial general liability policies

14 What constitutes bodily injury under a standard CGL policy?

Bodily injury under a standard CGL constitutes all injuries resulting in death, bodily harm or the impairment of a person's health.

15 What constitutes property damage under a standard CGL policy?

Property damage under a standard CGL policy is defined as all damage to tangible things or destruction of tangible things. Although animals are not things within the meaning of Austrian civil law, damage to animals constitutes property damage. The loss, change or non-accessibility of data on an electronic storage medium does not constitute property damage.

16 What constitutes an occurrence under a standard CGL policy?

An occurrence is a damaging event deriving from the insured risk out of which the insured is liable or could become liable. Coverage is only triggered after the damage occurs, and not at the time of the damaging behaviour of the insured.

17 How is the number of covered occurrences determined?

There are no statutory rules regarding the number of covered occurrences in third-party liability policies. Rather, the extent of coverage is agreed upon individually by the parties in the insurance contract and the applicable terms and conditions. Pursuant to the standard terms and conditions for CGL policies, the insured amount is the maximum indemnification per occurrence. This also applies if more than one insured person is liable for the damage. Additionally, the terms and conditions stipulate a maximum total indemnification per year.

Regarding serial losses, the standard terms and conditions for CGL policies provide that if an incident results in several damaging events they are deemed to be one occurrence. Moreover, occurrences caused by similar incidents in a temporal context will be deemed to be one occurrence if these incidents are legally, economically or technically linked.

18 What event or events trigger insurance coverage?

The kinds of events that trigger insurance coverage depend on the type of insurance, the stipulations of the specific insurance policy, and the applicable terms and conditions.

Coverage will not be triggered upon the damaging behaviour of the insured. Rather, coverage from a third-party liability policy will generally be triggered only after the damage occurred, irrespective of the moment at which the insured or the damaged third party become aware of the damage and irrespective of the moment when the damage becomes apparent.

Terms and conditions usually contain definitions for certain areas specifying this general principle. For example, property damage resulting from an environmental occurrence is defined as the first verifiable environmental damage that could lead to a liability of the insured. Policies including product liability will cover damage arising from products delivered within the local and temporal scope of the policy.

However, rules deviating from this general rule exist. If coverage for pure financial loss is agreed upon, an occurrence is usually defined as misconduct resulting from an insured activity that could lead to the liability of the insured. Hence, in this case, the misconduct itself triggers coverage. In D&O policies, which follow the claims-made principle, the first written request for indemnification by a damaged party against an insured person will trigger coverage.

19 How is insurance coverage allocated across multiple insurance policies?

How insurance coverage is allocated across multiple insurance policies depends on several factors.

A risk can be insured by several insurance companies bearing the risk together. The insured will conclude separate insurance contracts with every insurer regarding a certain quota of the risk. The insurance companies are aware that the risk is insured by several companies and that every insurer is covering the quota as provided for by its insurance policy.

The insured could also take out insurance for a certain risk with several insurers who act independently and who thus are at first not aware that the risk shall be borne by several insurers. This is admissible if the insurance sum of all policies does not exceed the insurance value and if the total indemnification would not exceed the damage. However, the insured has to notify all insurers about the fact that he or she is insuring the risk with several insurance companies immediately upon conclusion of the contracts. Each insurance company then covers a quota of the risk calculated on the basis of the ratio between the insurance sum and the insurance value.

Specific rules apply if the insurance sum exceeds the insurance value or if the indemnification from different policies would exceed the total damage. If the insured has taken out several policies in bad faith in order to gain a monetary advantage, all policies will be null and void. If the insured did not conclude such double insurance in bad faith, he or she has the right to request cancellation or a reduction of the insurance sum of the later policy immediately upon knowledge of this fact.

Regarding the relationship between the insurers and the insured, generally each insurer has to cover the whole damage in line with the policy. However, the insured is not entitled to an indemnification exceeding the actual loss. An insurer has no duty to pay more than its quota calculated on the basis of the ratio between the insurance sum and the insurance value. In cases where the actual indemnification exceeds the quota, the respective insurer can take recourse against the other insurer or insurers.

Double insurance may be avoided by including a subsidiarity clause in the contract providing for coverage only if no other insurer will cover the occurrence. However, the value of such clause will be lost if it is included in several insurance policies.

First-party property insurance

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

The general scope of first-party property coverage is indemnification for damage to the insured's property. Depending on the type of insurance, the property of family members living with the insured or the property of employees of the insured may also be covered.

Examples include fire insurance to cover all losses incurred by fire, explosion or lightning strike; motor insurance to cover damage to and loss of a vehicle itself and any property stored in that locked vehicle; and household insurance to cover the contents of a house or flat (eg, all the property of the insured, his or her partner, children and all other relatives living in the insured property).

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

The insurance value is – if not otherwise agreed upon – the value of the insured property. Terms and conditions usually substantiate this general rule. The rules stipulating how property is valued mostly follow a similar ratio and differ depending on the type of insurance. Below are some examples of how property is valued in certain types of standard first-party property insurance policies.

The insurance value in fire insurance is determined, with regard to the value of household articles and other articles of daily use as well as machines, as the amount necessary to purchase articles of a similar type. The deductible value resulting from the difference between a new and a used product has to be taken into consideration.

The terms and conditions for household insurance apply a similar rule: the insurance value of the content of the housing is the replacement value, being the cost for replacement of the affected property with items of similar type. However, if the value of the affected property was below 40 per cent of the replacement value, only the value the property had immediately prior to the damaging event will be covered.

The insurance value for glass breakage insurance is defined as the common costs for replacing or restoring the glass, including the costs for removing the damaged glass and cleaning the glass residue.

Directors' and officers' insurance

22 What is the scope of D&O coverage?

D&O insurance is a third-party liability insurance covering only pure financial loss resulting from the misconduct of the organs and executive employees of a company in their official capacity during the policy period. The policyholder is the company taking out the insurance for the insured persons. The insured persons will typically be the members of the management and the supervisory board as well as executive employees of the policyholder itself and its subsidiaries.

Pure financial loss entails neither property damage nor bodily injury; nor is it derived therefrom. Extended pure financial loss can be insured to cover losses resulting from property damage or bodily injury only insofar as the misconduct of the insured person merely caused a pure financial loss, or if the policyholder itself suffers losses such as loss of profits.

If not explicitly excluded in the policy, losses suffered by the policyholder itself due to the misconduct of the insured persons are also covered. Typically excluded from coverage are losses resulting from any intentional behaviour of the insured persons, criminal and administrative fines, as well as losses suffered by the policyholder itself that are litigated in the US or pursuant to US law.

Update and trends

Cyber insurance will become more important in the future in Austria. For now, it is a recent product in Austria, and so far no case law exists in this regard. Pursuant to risk barometers published by insurance companies, cyber risks represent the second most important risks for businesses in Austria.

The new EU Data Protection Regulation is due to enter into force at the beginning of 2018. This Regulation will likely require companies to notify the authorities in the event of certain security breaches, such as data theft by a hacker attack. Substantial fines can be ordered in the event of non-compliance with these rules. Hence, companies will likely include insurance against cyber risks in their standard insurance portfolio in future. As a consequence, it can be expected that litigation in connection with the interpretation of cyber insurance policies will increase. The products that are now available cover company cyber risks. However, insurance products covering cyber risks for private persons might also become relevant.

From a regulatory perspective, it should be noted that on 1 January 2016, a new Insurance Supervision Act came into force, implementing Directive 2009/138/EC (Solvency II), which introduces a fundamentally new approach for the supervision of insurance companies.

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

There is virtually no published jurisprudence of the higher courts regarding D&O policies in Austria. However, a relevant topic certainly is the coverage of losses suffered by the policyholder itself arising from the misconduct of the insured person, as such insurance is in contradiction with the general Austrian principles of third-party liability insurance according to which a policyholder cannot claim indemnification for its own losses.

Cyber insurance

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

Cyber insurance policies may provide coverage for first-party costs as well as third-party losses. The risks included will depend on the agreement between the insurer and the insured. Insurers usually offer products that take into account the individual cyber exposure of the insured company.

Coverage will usually be provided for third-party loss resulting from a data breach or cyber breach (such as a breach of legal provisions aimed at protecting data, a breach of secrecy obligations regarding business information, the transmitting of a virus to a third-party computer system). Insurance will cover the costs for indemnifying the damaged third party as well as the defence of unsubstantiated claims against the third party.

Regarding direct first-party costs, the following costs resulting from a data breach could typically be covered:

- costs resulting from responding to a breach, such as the costs connected with the forensic analysis of the cause of the breach, the costs for legal counsel and the costs incurred in connection with informing third parties affected by the data breach;
- lost income due to business interruption;
- costs incurred in connection with crisis management and public relation measures; and
- payment of ransom money in connection with the threat to disclose data or attack a system to extort money.

25 What cyber insurance issues have been litigated?

The possibility to insure cyber risks with a specified product is a rather recent development in Austria, and the major insurance companies have only included such products in their portfolio in the past couple of years. Hence, there is no published case law relating to cyber insurance in Austria to date.

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Preliminary and jurisdictional considerations in insurance litigation

1 In what fora are insurance disputes litigated?

Insurance and reinsurance disputes involving Bermuda companies are typically arbitrated, as arbitration clauses are very common in reinsurance contracts. Liability insurance written on the 'Bermuda form' contains a provision for arbitration in either London or Bermuda. It is also common for domestic insurance contracts in Bermuda to provide for arbitration.

If there is no arbitration clause, the forum for litigation of insurance disputes is the Commercial Court, which is an administrative subdivision of the Supreme Court of Bermuda.

2 When do insurance-related causes of action accrue?

In the absence of any wording in an insurance policy to the contrary, the obligation of an insurer to indemnify the insured in respect of a claim arises the moment that the insured event occurs and loss is suffered.

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

From a procedural perspective, insurance litigation is no different to any other kind of commercial litigation undertaken in Bermuda. Any writ action will be commenced in the Commercial Court, and will be heard by a judge with experience in insurance disputes. Discovery is limited to the production of documents in the possession or control of a party that are relevant to the issues pleaded. Perhaps the most important strategic considerations are the absence of punitive damages under Bermuda law (see below) and the exposure of the losing party to an award of costs. These costs are typically taxed on the standard basis, which will allow the winning party to recover approximately 60 per cent of its attorneys' fees.

4 What remedies or damages may apply?

As a matter of principle, the same remedies apply to insurance contract claims as to other claims for breach of contract. The insured is entitled to an indemnity for the insured loss he or she has suffered and may sue for declaratory relief or damages. The amount of damages is limited to the contractual indemnity to which the insured is entitled (ie, the insured is to be put into the same position in financial terms as he or she would have been in if the insurer had performed the contract). No damages are available for breach of the duty of good faith; nor are punitive damages available under Bermuda law.

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

Exemplary damages (or punitive damages, as they are known in the US) are perceived in the UK and Bermuda to be a departure from the principle that damages are intended to compensate the claimant rather than punish the defendant. In an insurance context, under Bermuda law, bad faith and punitive damages do not exist. While there is a duty of utmost good faith under Bermudian law, in the case of insurance and reinsurance contracts, this does not give rise to a claim for punitive damages. All that is available regarding the above is for the insured to be indemnified for the loss he or she has suffered, with a cap being the amount specified under the policy in dispute.

Interpretation of insurance contracts

6 What rules govern interpretation of insurance policies?

The same general rules govern the interpretation of insurance contracts as apply to other contracts, namely the language of the policy is to be given its natural and ordinary meaning in the commercial context. Courts have regard to the commercial purpose to which the policy is intended to give effect. However, evidence of prior negotiations is excluded unless a plea of rectification or estoppel by convention is made.

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

In a case of genuine ambiguity, where the words are reasonably capable of bearing two different meanings, the contra proferentem rule of construction generally applies and the policy language is construed against the insurer. It should be noted that in liability policies written on the 'Bermuda form', the choice of law clause provides for the policy to be construed under New York law. However, this is subject to the modification that the ambiguity rule is not to be invoked, and that the language is to be construed in an even-handed manner without favouring one party or the other.

Notice to insurance companies

8 What are the mechanics of providing notice?

There is no general rule of common law regarding notice. The mechanics of providing notice are a matter for the policy to specify.

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

This is specified in the policy.

10 When is notice untimely?

This depends on the construction of the policy.

11 What are the consequences of late notice?

Unless timely notice is expressed to be a condition precedent to liability, late notice will not provide the insurer with a defence in the absence of proof of prejudice (with the burden of proof being on the insurer).

Insurer's duty to defend

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

There is no common law duty to defend under a liability policy. Such a policy will typically set out the insurer's obligations to defend (if any).

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

Where the insurer fails to defend in breach of a contractual duty to do so, he or she will be liable for damages proximately caused by his or her breach.

Standard commercial general liability policies

14 What constitutes bodily injury under a standard CGL policy?

The term 'CGL' is an American expression not commonly used in the Bermuda domestic market. However, CGL policies are typically issued by fronting companies in the United States and reinsured by captive insurance

companies in Bermuda. Where the reinsurance contract contains a 'follow the settlements' clause, the captive will typically be bound by a judgment of a court of competent jurisdiction finding the fronting company liable under applicable US law.

A typical definition of 'injury' under a Bermudian domestic public liability policy is 'bodily injury, sickness or disease sustained by a person, including death resulting therefrom'. A Bermuda court is likely to follow English case law, which construes the meaning of 'bodily injury' to include cellular dysfunction (eg, cancer) as persuasive authority.

15 What constitutes property damage under a standard CGL policy?

See question 14. A typical definition of 'loss of or damage to material property' under a Bermudian domestic public liability policy is 'physical damage to tangible property including all resulting loss of use of that property or loss of use of tangible property that is not physically damaged'. English case law on what constitutes property damage is likely to be followed as persuasive authority.

16 What constitutes an occurrence under a standard CGL policy?

See question 14. Bermudian domestic public liability policies will typically provide coverage for injury to a person, or loss or damage to property 'occurring within Bermuda during the policy period'. There is no Bermudian case law construing 'occurrence' within the context of domestic liability insurance. It will be a question of contractual interpretation in each case and having regard to English case law, which draws a distinction between liability insurance and property insurance.

17 How is the number of covered occurrences determined?

See question 14. Bermudian domestic liability policies typically define 'occurrence' by reference to occurrences arising out of a common cause for the purpose of limiting the insurer's liability. The number of covered occurrences will depend on the contract language and the facts of the case. English case law on similar contract language is likely to be followed as persuasive authority.

18 What event or events trigger insurance coverage?

This will depend entirely on the language of the particular contract. It should be noted that liability insurance written on the 'Bermuda form' is on an 'occurrence first reported' basis, so that notice given by the insured is the trigger of coverage.

19 How is insurance coverage allocated across multiple insurance policies?

See question 14. There is no Bermudian case law on allocation of losses across multiple insurance policies, so English case law is likely to be followed as persuasive authority. The inquiry will focus on the policy language and the facts of the case. As a matter of principle, the insured will have to prove (the burden being on him or her) that something happened during the policy period – an 'occurrence', however it may be defined in the policy – that triggered cover under that particular policy. The next stage of the inquiry is for the insured to prove how much loss 'occurred' during that policy period. There is no basis under Bermuda insurance law, whether as a matter of principle or by reference to English authority, which would allow a Bermuda court to allocate losses over time by reference to a mathematical formula.

First-party property insurance

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

First-party property policies relating to property in the United States (and elsewhere outside Bermuda) are typically issued by fronting companies in the United States and reinsured by captive insurance companies in Bermuda. Where the reinsurance contract contains a 'follow the settlements' clause, the captive will typically be bound by a judgment of a court of competent jurisdiction finding the fronting company liable under applicable US law.

First-party property policies issued by domestic Bermuda carriers will typically be of two kinds: home insurance policies and commercial fire insurance policies. The scope of coverage will vary from policy to policy. However, it is typical for both homeowners' property insurance and commercial 'fire insurance' policies to cover a variety of risks including fire, water damage, hurricane and storm damage, subsidence and earthquakes.

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

The point in time at which damages are to be assessed for a domestic Bermudian property insurance claim is likely to be at the date of trial, unless the insurer can persuade the court that the insured ought reasonably to have repaired the property at an earlier date.

Directors' and officers' insurance

22 What is the scope of D&O coverage?

Policy forms tend to follow US precedents. Typical coverage includes loss suffered from management liability and investigations, reasonable defence costs and expenses incurred by an insured for crisis containment and public relations. Some policies may also cover entity coverage for securities claims against the company, but its potential to reduce coverage for directors and officers, who are the intended beneficiaries, has prompted some insurers to remove it.

A significant difference between Bermuda and UK law relating to the liability of directors and officers of Bermuda companies is that the Companies Act 1981 permits companies to have by-laws that exclude all liability for acts of 'mere' negligence and wilful default and neglect, so that directors and officers of Bermuda companies are only liable for fraud or dishonesty. Fraud and dishonesty are universally excluded from D&O policies. Other exclusions may include claims arising from bodily injury, and claims that are based on the same facts or wrongful acts as a claim already reported to the insurer.

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

There are no reported Bermuda court decisions specifically dealing with D&O policy disputes. Several cases, brought typically by plaintiff liquidators, deal with the indemnification of directors of Bermuda companies under their by-laws, and the exclusion of liability for mere negligence.

Cyber insurance

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

Cyber insurance policies have been around since the early 1990s, but there has been a recent increase in the amount of companies seeking coverage in this area given the high-profile data breaches occurring throughout the world. Cyber insurance covers losses relating to damage to, or loss of information from, IT systems and networks. Cyber policies typically provide detailed assistance with and a platform from which to conduct the management of the incident itself. This is of the utmost importance when presented with a quickly escalating event involving reputational damage or regulatory enforcement.

The most typical forms of cyber risks fall into first party and third-party risks. The type of policy purchased can cover either both or only one of these risks.

Examples of first-party insurance include:

- loss or damage to digital assets such as data or software programmes;
- business interruption due to network downtime;
- cyber exhortation, where third parties threaten to damage or release data if money is not paid to them;
- customer notification expenses when there is a legal or regulatory requirement to notify them of a security or privacy breach;
- reputational damage arising from a breach of data that results in the loss of intellectual property or customers; and
- theft of money or digital assets through the theft of equipment or electronic theft.

Examples of third-party insurance for the most part cover losses suffered by a company's customers, and include:

- security and privacy breaches, and the investigation, defence costs, and civil damages associated with them;
- multi-media liability to cover investigation, defence costs and civil damages arising from defamation, breach of privacy or negligence in publication in electronic or print media; and
- loss of third-party data, including payment of compensation to customers for denial of access, and failure of software or systems.

25 What cyber insurance issues have been litigated?

We have not been involved in any cyber insurance disputes to date. However, from what we read and hear within the market, litigation over cyber claims so far has centred on general liability policies, and whether cyber breaches fit within the expressly defined terms and conditions of general liability policies.

Brazil

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Preliminary and jurisdictional considerations in insurance litigation

1 In what fora are insurance disputes litigated?

Normally, disputes over insurance matters are decided in the common state courts and the respective appellate courts. Each state has a court of appeals, in which the judges sit in panels or chambers. Each case is assigned to a reporting judge responsible for examining it in detail, summarising the issues for the other judges on the panel or chamber, and writing a leading opinion, which may or may not prevail in the final vote. The reporting judge, acting alone, can also issue certain interim decisions and measures, subject to review by the full panel or chamber. At the federal level, there are regional courts of appeal covering one or more states. At the top of both systems are the Superior Tribunal of Justice, responsible for non-constitutional matters, and the Federal Supreme Court, with jurisdiction over constitutional questions. At the request of the insured, cases involving up to 40 times the minimum monthly wage (currently 35,200 reais) and less complex cases can be brought in the small claims courts.

If the dispute involves an interest of the government or one of its agencies or government-controlled companies, cases typically fall under the remit of the federal courts. Private questions involving insurance are rarely heard by the federal judiciary.

Arbitration is also increasingly used, especially in matters involving large risks.

2 When do insurance-related causes of action accrue?

Generally, the disputes that motivate lawsuits involve claims of default of the obligations assumed by the insurance company.

According to Brazilian law, the claim of the victim arises at the moment of violation of the right – the theory of actio nata. This marks the start of the limitation period.

With respect to insurance contracts, this general system is variable according to the type of insurance. As a rule, in insurance for damages, the time-bar period starts to run from the date the insurer refuses coverage by notifying the insured. In turn, in insurance covering persons, especially personal accident insurance, the limitation period starts when the insured learns of the state of health that causes disability (partial or total), subject to suspension during any period necessary for the insurer to investigate whether the condition is covered (loss adjustment).

It is very important to pay heed to the limitation period, which is very short in insurance matters (one year, according to article 206 of the Civil Code). Recognition that the time bar has run in effect means a decision on the merits, preventing any judicial discussion of the matter.

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

Before commencing a lawsuit, it is essential to examine the general and specific conditions of the policy. For preventive purposes, it is important to carefully delimit the risks and respective coverages to avoid allegations of clauses that are abusive and hence null.

An analysis of claims involves examination of all the documents pertinent to the claims adjustment process to decide on whether to refuse payment of the indemnity, or to pay it in full or partially.

As stated in question 1, the great majority of insurance lawsuits are heard by the state courts, with those of lower complexity and value falling under the jurisdiction of the small claims courts, at the plaintiff's option.

Arbitration has made great strides in recent years in Brazil. As stated, it is most often used in matters involving large risks.

Regarding the applicable laws, insurance in general is covered by articles 757 to 802 of the Civil Code (general part, insurance of property and of persons). The Consumer Defence Code also generally applies to cases where the insured is an individual, and very occasionally in cases where the insured is a company, by force of its article 3, section 2.

More specifically, Decree-Law 73/1966 created the national private insurance system and defined the competencies of the National Private Insurance Council, which is responsible for formulating general policies for the insurance market, and the competencies of the Superintendent Office of Private Insurance (SUSEP), the regulator of insurers, reinsurers and insurance brokers.

4 What remedies or damages may apply?

The damages most often discussed are material damages (a category that includes actual damages and lost profits or earnings, or business interruption), moral damages (pain and suffering or harm to reputation), bodily injury, and insured capital in life and personal accident policies.

If the insurance company is tardy in settling a valid claim, the amount owed will be subject to the legal interest rate, as set forth in article 406 of the Civil Code, of 1 per cent per month, plus inflation adjustment.

If the delay in settling a claim is declared illegal, the insurer can be held liable for the additional losses caused, notably lost profits. For instance, in a fire insurance claim by a business, where the claims adjustment process is typically complex and lengthy, the insured usually cannot operate until he or she receives the indemnity, so any delay held by a court to be unjustified or abusive can require payment of lost profits.

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

Brazilian law does not allow an award purely based on punitive damages. There is a distinction between criminal and civil liabilities that justifies the non-existence of punitive damages from the civil liability perspective.

A person that commits a crime is subject to sanctions that can range from the rendering of social services to imprisonment. The nature of this sanction is really to punish the criminal, to educate and to avoid such practice against the law happening again.

From the civil liability perspective, the nature of a sanction is completely different, and the aim is to indemnify the victim of a tort or a contractual fault, bringing his or her assets to the same position that they were in prior to the occurrence of an accident. If the victim becomes an invalid or crashes his or her car, the indemnity shall be calculated in the exact proportion of the losses. This is the amount owed by the tortfeasor, nothing more and nothing less. Therefore, Brazilian law does not allow an award purely based on punitive damages.

As a 'construction' of Brazilian jurisprudence, moral damages in Brazil, which are usually related to psychological damages suffered by the victim, are used with a punitive or educational goal, but these should not be confused with punitive damages.

Interpretation of insurance contracts

6 What rules govern interpretation of insurance policies?

The general rule for interpretation of the insurance contract involves the following question: were the limitations and exclusions of coverage communicated to the insured in a clear, transparent and fair way?

In cases involving mass insurance policies, which are usually adhesion contracts, the terms should be carefully drafted because, in the case of any errors, omissions or discrepancies, the interpretation will generally be favourable to the insured. The contra proferentem rule is applicable.

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

Ambiguity results when a determined clause is hard to interpret, or when there are two clauses that determine different types of coverage or policy limits. As stated above, ambiguities are generally resolved by the courts through the interpretation that is most favourable to the insured, because the insurance company is deemed prima facie to be responsible for preparing the contract without any omissions or contradictions.

As explained in questions 3 and 6, in cases involving insureds who are individuals, the Consumer Defence Code applies, specifically article 47: 'Contractual clauses shall be interpreted in the manner most favourable to the consumer.'

In interpreting ambiguities, the courts typically try to ascertain the real intention of the parties in contracting a determined guarantee in a way that preserves the social function of the contract. The pacta sunt servanda and a literal interpretation give space to several interpretation rules that run in favour of the less (technically and economically) acknowledged party, such as, for example, the objective good faith and social goal of the contracts, and the parties' reasonable expectations.

Notice to insurance companies

8 What are the mechanics of providing notice?

A loss to the insurance company can be reported by letter, email, fax or telephone. All these means are acceptable. The policy can, however, determine specific means of official notification, such as a registered letter to follow a loss reported by telephone or email.

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

To avoid any problems resulting from possible late communication to the insurance company, the insured should immediately report any circumstance that could potentially involve losses to a third party. Depending on the type of clause that has been used, the policyholder must communicate that the third party's claim or a potential claim (namely, the claim by itself) still does not exist, but that there is a reasonable expectation that it is going to be presented very soon. If the policy has been made on a claims-made basis with notification, then the policyholder will have to communicate with the insurer as soon as he or she knows about any evidence that can become a formal claim in the future.

10 When is notice untimely?

Brazilian law does not specify a fixed period of days for a loss to be reported by insureds. Article 771 of the Civil Code states that: 'Under pain of losing the right to the indemnity, the insured shall report the loss to the insurer, as soon as learning thereof, and shall take immediate measures to minimise the consequences.' Obviously, the expression 'as soon as learning' cannot be interpreted irresponsibly, as if to suggest that the insured can delay in reporting the loss. In any event, it is only good sense for the insured to report a loss event as soon as possible. This also depends on the type of insurance contract under discussion. To clarify, if the case relates to a huge fire that is currently destroying a property, it seems clear that the communication to the insurer must be done very quickly; on the other hand, if the discussion is about a life insurance with a guarantee for an insured's death, if the event has already happened, it does not make any difference if it is communicated in two or 20 days. There is no possibility of adopting any salvage measures or of reducing damages. Our jurisprudence is sensitive to this kind of thinking.

11 What are the consequences of late notice?

As explained in question 10, late communication can result in the loss of the right to be indemnified.

However, the definition of late communication depends on the type of insurance, and delay can have more or less serious consequences. For example, in the case of a natural disaster, time is of the essence, and the insurer can even use its expertise or resources to mitigate the loss and preserve salvageable items. In contrast, in life insurance, once death happens, there is nothing to mitigate or preserve. The courts typically apply good sense to try to reach the most balanced solution.

Insurer's duty to defend

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

SUSEP, by means of Circular Letter SUSEP/DETEC/GAB 05/2008, prohibits insurance companies from providing for the defence of insureds. The reason is to avoid possible conflicts of interest, since the interests of the insurer and insured often diverge.

Therefore, it is up to the insured to defend itself, at its own expense, with those expenses under some civil liability policies being subject to reimbursement by the insurer, such as payment of attorneys' fees.

What typically happens in lawsuits filed by third parties against insureds is that the defendant files an impleader to vouch for the insurance company as a co-defendant.

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

If the insurer loses a lawsuit, it will have to pay the amount of the indemnity granted by the court, plus interest of 1 per cent per month and inflation adjustment, besides the possibility of having to pay extra if the court recognises the existence of extracontractual civil liability (illicit act).

The loser-pays principle applies in the Brazilian legal system, whereby the party losing the case must pay the court costs and attorneys' fees of the winning party.

Standard commercial general liability policies

14 What constitutes bodily injury under a standard CGL policy?

Bodily damage is any bodily injury or disease suffered by an individual, including death and disability. The pecuniary consequences of this injury also fall under this concept, along with moral and aesthetic damages.

15 What constitutes property damage under a standard CGL policy?

It is any physical damage to tangible property (deterioration or destruction of objects, substances, livestock, etc). The damage directly affects a pecuniary asset, reducing its value by restricting its use or destroying it.

16 What constitutes an occurrence under a standard CGL policy?

For civil liability policies in general, an occurrence is the event that is claimed to be covered by the insured and either accepted or not by the insurer, according to the respective interpretations of the policy.

The loss event must be random and cannot happen due to the intentional conduct of the insured, pursuant to article 762 of the Civil Code, under pain of nullity of the contract.

17 How is the number of covered occurrences determined?

The determination of the number of events (occurrences) covered basically requires the careful analysis of two points: the maximum indemnity per loss event (or per occurrence), and the aggregate policy limit or ceiling.

Considering the maximum indemnity per loss event (or occurrence), it is necessary to investigate whether there was one cause triggering a series of loss events. Once this cause is identified, then all the events resulting from it will be considered as a single loss event, subject to the indemnity limit per event.

In turn, the aggregate limit is normally set at a value equal to or greater than the limit per loss event (or occurrence), and represents the maximum amount of the indemnity under the contract considering all the loss events that occur during its effective term.

Therefore, these two items must be examined: the maximum indemnity per loss event and the aggregate limit for all loss events.

18 What event or events trigger insurance coverage?

The loss events that are covered by insurance are extremely varied, and of course depend on the type of insurance.

Update and trends

Brazilian mine disaster

Following the collapse of a dam at a Brazilian mine on 5 November 2015, iron ore and sludge from the dam formed tons of toxic mud that destroyed an entire residential neighbourhood in Mariana, leaving 17 people dead, two missing and hundreds more homeless.

The mud damaged other neighbourhoods before reaching the most important river in the region, the Doce River, and destroying its fauna.

It then flowed 800km to the Atlantic, causing more environmental damage and water distribution problems for a number of towns, as well as putting fishermen out of work.

The resulting insurance claim will be the largest in Brazil to date.

New rules on the Brazilian reinsurance market

SUSEP has published Resolution No. 322, which establishes new limits in connection with intragroup reinsurance cessions and introduces new rules for the mandatory offering of insurance risk to local reinsurers. Resolution No. 322 amends Resolution No. 168/07.

In summary, Resolution No. 322 states the following:

- it prohibits local insurers and reinsurers from transferring more than 20 per cent of the premium for each contracted coverage to related companies or companies belonging to the same economic group that are located outside Brazil;
- it stipulates a progressive increase in such percentage as follows:
  - 20 per cent up to 31 December 2016;
  - 30 per cent as from 1 January 2017;
  - 45 per cent as from 1 January 2018;
  - 60 per cent as from 1 January 2019; and
  - 75 per cent as from 1 January 2020.

All other rules applicable to risk cession, such as limitations imposed on cessions to occasional reinsurers, remain in place, and:

- it regulates cession of risks to local reinsurers. Pursuant to prior regulations, insurance companies had to contract with local reinsurers at least 40 per cent of each reinsurance cession, whether through treaties or facultative contracts. While the new resolution maintained the obligation of insurance companies to offer at least 40 per cent of their reinsurance business to local reinsurers, it imposes a progressive decrease of the percentage that must be contracted from local reinsurers as follows:
  - 40 per cent up to 31 December 2016;
  - 30 per cent as from 1 January 2017;
  - 25 per cent as from 1 January 2018;
  - 20 per cent as from 1 January 2019; and
  - 15 per cent as from 1 January 2020.

In a life insurance policy with coverage for natural death, for example, the trigger will be the death of the insured. In turn, in a policy for personal accidents, this will be when the insured suffers a debilitating injury, and in a policy covering property damage (eg, fire insurance), the trigger is the moment of the fire.

With respect to civil liability policies, the identification of the trigger can be more complex and difficult, since the insured's knowledge of the claim by the third party is often outside the control of the insured. For example, in a hypothetical environmental accident causing pollution to a lake, a fishing community can be affected due to the people's consumption (or inability to consume) the fish as well as the lost sales of the excess catch, or even the harm unknowingly caused to the buyers of the fish. It is very hard to predict when and under what circumstances the various claims will materialise, because each human being reacts differently to contaminated fish, in terms of health and of combativeness in seeking indemnification. Therefore, in situations where the exposure of the insurer is accentuated and potentially lengthy, the normal practice is to use claims-made basis policies with limited periods.

In the final analysis, the identification of the trigger in an occurrence-basis policy and in a claims-made basis policy will necessarily be different.

19 How is insurance coverage allocated across multiple insurance policies?

The allocation of risks through various policies can be achieved by co-insurance, which is contemplated in article 761 of the Civil Code. It is a mechanism adopted by the market to disperse large risks by dividing them among a number of insurers, each receiving a commensurate share of the premium.

First-party property insurance

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

The objective is to cover the legitimate interests of the insureds, not the interests of third parties. The most recurrent discussions between insurers and insureds involve whether utmost good faith is present, which both parties must observe, as well as the limitations or exclusions of coverage, aggravation of risk, and any intentional or culpable conduct of the insured.

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

The valuation of the insured's assets is usually done by the insurer through an inspection. Controversies over the right to indemnification (ie, restricted to the loss that occurred) versus the policy limit are frequently addressed by Brazilian courts.

The apportionment clause, which calls for proportional indemnity, is adopted in cases where the insured contracts' coverage is lower than the value of the legitimate interest to be insured, under which the insurer must pay the indemnity in proportion to the guarantee contracted.

In this respect, it is not uncommon for the courts to rule that the insurer, before signing the contract, should have inspected the asset to be protected to avoid divergences and the consequent application of proportional indemnification.

Directors' and officers' insurance

22 What is the scope of D&O coverage?

In Brazil, insurance to cover the liability of executives can still be considered a relatively incipient type of civil liability coverage, but its use has been growing substantially. The aim is to protect the personal assets of the covered executives against damage caused to third parties due to possible errors or omissions in their management functions. Third parties can be, inter alia, minority shareholders, the financial market or investors in general, affiliated companies or external auditors.

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

In matters of D&O insurance, the most common disputes involve the duties of care and of loyalty, which are deemed the main obligations of corporate executives. Whether these duties were satisfied involves the application of the business judgment rule. The analysis of the conduct of executives of listed corporations is mainly under the responsibility of the Brazilian Securities Commission, as well as the courts.

Although D&O insurance was introduced in the Brazilian market in the 1990s, there are relatively few decisions by the higher courts on this matter. One important ruling that can be mentioned is that in Civil Appeal No. 543.194.4/9-00, decided by the 6th Civil Chamber (Reporting Judge Vito Guglielmi) of the São Paulo State Court of Appeal on 11 December 2008. The judges in this case addressed the most important concepts, including mentioning foreign legal doctrine and jurisprudence.

In the case, the insured (the former CEO and main shareholder of a bank) filed suit against the insurer to contest the refusal to pay the indemnity. The judges held that the insurer's refusal to pay was justified because of the plaintiff's failure to observe the duties of loyalty and care, considering that there had been commingling of his assets with those of the bank; the accounting information did not reflect the bank's true financial situation; and the management actions had been mainly tailored to protect the personal interests of the controller, in the person of the former CEO, who held nearly all the capital. Hence, there was a clear conflict of interest, justifying the refusal to pay the indemnity.

Bit by bit, D&O insurance has been growing in recognition in the market, and official data provided by BMFBovespa, the Brazilian Stock Options Market, state that more than 70 per cent of listed companies have already purchased this insurance protection.

Cyber insurance

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

A 'cyber insurance policy' basically provides coverage for first party and third-party losses. If a company that works with e-commerce has its servers attacked by hackers and this completely freezes them, it should be protected against this hazard.

Cyber coverage of third-party claims provides protection to insureds as per the administration of third-party data.

Safeguarding third-party data has become a growing matter of concern to companies, since more and more information is being stored digitally, and the increasing use of cloud computing services is emerging as a trend.

In Brazil, Law No. 12.965/2014 will probably increase the legal liability of civilian agents in this matter.

25 What cyber insurance issues have been litigated?

The following issues may be subject to litigation or controversy:

- defence costs related to the claim;
- violation of the privacy of personal or corporate information under the responsibility of the insured;
- responsibility for the failure to protect data security, which may result in data contamination, denial of access to data, code theft, or even in the destruction, modification or corruption of stored data;
- reinstating of the personal and corporate image in order to mitigate damage to a company's reputation;
- notification and monitoring costs of an eventual data breach that may be required to prevent the dissemination of sensitive data and greater losses caused by the misuse of leaked data;
- extortion resulting from a security threat; and
- loss of profits that the insured may suffer because of a network interruption caused by a data security breach.

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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 on 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 the court of 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. Furthermore, since 30 December 2014, the Fourth Intermediate Court tries the appeals from these four districts. The maritime courts shall hear cases regarding marine insurance claims and related subrogation litigations.

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 inquires 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 of making 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 of making an honest disclosure, the insurer shall bear no insurance obligation with regard to the insured incident occurring prior to the rescission of the contract, or for returning the paid insurance premiums. If an insurance applicant fails to perform his or her obligation of making 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 prior to 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 don't 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. The insurance contract always stipulates that the payment of premiums acts as a condition for the validity of the insurance contract in China.

Complaints to the China Insurance Regulatory Commission (CIRC)
Whether the insured or the beneficiary complains to the CIRC and how the CIRC deals with the complaint shall influence the litigation. In China, the regulator strictly monitors the insurance market, and the CIRC 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 the liability for the delayed payment, which will always consist of the bank interest 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 while establishing the 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 a claim of an insured, or in a situation where the insurer denies a claim that is not fairly disputable according to the terms of an 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 by 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;
- other methods of interpretation;
- systemic interpretation;
- contract aim-based interpretation;
- the utmost good faith interpretation;
- the 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 of 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 the insurance indemnification liability 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 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.

Update and trends

On 25 November 2015, the Supreme People's Court promulgated the Interpretations of the Supreme People's Court on Several Issues Concerning the Application of the Insurance Law of the People's Republic of China (III)(3rd Judicial Interpretation), which entered into effect on 1 December 2015. The 3rd Judicial Interpretation consists of 26 articles that mainly discuss the following six aspects:

- the judicial interpretation explaining the principle of proactively examining insurable interests for personal insurance in order to avoid ethical risks;
- the refining of the articles of the Insurance Law concerning death insurance, while at the same time encouraging insurance transactions in such matter;
- the provision of a more in-depth explanation of the articles of the Insurance Law concerning the obligation of honest disclosure to maintain honesty and credibility, including through physical examinations;
- the conditions that need to be fulfilled to restore the effect of an insurance contract;
- the regulation of the designation and modification of beneficiaries to protect their beneficial rights; and
- the standard clauses in medical insurance that are to be regulated to maintain the balance of considerations.

Additionally, the 3rd Judicial Interpretation regulates issues such as:

- the transfer of the right to claim insurance benefits;
- the payment of insurance benefits as the legacy of the insured;
- the presumption of the simultaneous death of the beneficiaries and of the insured; and
- how intentional crimes should be identified.

The Insurance Law has been amended twice since being enacted in 1995. In 2002, to fulfil China's commitments for joining the World Trade Organization, the standing committee of the National People's Congress revised part of the Insurance Law. In 2009, the standing committee revised the Insurance Law again, significantly altering the provisions relating to the insurance industry and insurance contracts, especially the part regarding insurance contracts.

Following the amendment in 2009, the Supreme People's Court promulgated the 1st Judicial Interpretation of the Insurance Law, which solved the problem of the application and cohesion of the new and old laws. In 2013, the Supreme People's Court issued the 2nd Judicial Interpretation of the Insurance Law to interpret the general provisions in the chapter regarding insurance contracts, which solved the problem of the application of law with respect to the general provisions in said chapter.

Nevertheless, when compared with the insurance laws of some countries, China's current Insurance Law seems relatively sketchy, as it has many provisions and principles that are over-broad, and it lacks detailed or specific provisions. As a result, judges have had more discretion in adjudicating cases. In recent years, however, new conditions and new issues are occurring more and more frequently. Thus, some provisions of the current Insurance Law cannot satisfy the development of the insurance industry in China.

The insurance industry is considered to be exotic in China, and the corresponding judicial practice is therefore not very well developed. Overall, due to this lack of experience, judicial interpretation provides the necessary guidance for the application of the Insurance Law by the courts, the operation of the insurance industry and the activities of consumers.

The 3rd Judicial Interpretation of the Insurance Law and the upcoming 4th Judicial Interpretation of the Insurance Law respectively interpret certain provisions regarding life insurance contracts and general insurance contracts in the chapter regarding insurance contracts, the purpose of which are to solve the problems of its application in judicial practice, satisfy the needs of commercial trials and respond to the demands of the market.

With the development of the insurance industry in China, it is believed that the next amendment of the Insurance Law may focus on the alteration of its provisions regarding the insurance industry, and that there would be no amendment made with respect to the part regarding insurance contracts. By this token, the judicial interpretation would have significant meaning on the part of the insurance contract elements of the Insurance Law. We have reason to believe that the 3rd Judicial Interpretation of Insurance Law will play an important role in China's future judicial practice.

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 is caused by 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.

Directors' and officers' insurance

22 What is the scope of D&O coverage?

Under PRC laws, 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 of D&O insurance generally define D&O coverage as follows in the policy:

- 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;
- 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.

23 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, and the insured will deny the disclosure obligation in such circumstances.

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 in another jurisdiction will be another issue for debate. When the insured was fined or a judgment was 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 argued.

Cyber insurance

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

Currently, as cyber insurance policies are still relatively new in the PRC, Allianz China General Insurance Company Ltd is the only insurance company that offers a cyber insurance policy. The Allianz China General Insurance Company Ltd cyber insurance policy covers a variety of first and third-party damage sustained by businesses in the event that they are the victims of cyber crime or in cases where their customers hold them liable for security breaches. First-party loss, which is covered by the cyber insurance policy, includes business interruption, restoration and crisis communication costs. A third-party loss includes cover for data breaches, network interruption and notification expenses. Furthermore, the cyber insurance policy may also include regulatory costs associated with defence expenditures.

25 What cyber insurance issues have been litigated?

Since cyber insurance is still a new area for PRC insurance companies, and Allianz China General Insurance Company Ltd's cyber insurance product was only launched few months ago, no case has yet been litigated in the PRC concerning cyber insurance issues.

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Colombia

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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 1480 of 2011 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 due to its jurisdictional functions, provided that the controversies are related to the compliance with and enforcement of insurance contracts and not to 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.

There might also be certain preliminary steps in scenarios where the arbitration courts is competent. Some arbitration agreements establish extrajudicial mechanisms that must be fulfilled before the commencement of the arbitration process, and the purpose of these mechanisms is also to find a solution to the dispute. Normally, such mechanisms are conciliation, mediation or an out-of-court settlement.

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.

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.

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

In Colombia, there are no punitive damages; the payment made by the insurer (indemnification) has a contractual origin and is limited, as a general rule, to the insured value and to any default interest where the indemnification was not timely paid, 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:

- 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 due to 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 due to a 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 due to 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 of receiving 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, injury or damages to the health of a person, 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 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 are a number of insurers. 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.

Directors' and officers' insurance

22 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.

23 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

24 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 three 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.

25 What cyber insurance issues have been litigated?

As noted in question 24, 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.

Update and trends

Currently, at the local legal level, issues relating to the suitability of insurance intermediaries, and certifying minimum standards in this respect, are being discussed.

Additionally, the Colombian Financial Superintendency is analysing abusive practices within the insurance industry to provide the adequate defence of financial consumers.

Finally, legal professionals are discussing the application and scope of arbitration clauses within surety insurances aiming to guarantee state contracts, which are currently booming.

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Preliminary and jurisdictional considerations in insurance litigation

1 In what fora are insurance disputes litigated?

The French Insurance Code (FIC) article R.114-1 provides that a dispute related to the determination and settlement of insurance indemnities shall be brought to the court where the insured is domiciled, except when the indemnity relates to goods or real estate, where the case will be heard by the court in the jurisdiction where the goods or the real estate are located.

If the insurance relates to accidents of any type, the insured may bring the case to the court where the event at the origin of the loss took place, in addition to the court in which he or she is domiciled.

2 When do insurance-related causes of action accrue?

Under French law, a party can start an insurance coverage dispute at any time when he or she has sufficient proof of the breach by the insurer of his or her coverage obligation, knowing that the insurer has to carry out his or her contractual duties as provided by the policy upon the date of the loss within the time period provided for in the contract (article L.113-5 of the FIC). That may be when the insured becomes aware of the breach or when the insurer notifies a denial of coverage, although there is no specific rule governing the notification of its position by the insurer.

The only time limit is that the insured has to start its coverage action before the end of the specific two-year limitation period provided for by article L.114-1 of the FIC, pursuant to which any action arising out of an insurance contract (basically, actions instituted by insureds to obtain an insurance indemnity and actions instituted by insurers against insureds to obtain the payment of the premium) has to be initiated within a period of two years as of the event that gave rise to it.

As provided by article L.114-1 of the FIC, the limitation period runs:

- in the event of non-disclosure, omission, fraudulent representation or misrepresentation of the risk incurred, only as of the date on which the insurer is aware of it;
- in the event of loss, only as from the date the concerned parties are aware of it, if they prove that they were not aware of it until then; and
- when the insured's action against the insurer arises from a third party's action, the limitation period shall run only as of the date of the service of the writ by the third party to the insured or as of the date the latter paid it an indemnity.

The limitation period shall be increased to 10 years for life insurance contracts when the beneficiary is not the policyholder and for insurance contracts covering personal injury when the beneficiaries are the deceased insured's assignees.

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

The following procedural and strategic considerations should be taken into account:

The short and specific limitation period for any action arising from an insurance policy

Whereas the most common limitation period to start an action is five years, actions arising from an insurance policy have to be started within a period of two years (article L.114-1 of the FIC).

The two-year period may, however, be interrupted by two causes that are specific to insurance law (article L.114-2 of the FIC): the sending of a registered letter with acknowledgement of receipt by the insurer to the insured for the payment of the premium and by the insured to the insurer for the payment of the indemnity; and the appointment of an expert following the loss.

The two-year period may also be interrupted by civil law causes: a judicial action (even by way of a summary proceeding writ), an act of the debtor who admits the creditor's rights, or an act tending to the payment of a debt (attachment proceedings, summons to pay), such as provided by articles 2240 and 2241 of French Civil Code.

The articles of the FIC on the limitation period (starting point, duration an interruption) have to be inserted in the policy (article R.112-1 of the FIC).

In cases where those articles are lacking, the insurer will not be in position to invoke them. (See for instance, recent case law of the French Supreme Court from 18 April 2013.)

The risk for a civil liability insurer to be notified with a writ by a third-party victim of the insured

According to article L.124-3 of the FIC, the victim has a specific right to the indemnity and the insurer may not pay the compensation of the pecuniary consequences of the insured's liability to anyone else.

From a practical point of view, the victim does not need to serve his or her writ against the insured. The victim must prove, however, first that the insured is liable for the damage, and secondly that the loss falls within the scope of the policy. On that last point, the insurer may deny coverage to the third party on grounds provided for in the policy (exclusions, excess, limits of guarantee) or on grounds related to the existence of the policy itself (nullity, termination, suspension of the guarantee for non-payment of the premium). The insurer may not deny coverage in relation to the third party on the ground that the insured did not comply with one of its contractual duties after the loss (article R.124-1 of the FIC).

The victim may start his or her direct action against the insurer as long as the insured may start an action against the insurer.

The possibility for the insurer to carry out the insured's actions against third parties who are liable for the insured's loss

Pursuant to article L.121-12 of the FIC, the insurer who indemnifies the insured is subrogated up to the amount of the indemnity in the insured's actions against the third parties liable for the latter's loss. The insured keeps his or her right of action for the part of the loss not indemnified (usually corresponding to the excess and the limits of guarantee).

The insurer does not, however, have any recourse against the children, descendants, ascendants, relations in direct line and employees of the insured, except in the case of malevolence committed by one of those persons (article L.121-12 of the FIC).

The insurer does not have to indemnify the insured if the subrogation is no longer possible due to the behaviour of the insured (article L.121-12 of the FIC). This would be the case if the insured were to waive an action or accept an indemnification from the third party liable for its loss.

Last, the insurer will not have any action against the third party if it has not indemnified the insured (for instance, on the ground that the policy is void, or terminated or suspended for non-payment of the premium).

The insurer must check, before taking over the insured's defence, that there is no ground for denial of coverage

Indeed, pursuant to article L.113-17 of the FIC, the insurer who takes over the insured's defence is deemed to have waived all grounds for denial of coverage it is aware of.

This implies that the insurer must express clear and precise reservations on any denial grounds it may invoke.

Those reservations may relate to:

- the nullity of the policy;
- the termination of the policy;
- exclusion on the ground that the insured deliberately breached its duties (provided for in article L.113-1 and 2 of the FIC);
- contractual exclusions; and
- forfeiture of coverage due to the insured's breach of the contractual duties set in the policy, after the loss.

Class action

The Act of 17 March 2014 Act (called the Hamon Act) introduced the notion of class action into French law. This action is now governed by articles L.423-1 to L.423-26 of the French Consumer Code and is an opt-in class action. A consumer association may now start an action for the indemnification of the loss incurred by each of its members individually (article 1 of the Act of 17 March 2014). For instance, insureds may start an action against an insurer who would have distributed documents causing them a loss.

4 What remedies or damages may apply?

The insured is entitled to obtain the coverage indemnity plus late payment interest at a rate fixed by law, usually as of the date of the first request to obtain payment.

The insured is also entitled to obtain damages in compensation of the loss created by the late payment or the wrongful denial of coverage, pursuant to article 1153 of the Civil Code, in the case of the bad faith of the insurer.

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

In the framework of the insurer–insured relationship, extracontractual damages may be awarded to the insured in cases where the insurer is found guilty of an extracontractual breach, such as an unfair breakdown in the negotiating process, based on article 1382 of the French Civil Code.

French law does not allow the award of punitive damages.

French civil liability policies cover the consequences of both tort and contractual liability. Punitive damages are always excluded.

Interpretation of insurance contracts

6 What rules govern interpretation of insurance policies?

The rules governing the interpretation of an insurance policy are:

- article L.133-2 of the Consumer Code, which provides that contract terms proposed by professionals to consumers or non-professionals must be presented and written in a clear and comprehensible manner. In the event of doubt, they are interpreted in the sense that is most favourable to the consumer or the non-professional (ie, the insured in the case of an insurance contract);
- the contract interpretation principles provided for by articles 1156 to 1164 of the Civil Code:
  - search for the common intention of the parties rather than the literal meaning of the terms;
  - when the clause has two meanings, the meaning to be taken into account is the one having some effect rather than the one having no effect or the one that best suits the subject matter of the contract interpretation by use;
  - all terms have to be interpreted with reference to one another; and
  - interpretation against the one who has stipulated and in favour of the one who has contracted the obligation; and
- the parties' behaviour.

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

An insurance policy provision is ambiguous notably when it contains terms that can be understood in different ways, it has an absurd meaning or it has to be interpreted.

The ambiguities are resolved by:

- referring to the common intention of the parties;
- a literal interpretation;
- a useful and logical effect of the contract; or
- interpretation in the sense that is most favourable to the insured.

Notice to insurance companies

8 What are the mechanics of providing notice?

The insured is under a duty to notify the risk, modification of the risk, and any claim or loss (article L.113-2 of the FIC):

- article L.113-2, 2 of the FIC provides that the insured must answer the questions asked by the insurer with precision, notably in the risk notification form provided for by the latter upon underwriting of the contract whereby the insurer questions him or her on the circumstances in order to assess the covered risk;
- article L.113-2, 3 of the FIC provides that the insured must notify during the contract (except for a life insurance contract), by registered letter, new circumstances that have the effect of either increasing the risks or of creating new ones and that on this account make the answers in the form referred to above either untrue or lapsed; and
- article L.113-2, 4 of the FIC provides that the insured must inform the insurer of any loss that may trigger coverage (except for life insurance contracts).

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

There is no specific obligation in the case of a claims-made policy.

10 When is notice untimely?

The notification of risk modification or of new risks has to be made by registered letter within a period of two weeks as of the date when the insured becomes aware of it (article L.113-2, 3 of the FIC).

Article L.113-2, 4 of the FIC provides that the notification of a loss has to be made as soon as the insured is aware of it and no later than the time set in the contract. This time may not be less than five working days except in the event of theft (when the time is reduced to two working days) and livestock mortality (the time is reduced to 24 hours). The above times may be extended by mutual agreement of the contracting parties.

11 What are the consequences of late notice?

Pursuant to article L.113-2, 4 of the FIC, when provided for in a clause in the policy, the insurer may deny coverage in the case of late notification of modified risks, new risks or a loss, if it proves that the late notification made it incur a loss. Coverage may not, however, be denied if the delay results from an accidental case or force majeure.

The insured may even be time-barred from claiming an indemnification if he or she notifies a loss two years after having discovered it or two years after having been served with a writ by a third party (article L.114-1 of the FIC).

Insurer's duty to defend

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

An insurer is not bound under French law to defend its insured.

Pursuant to article L.113-17 of the FIC, an insurer has the possibility (and not the obligation) to take over and direct the insured's defence. In such a case, the insurer is deemed to have waived any denial of coverage clauses it was aware of when it took over the insured's defence.

Insureds have, however, the possibility to underwrite specific policies, called legal expenses insurance policies, whereby the insurer undertakes to defend the insured or represent him or her as a plaintiff in the event of a dispute between the latter and a third party (article L.127-1 et al of the FIC).

That specific cover shall be separate from that drawn up for the other insurance classes or in a separate chapter of a sole policy that specifies the content of the legal expense insurance and the relevant premium.

All legal expense insurance contracts shall explicitly stipulate that when a lawyer or any other person qualified under current law or regulations is called on to defend, represent or serve the insured's interests in the circumstances, it is provided for in article L.127-3 that the insured shall be free to choose such person.

The contract will also stipulate that the insured is free to choose a lawyer or, if he or she prefers, a qualified person to assist him or her whenever a conflict of interest arises between him or her and the insurer.

No contract clause shall interfere with the insured's freedom of choice, within the cover limit, under the previous two paragraphs.

The insurer may not propose the name of a lawyer without being requested to do so by the insured.

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

If the insured underwrote a specific legal expenses insurance, and if he or she brought contentious proceedings at his or her expense and obtained a more favourable solution than that proposed by the insurer, then the latter shall indemnify the insured for the costs incurred in bringing such legal action within the limit of the cover amount (article L.127-4 of the FIC).

Standard commercial general liability policies

14 What constitutes bodily injury under a standard CGL policy?

Bodily injury is defined as any physical harm to a person.

15 What constitutes property damage under a standard CGL policy?

Property damage is defined as any destruction, degradation or deterioration of a property or substance, or any harm to animals.

Property damage is to be distinguished from immaterial damage defined as a pecuniary loss of a third party, and consequential to a covered property damage or bodily injury resulting in the loss of enjoyment of his or her rights, due to the interruption of a service or from a loss of profit.

16 What constitutes an occurrence under a standard CGL policy?

An occurrence constitutes an event causing liability.

17 How is the number of covered occurrences determined?

Pursuant to article L.124-1-1 of the FIC, a set of events causing liability that have the same technical cause shall be assimilated into one event causing liability.

18 What event or events trigger insurance coverage?

Under article L.124-5 of the FIC, the cover shall be, according to the choice of the parties, triggered either by the event causing liability or by a claim. However, where it covers the liability of natural persons outside their professional activity, the cover shall be triggered by the event causing liability.

19 How is insurance coverage allocated across multiple insurance policies?

If two or more policies cover the same damage (same risk and same interest), indemnity payments are allocated alongside the provisions of article L.121-4 of the FIC. This article is usually referred to in the general conditions of any policy.

If the policies have been underwritten in a fraudulent manner, the insurers are entitled to start an action against the insured to declare the policies null and void and be granted damages.

If the policies have been underwritten without fraud, each policy is valid within the limit of the value of the insured property. The insured may, in such a case, contact the insurer of its choice and obtain payment of the full amount covered. Indeed, pursuant to article L.121-1 of the FIC, the indemnity paid by an insurer cannot exceed the value of the property at the time of the loss.

Insurers' contributions between themselves are then determined by applying to the amount of the loss the ratio between the indemnity that each would have paid if they had been alone and the total amount of the indemnity that each insurer would have borne if it had been alone (article L.121-4 of the FIC).

In any case, the insured must immediately inform each insurer of the existence of the other insurers, and gave each of them the name of the other insurers and the covered amount (article L.121-4 of the FIC).

First-party property insurance

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

The scope of first-party property coverage is to cover the property (moveable and immoveable property) of an insured pursuant to covered events such as fire, water damage, storms, hail, snow, machinery breakdown, terrorism and natural disasters.

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

Property valuation usually takes into account the wear and tear on the property.

Immoveable property is usually valued by taking into account the reconstruction cost on the date of the loss, less a depreciation for wear and tear, and plus the architect's fees.

Moveable property is usually valued by taking into account its replacement value on the date of the loss less depreciation for wear and tear.

Some policies do provide cover for a 'value as new' assessment.

Directors' and officers' insurance

22 What is the scope of D&O coverage?

The object of D&O policies is to provide cover:

- to directors and officers (reimbursement or payment to the third party) of a company and its subsidiaries for the pecuniary consequences of their individual or joint civil liability resulting from any professional wrongful act, actual or alleged, committed in their capacity as directors and officers;
- to the underwriting company (reimbursement) when it has taken over the pecuniary consequences of its directors' and officers' individual or joint civil liability resulting from any professional wrongful act, actual or alleged, committed in their capacity as directors and officers; and
- for the directors' and officers' defence costs exposed before a civil, administrative, arbitral or criminal court.

Cover is provided for claims notified to the de jure or de facto directors and officers (as well as, depending on policies, some committee members, financial managers and appointed commissioners of the firm) during the policy period or during a specific subsequent five-year period pursuant to wrongful acts (notably, any breach of law, statutes or rules, and any management errors, omissions or misstatements) committed before the termination of the policy.

Cover may be extended to:

- defence costs incurred jointly by the underwriting company and the directors and officers;
- individual persons empowered by the underwriting company or its subsidiaries in another company that is not a subsidiary;
- defence costs linked to an investigation against the underwriting company;
- rehabilitation costs incurred by a director pursuant to a covered claim;
- psychologists' fees paid by a director pursuant to a covered claim; and
- legal entities in their capacity as directors and officers of the underwriting company and its subsidiaries.

Any personal advantage, a wrongful act deliberately committed, fines, taxes, penalties, bodily injury, property damage, financial consequences of damage where the insured had knowledge of the wrongful act upon underwriting of the policy and punitive damages are excluded from coverage.

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

The following issues are commonly litigated in the context of D&O policies:

- liability faced by directors and officers of a company where the liabilities are superior to its assets. In such a case, the receiver may start an action against the de facto or de jure directors who have contributed to the excess of liabilities over the assets if such directors and officers have committed a management fault having contributed to that excess of liabilities. The debts of the company are then borne, in whole or in part, by all or some of the de jure or de facto directors. If there are several directors, the court may declare them jointly and severally liable (article 651-2 of the Commerce Code); and
- liability faced by directors and officers pursuant to actions instituted by shareholders on behalf of the company based on a management fault, provided for by articles L.223-22 and L.225-252 of the Commerce Code.

Cyber insurance

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

The following cyber risks are covered in cyber insurance policies:

- malicious acts;
- computer viruses;
- hacking;
- economic or industrial espionage;
- theft of personal data;
- malicious acts by employees;
- extortion of funds;
- defamation of the character of people or organisations, and reputational damage;
- identity theft; and
- network inoperability.

Preventive measures and support may be provided under such policies.

Update and trends

The following topics are currently being discussed in France:

- the possibility of introducing class actions under the March 2014 Harmon Act;
- the expansion of alternative dispute resolution, in particular mediation; and
- an increase in the level of protection of insureds under the the March 2014 Harmon Act through:
  - the possibility of terminating car and home insurance contracts after one year, or within a year for loan insurance contracts; and
  - the possibility of cancelling an affinity insurance contract if the risk is already covered.

25 What cyber insurance issues have been litigated?

To our knowledge, no cyber insurance issues have been litigated to date.

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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 prior to 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 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 prior to 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 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 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 who drafted the provision (section 305c paragraph 2 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 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 after the insured event occurred. 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 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 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 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 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 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 airplanes;
- 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.

Directors' and officers' insurance

22 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).

23 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 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).

Cyber insurance

24 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.

25 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.

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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 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 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 629 district consumer disputes redressal commissions, which can accept claims up to a value of approximately US$ 29,500. There are 35 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.

In a recent move aimed at the quick resolution of commercial disputes, the government enacted the Commercial Courts, Commercial Division and Commercial Appellate Division of High Court Act, 2015 (Commercial Courts Act), which mandates the creation of commercial courts at the district level and a commercial division in the high courts for exclusively hearing commercial disputes. The 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.

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 applicability of exclusions or compliance with the policy terms and conditions. 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.

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 paperwork 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.

Important changes have been introduced by the Commercial Courts Act, which removes the statutory limits for costs, thereby allowing costs to be awarded in accordance with the actual expenditure incurred by the winning party. However, awarding of costs is not compulsory and is 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. 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. The other option that is more applicable to insurance disputes is calling for deposits.

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. Even in contracts where the damage amount is stipulated, courts will examine whether the amount stipulated is in the form of a penalty, and can reduce such 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* AIR1963SC1405, 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, since 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 in order 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. The most recent Supreme Court decision 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 be a situation where 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.

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. The notice can be required to be given by way of post, email or facsimile, and the name and address of the person to whom the 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 should contain a summary of the matter including the details of its inception, 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: 'As 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'.

Recently, 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.

In practice, 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 due to unavoidable circumstances. This is the position that the Indian Insurance Regulator (IRDA) has also recommended in its circulars, where insurers were directed not to reject claim unless and until the reasons of 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 IRDA 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.

Recently, however, 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.*

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 who use a duty to defend clause in their policies have the obligation to manage the litigation process from the initiation 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 is 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 forth 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.

18 What event or events trigger insurance coverage?

This will be dependent on the wording of the insuring clause in a policy. By way of illustration, cover under a D&O policy will be triggered if there is a claim (written demand, suit, complaint) made against a director or officer of a company who has taken out the policy.

19 How is insurance coverage allocated across multiple insurance policies?

Policies usually contain another 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.

Directors' and officers' insurance

22 What is the scope of D&O coverage?

D&O policies typically taken out by companies provide cover for the following:

- the personal liability of directors and officers of the company (policyholders or the company's subsidiaries arising due to wrongful acts in their managerial capacity);
- the personal liability of a director outside the entity (company's director or officer who has been asked to serve as a director or officer of another company) arising due to wrongful acts in their managerial capacity; and
- the amounts paid by the company for losses caused by directors and officers of the company arising due to wrongful acts in their managerial capacity.

The scope of the cover may be extended by way of endorsement to cover the company for securities actions made against the company and employment practice violations.

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

We have not seen much litigation in the context of D&O policies in India. In addition, D&O policies typically have an arbitration clause, so most disputes would first be referred to an arbitral tribunal. Unlike in other jurisdictions, such as the United States, we have not seen disputes being raised in India in respect of allocation, scope of cover and coverage for a claimants' attorneys' fees.

Cyber insurance

24 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.

25 What cyber insurance issues have been litigated?

There has been very little or no litigation in the context of cyber liability insurance policies in India.

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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 8–13) of Council Regulation (EC) No. 44/2001 of 22 December 2000 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. The EU Court of Justice, in judgment No. 6 dated 13 December 2007-C463, interpreting Regulation (EC) No. 44/2001, 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. 44/2001 of 22 December 2000, 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 two main preliminary procedural and strategic considerations to be carefully considered when an insurance litigation becomes a reality: 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?; and is the case suitable for a declaratory relief action, or it is better to adopt a passive attitude and wait to be sued?

4 What remedies or damages may apply?

When insurance disputes are litigated, the parties can chose 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 rate for 2014 was as low as 0.5 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 2015 and the early months of 2016, the annual rate should be 8.05 per cent. For the remaining months of 2016, the level will vary 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 due 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.

As consequence , currently it is 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', and hence thoroughly regulated by the Civil Code. Articles 1360 to 1371 of the Civil Code dictate subsidiary 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 clarification.

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 pre-printed 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.

To the contrary, whenever the insurance contract is in a pre-printed 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 who drafted the policy wording.

Notice to insurance companies

8 What are the mechanics of providing notice?

Once an insured event has taken place the insured, unless the insurer or reinsurer has already had notice of the loss, in accordance with article 1913 of the Civil Code, within three days from the day on which he or she became aware of the loss occurrence, shall inform the insurer or reinsurer of such event.

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 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 should totally omit to give 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 due to the fact that the policyholder withheld his or her consent to the settlement.

Should the sub-limit for defence costs be exhausted while the case is still 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 ones. 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 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 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 just 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

Update and trends

On 19 November 2015, the Parliament's Social Affairs Committee approved a bill on medical professional liability, and it is almost certain that it will be licensed during 2016.

The bill introduces the compulsory management of health risks, providing that all medical structures shall activate adequate monitoring, prevention and risk management functions. Such activity shall be coordinated, and structures will work with centres for clinical risk management and patient safety, which will be set up in each region. These centres will be in charge of collecting regional data on litigation and medical malpractice, and will transmit them to the national body of reference at the Ministry of Health.

Following the path opened up by leading judgment 17/07/2014 of the first section of the Milan Tribunal, the bill moreover confirms that medical malpractice involves an inversion of the burden of proof borne by the patient, who shall prove the medical error, and reduces the statute of limitations from 10 to five years for actions brought against doctors, leaving untouched the 10-year statute provided for actions on contracts against hospitals.

Two major innovations are the enlarging of the scope of the contractual liability of structures for medical malpractice acts committed by self-employed doctors within any public or private health facilities, as well as by way of telemedicine; and the exclusion of self-employed doctors from tort liability.

If the legislation should be approved as it stands, it will provide some peace of mind to physicians and their insurers, as it should have a positive impact upon the number of cases being brought against them as well as sensibly reducing the level of medical malpractice awards made to patients.

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 policy, that the policyholder caused 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 are 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.

Directors' and officers' insurance

22 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.

23 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 due to 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 bankruptcy claims, defamation, mobbing and harassment.

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

24 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.

25 What cyber insurance issues have been litigated?

Recently, a few high-profile data breaches have caused the party who suffered the breach to litigate with his or her 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.

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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 often are 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 prior to 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 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 is notice 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 due to exposure to a harmful substance for quite 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 interpretations 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 Act (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 moveables, 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.

Directors' and officers' insurance

22 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.

Update and trends

The 2014 Law Amending the Insurance Business Law (Law No. 45, 2014) has been enacted in several steps, and the last part will take effect as of 29 May 2016. The amended law will clarify or strengthen the obligations inherent in insurance distribution, such as agents' obligations to secure internal control systems regarding solicitation conducts, customer data protection and service vendor management. In civil lawsuits where the plaintiffs accuse insurers of 'mis-selling', the plaintiffs would have to establish negligence on the part of the insurers. Failure to observe the administrative obligations under the amended law generally by insurance agents would be considered as a fact to establish negligence in mis-selling lawsuits, although it should not be decisive in establishing negligence against an individual plaintiff.

23 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 due to his or her action 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 prior to 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

24 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 adverse the effects of data divulgence or cyber attacks. An endorsement to cover losses and expenses caused by network interruption is available as an option.

25 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.

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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 Code (KCC), 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 KCC). (The part of the KCC regarding insurance was revised on 11 March 2014, and the revised KCC became effective as from 12 March 2015. The revised KCC is explained in the relevant parts below.)

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 KCC). In other words, under the KCC, 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, since 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 expiration of the three-year time bar period if it is drawing close (the three-year time bar period as per article 662 of the revised KCC, which became effective as from 12 March 2015; the time bar period for an accident that occurred before 12 March 2015 is two years under article 662 of the old KCC).

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 KCC.)

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 to an amount below the maximum amount of 100 million won set by court (as from 1 March 2015). 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 KCC, the Regulation of Standardized Contracts Act (RSCA) or the Korean Civil Code, etc, will apply. The RSCA is a distinctive Korean law applying to all standardised contracts, including insurance policies.

Under article 638-3 of the revised KCC, 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 RSCA, in the event of the insurer's violation of its duty to explain a clause, 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 KCC), 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 KCC.)

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 KCC). If the policyholder notifies the insurer of the accident after expiration 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 due to late notice (article 657, section 2 of the KCC). 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 KCC). 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 KCC 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 KCC). 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 KCC).

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 due 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.

In determining 'one occurrence', whether there is a unity in terms of cause, locality, time and intent will be the important standard.

18 What event or events trigger insurance coverage?

The insurer shall indemnify the following damages, according to 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 damages 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 damages 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) exceed the damages.

According to article 672, section 1 of the KCC, 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.

Update and trends

With the aim of providing prompt and fair aid to victims of environmental pollution, the Act on Aid and Compensation of Damages for Environmental Pollutions came into effect as from 1 January 2016, under which business operators operating facilities that have a high risk of creating environmental pollution are obligated to carry environment liability insurance as from 1 July 2016. Business operators will bear strict liability for any environmental pollution damages that they cause, but their liability can be limited 200 billion won.

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 moveables) 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 KCC, 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 KCC, 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 KCC).

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 tear and wear. 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 KCC).

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.

Directors' and officers' insurance

22 What is the scope of D&O coverage?

A D&O insurance policy offers indemnification in respect of the sums the insured persons, as directors or officers, become legally obliged to pay to a victim as damages in connection with their business conduct (including omission) due to a claim by the victim against the insured raised within the territorial limit of the policy, according to the general and special conditions of the policy. According to the terms of the policy, suing and labour costs and the legal costs (court costs, lawyers' fees, etc) will also be covered.

23 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 KCC, 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 KCC regarding the liability.

Cyber insurance

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

Widely used in Korea, e-Biz liability insurance covers an insured's risks of liability (to a third party) arising from acts in relation to his or her internet and network activity. Personal information protection liability insurance is also available, and covers the risks of liability (to a third party) due to a leakage of personal data that are owned, used or managed by the insured in the course of the performance of his or her services. Finally, e-banking liability insurance, which financial institutions and electronic financial business operators are obligated to purchase and which covers their risks of liability regarding customers who have suffered loss due to hacking or computer problems, etc, is also available.

25 What cyber insurance issues have been litigated?

In one case, a hacking incident occurred on an internet open market server, and the names, residence registration numbers, mobile phone numbers, email addresses, etc, of its members that were stored in the server were stolen. In another case, the personal information of applicants on an online job application site were leaked to the public by way of a link file made by a third party.

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Preliminary and jurisdictional considerations in insurance litigation

1 In what fora are insurance disputes litigated?

Insurance disputes are litigated in the civil courts.

The choice of civil court depends on the value of a dispute:

- the Magistrate's Court has jurisdiction to hear matters valued at up to 100,000 ringgit;
- the Sessions' Court has jurisdiction to hear matters valued up to 1 million ringgit; and
- the High Court has jurisdiction to hear matters above 1 million ringgit.

Any appeals will go to the next higher court. The Court of Appeal has jurisdiction to hear appeals arising from the lower courts, while the apex Federal Court will only hear appeals where the court of first instance was the High Court.

Insurance contracts may include an arbitration clause, in which case a dispute should be referred to arbitration.

Alternatively, reference to mediation may be an option to resolve a dispute. The Financial Mediation Bureau will hear most types of insurance disputes valued up to 100,000 ringgit.

2 When do insurance-related causes of action accrue?

Generally, tortious and contractual disputes have a limitation period of six years from the date the cause of action accrued; therefore, claims must be filed before such period has elapsed, failing which the claim is time-barred.

For liability insurance (eg, a claim of professional negligence), time starts to run from the time the insured can reasonably anticipate the possibility of an impending claim.

For other insurance policies such as motor vehicle, fire, and burglary policies, the cause of action arises at the point of the event (eg, on the date of the accident, fire or burglary).

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

The following is a non-exhaustive list of considerations that should be accounted for when initiating litigation:

- time limitations: tortious and contractual disputes have a limitation period of six years from the date the cause of action accrued so claims must be filed before such period has elapsed, otherwise the action is time-barred and the litigant will lose any recourse to the court;
- forum to hear the dispute: the insurance contract may provide an arbitration clause, mediation clause or a clause that requires party to first negotiate before proceeding with a legal action;
- the claims notification process: whether the insured notified the insurer of the loss in a timely manner according to the terms and conditions;
- factual basis: supporting documents and proof of loss: consideration must be given to whether supporting information required to prove the claim can or has been obtained. This includes documents, photographs, witness accounts or statements, and expert or police reports available;
- the legal basis: consideration must be given first to whether there is a legal basis to claim, namely, in what way has the other party breached a contract or caused a loss? If the matter is between the insured litigant and the insurer, then the insured should consider whether it has followed the necessary procedure in the insurance contract and whether it is premature to make a legal claim. Particular focus should be given to exclusion clauses and whether an exclusion clause applies. If the insurer is defending, then it should be considered whether the claimant or plaintiff has breached the contract in any way, or whether they have provided all the required claim documents for the insurer to make a decision on whether to pay for the claim. Particular attention should be paid to whether the insured disclosed all material facts surrounding the claim prior to the occurrence;
- if a third party is intent on making a claim, thought should be given to which party should be sued. This could be the insured (the party at fault for causing the loss), the insurer (the party who will eventually pay for the loss) or, in some cases, a broker who brokered the insurance coverage (and likewise, the broker's insurer);
- financial exposure: a litigant will not only be paying for his or her own legal representation; if the litigant loses, the court will likely order that the litigant pay for the winning party's costs. If the dispute has to be arbitrated, the litigant may also have to pay for the arbitration tribunal's legal costs and any expenses incurred;
- length of proceedings: litigation proceedings may take years depending on the complexity of the matter. Consideration should be given to whether the litigant is prepared to go through such a lengthy process;
- counterclaims: the insured litigant may make a claim for damages, and the defending insurer may decide to counterclaim. A typical counterclaim would be for a declaration from the court that the insurer is not required to pay;
- appeals: if the litigant wins, the other party may appeal. This will incur further costs;
- out-of-court settlements: the insurer may make an offer to the insured to settle the matter without resorting to litigation. Consideration should be given to whether the offer is realistic and fair, taking into account the time and cost that traditional litigation may incur;
- future relationship with the insurer: the insured may have several insurance policies with the insurer. Legal proceedings often have a detrimental effect on the relationship between the parties that could affect the efficacy of any possible future payout. Insurers have the discretion to give ex gratia payments, but an insurer may be unwilling to do so if the insured has been a difficult client; and
- other insurance: an insured may have multiple policies, and there could be some overlap in coverage. Consideration should be given to how the policies overlap and apply and interact with each other. A policy may require the insured to notify if litigation is pursued or for any other reason.

4 What remedies or damages may apply?

Often, the most desirable and practical remedy for an insured or third party is monetary compensation for reinstatement, repair or indemnity of the loss. A claim should also include a claim for interest on a court order (statutory interest is fixed at 5 per cent per annum).

For personal injury matters, the injured party may also apply for general damages, loss of amenity, and pain and suffering.

For the insurer, a normal claim would be for the court's declaration that it is not required to pay for any loss that might be claimed by the insured. The insurer will normally ask for such a declaration in the form of a counterclaim.

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

The Malaysian judicial system is restricted in granting punitive or exemplary damages. It is exceedingly rare for punitive or exemplary damages to be given in a contractual dispute.

Interpretation of insurance contracts

6 What rules govern interpretation of insurance policies?

Insurance policies are contracts. Therefore, the Contracts Act 1950 applies.

The Financial Services Act 2013 (FSA) governs the supervision of financial institutions, including insurance businesses, payment systems and other relevant entities; has oversight of the money market and foreign exchange market to promote financial stability; and is responsible for related, consequential or incidental matters.

Under the FSA, insurance businesses are subject to regulation by the central bank of Malaysia, Bank Negara Malaysia. Bank Negara Malaysia has the power to release guidelines and regulations governing the insurance industry in Malaysia. However, Bank Negara Malaysia does not make decisions on the interpretation of insurance policies.

Malaysian law is also made up of the common law, and the rulings of the courts will affect the interpretation of insurance policies. As Malaysia is a former Commonwealth country, rulings of the courts of other Commonwealth nations, particularly England and Wales, Singapore and Hong Kong, are persuasive in aiding a court's decision on interpretation of insurance policies.

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

Such provision is usually ambiguous when a term is left undefined and several possible interpretations and outcomes are possible. The insurer may give a certain meaning to a provision that the insured could disagree with. In such case, the only avenue to decide on the ambiguity is via the judicial system or arbitration.

A court would look at several aspects in making a decision:

- the natural meaning of the words;
- by looking at the evidence of previous correspondence between parties, if the words were discussed;
- within a commercial contract, the court will try to give the words a meaning that promotes business efficacy. In particular, the court may consider whether there could be an implied term based on the actions of the parties or based on how the insurance industry normally operates, or both; or
- by reference to the contra proferentum rule.

Notice to insurance companies

8 What are the mechanics of providing notice?

Notice should be given to the insurance agent, or to the insurer directly. The insurer may sometimes provide an initial claims notification form on its website wherein the insured only needs to provide basic information about the claim, such as the nature and date of the event.

There is usually a secondary, more comprehensive, claims notification form to be filled out thereafter when fuller details of the facts causing the claim are available. The claims notification form should be accompanied by the supporting documentation (ie, death certificate, police reports, photographs, doctors' records, estimates from workshops).

Each insurer sets out different requirements when providing notice, and the insured should always inquire as to the details and claims process when obtaining the insurance.

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

The insured or policyholder's first obligation is to notify the insurer of the claim or, in some cases (eg, professional indemnity insurance), of a potential claim. Particular care should be given to ensuring that the notice is given within the contractually provided time limit. It is common that the insurer will require the insured to notify 'as soon as possible' or 'immediately' after the occurrence or within a given time period (eg, 30 days from the date that the loss was incurred or within 90 days of the insured being made aware of a potential claim for negligence).

The policyholder should without delay provide the necessary supporting documentation or any documents requested by the insurer to process the claim as and when they become available.

10 When is notice untimely?

When the notice is given past the contractually provided date. If there is no date (eg, where the insurance contract provides that notice should be made 'as soon as possible'), then when there is significant delay before notice is given.

11 What are the consequences of late notice?

The insurer may repudiate the contract or refuse to pay for the particular late notification claim. In some circumstances, an ex gratia payment could still be made by the insurer, but this is extracontractual and at the sole discretion of the insurer.

Insurer's duty to defend

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

The insurer is under no general duty to defend. Insurance contracts may include a clause that provides that the insurer may pay for litigation expenses and any award or settlement thereof. It is commonplace for such an insurance contract to also include clauses providing that the insured subrogates its legal rights to the insurer, and that the insured will not make any admission or agree to any settlements. A breach of this term may allow the insurer the right to refuse coverage. The insurer will also appoint its own legal representatives.

The subrogation clause will provide that when the insured is compensated by the insurer, the insured will give up its legal rights to seek compensation from a tortfeasor (the party causing the damage), thus allowing the insurer to make the claim on the insured's behalf.

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

Once the insurer has invoked the subrogation clause, it will cover any order for payment made in the claimant or plaintiff's favour. The insurer may have decided against defending a claim because litigation expenses may be more costly than paying the claimed sum; in this case, this is an economic decision that the insurer has the right to take.

This is not always straightforward; for example, some insurance policies include a clause that provides that the insurer will pay expenses to maintain public relations. Hence, if a claim is not simply monetary, but could affect the reputation of the insured (ie, a defamation proceeding), matters may be more complicated. The insurer may deem it more viable to pay for a claim, but the insured may want to defend in order to protect its own reputation, which is something that it cannot recover with only a monetary payout from an insurer. If the insured decides that the insurer has breached its duty by failing to adhere to the public relations clause wherein it would pay for expenses to defend the insured's reputation, the insured may then file a claim against the insurer for compensation of the costs incurred in defending the defamation suit.

In professional indemnity insurance contracts, there is normally a provision that the insured is required to notify the insurer of any potential claims for negligence. A failure to notify in a timely manner would allow the insurer to refuse to defend and cover the claim.

Standard commercial general liability policies

14 What constitutes bodily injury under a standard CGL policy?

'Bodily injury' under a standard CGL policy should be defined in the terms and conditions. It would usually include any injury, death, illness, disease, sickness, psychological injury, emotional distress and nervous shock. This is only a description and is not exhaustive; it is not a legal definition.

CGL policies usually cover the insured against public liability or third-party claims, and are not designed to cover the insured's own property or employees.

15 What constitutes property damage under a standard CGL policy?

Property damage should be described in the terms and conditions, and may vary. Generally, it would cover physical damage or destruction or loss of use of any tangible property. CGL is not meant to cover the property of the insured, only that of a third party. This is only a description and is not exhaustive; it is not a legal definition.

16 What constitutes an occurrence under a standard CGL policy?

An occurrence should be properly defined in the terms and conditions. As a general rule, it is defined as an accident, including continuous or repeated exposure to substantially the same general harmful conditions.

Occurrence for personal injury would be different from occurrence for property damage. These should be defined individually and will require different supporting documents for any claims.

17 How is the number of covered occurrences determined?

The determination is usually provided by the insurer, and could vary according to the insurance contract.

Multiple actions within a period of time (eg, three days) may be seen as a single occurrence. Therefore, even if multiple claims are made, these may be aggregated into a single claim, and consequently, the limits of indemnity are only for a single claim. For example, an earthquake and any following aftershocks over the three days following the earthquake may be formed under a single occurrence even if the aftershocks caused further damage that did not occur during the initial earthquake.

The determination of an occurrence is dependent on the facts, and on whether the multiple claims arise from the same cause or the causes are independent.

18 What event or events trigger insurance coverage?

This would be provided for in the insurance contract. Coverage may only be triggered when an occurrence takes place, after the loss; this is known as 'losses-occurring'. In a claims-made policy, the trigger may be when the notice of a claim is served.

19 How is insurance coverage allocated across multiple insurance policies?

The allocation of which policy a particular claim falls under may be decided by the insurer.

If multiple policies are covered by multiple insurers, it could depend on the insured to decide which insurer it wishes to claim from for a particular loss, as claiming from difference insurances may grant different advantages.

An insurance contract may provide for how it will interact with other overlapping contracts.

First-party property insurance

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

Also known as comprehensive property insurance, this covers loss or damage to property and contents caused by fire, lightning, explosion, flood, damage from burst pipes, animals and vehicles. It would also usually include compensation for injury resulting from theft or by fire, and for liability to third parties for accidents on the property.

The insured should also carefully consider the limitations of general first-party property insurance because it usually limits the value of compensation of the contents of the property. It is commonplace for an insurance contract for homeowner's property insurance to state that no item within the property is worth more than 5 per cent of the total compensation. If the insured has a particularly valuable item on the property, separate insurance should be obtained for that particular item to cover it in full for any loss.

Numerous exclusions are applicable. The insurer will exclude any loss arising from wilful damage and arson, fraud and mysterious disappearances. There could also be a requirement that to claim for a loss due to theft or burglary, forceful entry must be evident. Exclusions for terrorism and war are common.

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

In an unvalued policy, the property, and in particular its contents, are usually subject to an average, meaning that if at the time that the loss and damage occurs the insured item is worth less than the full sum insured, the proportionately lower sum reflecting the insured item's value will be paid out.

If the value of rebuilding a property is more than the insured sum, only the maximum insured sum may be paid. Inflation and the subsequent increased cost of rebuilding should be accounted for when considering how much to value the property at.

After obtaining insurance, if the insured makes a claim, the insurance company may engage a qualified surveyor or adjuster to survey and report on the estimated value of the property. The report will be taken as is unless the insured disputes this. The insured should then obtain its own valuation.

Update and trends

In the landmark case of *Best Re (L) Limited v ACE Jerneh Insurance Berhad* [2015] 5 MLJ 513, the Court of Appeal, in deciding a novel question of law pertaining to the interpretation of a reference of incorporation of an arbitration clause in a reinsurance agreement, held that if a contract makes a general reference to and incorporates the whole of a separate document (eg, 'follow the terms and conditions of Document A'), then the contract will effectively incorporate all the terms and conditions, including the arbitration clause.

The effect of this decision reaches beyond the realm of reinsurance and potentially affects a contract as a whole. Parties should be aware that if a document is incorporated by a general reference, clauses must then be specifically excluded. Parties should be alert as to how a contract is drafted, especially when there is reference to a separate document.

Further, this decision steps away from the strict approach applied by the English courts requiring specific reference to the clause for effective incorporation. This further brings Malaysia into consonance with the courts of other UNCITRAL Model Law-compliant nations, including the Hong Kong and Singaporean courts, which have previously held that incorporation is effective with general reference.

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Alternatively, insurance for a fixed value item may be obtained. This is usually subject to a valuation by a qualified surveyor. The item may then be insured for that value. This insurance is more common for high-value items such as jewellery or paintings.

Directors' and officers' insurance

22 What is the scope of D&O coverage?

D&O insurance provides financial protection for directors and officers in the event that they are sued in the course of performing their duties.

Coverage is excluded for loss arising from fraud or dishonesty.

In the event that the insured is sued, D&O insurance would usually cover defence costs, legal representation, damages, judgments and settlements.

D&O insurance will also usually cover the expenses of defending extradition proceedings and criminal proceedings. As such, while the insurance may cover the cost of defending a criminal proceeding against directors and officers, it will not cover any fine imposed or any loss incurred as a result of the criminal act.

Employment-related claims brought against the company are also normally covered. D&O insurance normally also covers securities claims.

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

D&O policies are only beginning to gain traction in Malaysia since the introduction of the goods and services tax. There are no reported court cases concerning D&O policies.

Cyber insurance

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

Cyber insurance policies cover personal data liability, corporate data liability, outsourcing liability, data security liability and defence costs.

25 What cyber insurance issues have been litigated?

Cyber insurance is a new product in Malaysia, and there have been no reported disputes concerning cyber insurance issues to date.

Mexico

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Preliminary and jurisdictional considerations in insurance litigation

1 In what fora are insurance disputes litigated?

In Mexico, the Commercial Code considers insurance to be a commercial matter. Commercial matters should be litigated before civil judges. Those judges could be federal or local (the plaintiff would decide on the jurisdiction). The only condition is that where the claimant decides to file the lawsuit, there should be a National Financial Services User Protection Board (CONDUSEF) office.

2 When do insurance-related causes of action accrue?

Insurance-related causes of action accrue 30 days after the claimant has delivered all the documents proving loss to the insurer, according to the insurance contract and law.

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

There are no legal provisions to exhaust any procedure before going to court. However, there are some procedures that, depending on the amount in dispute in the case, it would be advisable to exhaust before filing a lawsuit.

Cases under US$40,000 can be brought to the CONDUSEF. If the CONDUSEF decides that the case has merits, it will issue a document with which policyholders can secure payment by the seizure of the insurer's goods. Cases involving amounts of between US$40,000 and US$2.3 million can be brought to the CONDUSEF, which will issue a report upon the policyholder's request that could sometimes be considered in trial as a witness expert report. Cases regarding amounts of over US$2.3 million should be delivered directly to a civil court.

4 What remedies or damages may apply?

No remedies or damages apply before going to court.

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

In a very recent case, the Supreme Court introduced the concept of punitive damages into Mexican jurisprudence. The case establishes a specific precedent that would actually enable a judge to impose such damages.

The Court now considers that, in order to adequately indemnify a victim, a judge has to consider not only the actual monetary value of the damaged assets or rights, but also both the degree of responsibility and the economic capacity of the offender. Therefore, the amounts set for indemnities will vary significantly from person to person and from situation to situation.

Interpretation of insurance contracts

6 What rules govern interpretation of insurance policies?

There are no written rules regarding the interpretation of insurance policies. Guidance is provided by civil, commercial and insurance law. Recently, Mexican courts have ruled on how insurance policies should be interpreted based on the nature of the underlying contracts.

Mexico has two types of insurance contracts: adhesive and non-adhesive contracts. The vast majority of insurance contracts (99 per cent or more) are adhesive contracts or are based upon adhesive contracts. The clauses and contents of an adhesive contract are drafted by only one of the parties signing it; for this reason, the rules of interpretation are harsher on the drafter (insurer) than the acceptor (insured).

Adhesive contracts should be interpreted as favouring the policyholder, and if any provision is ambiguous it should be interpreted on the side of the insured. The burden of proof is usually on the insurer.

Non-adhesive contracts should be interpreted using civil and commercial principles (the parties' will and intent should constitute the law between them).

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

Adhesive contracts

A provision will be deemed ambiguous if it is not clear enough about the insured's burdens, obligations and rights. In this case, the ambiguity should be resolved favouring the insured's interests.

Non-adhesive contracts

A provision will be deemed ambiguous if it is not clear enough about any of the parties' burdens, obligations and rights. In this case, the ambiguity should be resolved by analysing the parties' will within the insurance contracts and all the acts and documents related to the concrete case.

Notice to insurance companies

8 What are the mechanics of providing notice?

The only legal provision is that notice should be given as soon as the insured detects the loss. Usually the policy provides how and when the notice should be given to the insurer.

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

Policyholders should notify the insurer of any contingency as soon as possible.

10 When is notice untimely?

Notice is untimely when the loss circumstances have substantially changed, and the insurer is no longer able to determine the origin and extent of the loss and damages or the subrogation rights have been affected.

11 What are the consequences of late notice?

The insurer will be able to deduct from the lump sum the amount of money that should not have been lost if notice was given in a timely manner.

Insurer's duty to defend

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

There are no legal provisions regarding the insurer's duty to defend. Some policies can include this as an extra coverage. However, it is fairly common that in liability cases the insurance company manages the insured's defence.

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

If there are contractual provisions obliging the insurer to provide a defence, the insurer will be liable for damages and prejudices to the policyholder. If there are contractual provisions obliging the insurer to provide a defence and it fails to comply with such obligation, the insurer will be liable for damages and prejudices to the policyholder; in that scenario, the policyholder would have the possibility of presenting an action against the insurer to recover all losses that are a consequence of that failure to defend.

Standard commercial general liability policies

14 What constitutes bodily injury under a standard CGL policy?

Bodily injury constitutes any alteration to the physical configuration of a human being.

15 What constitutes property damage under a standard CGL policy?

Property damage constitutes any loss that occurred to any covered goods. This could be intangible (rights).

16 What constitutes an occurrence under a standard CGL policy?

An occurrence is damage caused to any third party by the nature of the activity of the insured, the action of any employee or damages caused by the use of insured facilities.

17 How is the number of covered occurrences determined?

The number of covered occurrences is determined by the various forms of coverage affected by an event. An event will be one occurrence.

18 What event or events trigger insurance coverage?

The occurrence of any of the covered risks will trigger insurance coverage.

19 How is insurance coverage allocated across multiple insurance policies?

'Concurrence' of policies will apply. Concurring insurers will pay the loss in equal and proportional parts, the insured sum being the only limitation for each insurer.

First-party property insurance

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

According to different legal definitions and customary insurance practices, 'first-party coverage' usually refers to compensation received under one's own insurance policy as opposed to payment received from someone else's insurance policy. If an insured causes damage to his or her property, the loss covered under the terms of a policy of insurance is commonly known as first-party coverage.

As the Mexican market has developed, we have found that almost every property and casualty insurance includes either coverage or a component of 'first-party' insurance.

It is not uncommon for coverage offered by insurance carriers to refer to general losses arising from any and all related causes (all risk), excluding only those damages caused intentionally by the insured. Therefore, any unintentional loss caused by the insured would be covered.

At the same time, it is obvious that insurance coverage as far as property is concerned is directed towards the efficient protection of the covered property (a car, a building or any other kind of facility), regardless of the cause of damage, so the policy and coverage should be operational to pay damages sustained and derived from a covered event.

In any case, the induction of deductibles in the policy is also customary; this, as in any other insurance, involves the insured directly on the loss, in an attempt to enhance the insured's motivation to preserve the insured asset as far as possible from risk.

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

There are no special rules for valuing properties under this scheme.

The value of a property will depend on the nature of the property (either moveable or real estate).

If the property is moveable (car, furniture, etc), a private appraisal would suffice. Often in the case of loss, the value is determined by the insurance adjuster at the same time that the event under the policy is verified and the potential loss is determined.

Even though the process to adjust the lost amount also applies to real estate as described above, the adequate determination of value will vary significantly since there must be a commercial appraisal undertaken according to specific standards to determine the appropriate value at the time of the estate's acquisition. This appraisal and the existence of rules to calculate different commercial value factors, such as location, materials of construction and improvements made, will enable any interested party to obtain a more certain amount regarding the value of real estate, and therefore be able to calculate more accurately any loss acquired.

Directors' and officers' insurance

22 What is the scope of D&O coverage?

This type of insurance does not differ greatly from the coverage offered in other parts of the world.

Even when the intention of a policy is to give coverage in a specific territory, technology and communications have enlarged the possibilities for a corporation's shares to be traded beyond the territory of a single or specific country.

As a result of this, D&O coverage in Mexico is very similar to the usual product sold in other countries. This means that D&O is business insurance designed to mainly cover the risk of the individual liability of a director or officer from lawsuits (and some regulatory actions) undertaken by shareholders, regulators, state investigators or others alleging wrongdoing.

Coverage must be sufficient to protect both the director and the corporation against the eventual claim and provide specific coverage for legal expenses, as effective litigation may be the difference between a large indemnification or even a liberation from responsibility.

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

D&O coverage is in essence liability coverage. In Mexico, legal liability is not as developed as it has become in other countries, even when tendencies indicate that this development may occur in the near future, since there have been recent changes to Mexican law and it is now possible to use class action-type lawsuits. Nevertheless, there is no real litigation culture in Mexico.

However, in order to understand how this kind of coverage would really function, it is important to remember that even though laws in the country have been evolving towards a more comprehensive regulation of liability, the fact remains that liability law in Mexico is still very limited. In addition, people are not really aware of it and have a very limited knowledge of remedies under the law, while a profound distrust of judges strongly discourages legal actions.

At the same time, is important to mention that in addition to the lack of litigation culture, the introduction of such coverage in the Mexican marketplace has been very limited due to the restricted access of Mexican corporations to the stock market or to foreign countries.

Even with the above-mentioned limitations, claims under this coverage have been filed, and several claims and trials affecting policies with this specific coverage are public knowledge. These claims are negatively directed at corporations trading stock on the Mexico stock exchange or those trading in New York.

The claims have mainly centred on the actual decision-making processes of the directors or officers involved and the possible damage sustained by a third party outside a corporation.

No class action has been brought against any officer of a corporation that could be offered as an example of a case involving a D&O policy.

Cyber insurance

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

To date, there is still only a limited understanding of the risk exposure in this matter in Mexico. Coverage is available through international reinsurance and international brokerage policies. Such policies basically cover internet-related liability, and are really intended for those that have a risk exposure in the US.

25 What cyber insurance issues have been litigated?

We do not know of any cyber insurance disputes based on coverage policies in Mexico. However, as in any other country, conflicts between internet users and service providers are becoming more common and more complex. Losses in this regard can only be expected to increase, and will arise from a variety of situations. This will provide a positive push for the commercialisation of cyber insurance coverage that is not only focused on individuals exposed to cyber risks in the US, but also on creating a domestic market.

Norway

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Preliminary and jurisdictional considerations in insurance litigation

1 In what fora are insurance disputes litigated?

Subject to the parties' agreement, insurance disputes are litigated in the civil courts, namely the city court, appeal court and possibly the Supreme Court.

The parties may agree to arbitrate the insurance dispute. However, like jurisdiction clauses, arbitration clauses are not binding on the private consumer if entered into prior to the dispute.

An alternative for the insured is to file a complaint to the Norwegian Financial Services Complaint Board. The Complaint Board's decisions are advisory, but will be binding upon the insurer if the insurer does not notify the Board in writing within 30 days that it will not accept the decision with an explanation as to why. The Board will then notify the insured that the decision is not accepted by the insurer and advise of any legal provisions or agreements that require the insurer to cover to a certain extent subsequent litigation costs for the insurer.

This procedure will prevent the claim from being time-barred, as long as an unsuccessful insured brings the claim before the civil courts within one year of the Complaint Board's decision.

2 When do insurance-related causes of action accrue?

Insurance-related claims are filed to the city courts when the policyholder is of the opinion that cover is wrongfully denied. Normally there will be discussions between the parties about the claim, and the dispute is also often settled before it comes to the courts.

Normally it will be the insured that initiates insurance-related causes of action. The insurance provider will normally only initiate such proceedings in order to enforce unpaid premiums. The insurers also have the possibility to initiate proceedings in order to get a judgment that the insurer is not liable (ie, file for a 'negative' ruling).

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

The following should be part of a non-exhaustive list of considerations in insurance litigation cases:

- all deadlines should be identified and noted (eg, when to notify the claim to the insurer, what steps to take to avoid the claim becoming time-barred);
- review the factual and legal basis for the claim to assess the risk involved in litigation (ie, a win/loss assessment, taking into account of the costs involved). The unsuccessful party will as a general rule be liable for the opposing party's litigation costs (a non-accepted advisory decision from the Complaint Board is a modification to this: see question 1). A thorough review of the factual and legal basis for the claim is also required to have proper grounds for negotiations and possibly settle the case out of court;
- the parties should communicate prior to any potential litigation to identify and clarify the disagreement and provide the other parties with relevant facts and evidence;
- decide whether the claim should be filed to the Complaint Board or directly to the civil courts. If the latter, check for any jurisdiction and arbitration clauses; and
- if you are a third party claiming damages from a policyholder, assess whether the claim should be filed both against the insurer and the insured.

4 What remedies or damages may apply?

The remedies that are available are decided by the terms and conditions of the policy; hence, insurance-related causes of action are initiated to get the cover agreed to in the policy.

Damages normally arise when third parties claim from a tortfeasor who has professional liability cover. The third party will then seek to have this claim for damages covered by the insurer under a direct action against the insurer.

In addition to coverage issues, the policyholder may also have a claim for 'damages' against the insurer, mainly in the form of penalty interest for delayed payment of the cover under the policy. In addition, a successful claimant will as a general rule recover its litigation costs from the insurer.

There are also cases of damages against an insurer where the insured's cover is less or more limited than expected, and the insurer ought to have informed the insurer about these limitations.

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

There are no specific provisions for insurance companies subjecting the insurer to extracontractual or punitive damages for a wrongful denial of claims. However, a company is exposed to an obligation to pay late payment interest, which includes a penalty element, if the claim is not settled within two months after the claim has been properly notified to the insurer. In addition, the insurer will be exposed to carrying both its own and the insured's (or a third party's) costs in unsuccessful court proceedings.

Interpretation of insurance contracts

6 What rules govern interpretation of insurance policies?

The insurance policy will be interpreted according to normal contract law principles, where the wording of the policy is central. This is particularly the case in commercial cases.

If the wording of the terms and conditions does not give the result, the court will look at other factors, in particular communications between the parties prior to entering into the insurance contract but also how the parties have lived up to the agreement. The court may also look at the purpose of the provision, and more generally what would give a reasonable result.

As the terms and conditions are often standard documents drafted by the insurer, provisions that are ambiguous, vague or unclear will as a general rule be construed in favour of the insured (contra proferentem doctrine), unless there is clear evidence that the insured knew or ought to have known what the insurer meant by the provision.

These principles apply if the Insurance Act allows for derogation, or does not regulate the said issue – typically, what perils that are agreed to be covered by the policy. If the Insurance Act regulates the issue and does not allow for derogation, the Insurance Act applies, and it will be the provisions in the Insurance Act that will be interpreted by the courts.

However, even though the Insurance Act allows for derogation, and the parties intend to derogate, the principles underlying the said provision in the Insurance Act derogated from will be part of the framework within which the agreement will be interpreted.

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

A policy provision is ambiguous when the wording may have more than one meaning, assuming that both or all meanings will give a reasonable interpretative result. If one or more words in the provision have two or more meanings, but it is clear from the context that all but one meaning cannot be relevant, it is not customary to say that the provision is ambiguous.

Ambiguities are solved by taking factors other than the wording into account (see question 6) and if necessary the application of the contra proferentem doctrine.

Notice to insurance companies

8 What are the mechanics of providing notice?

The mechanics of providing notice are regulated in the terms and conditions of the insurance contract, and require that the insured should notify the insurer in writing without undue delay and no later than one year after the insurable event has occurred or a claim is made under a professional indemnity policy. The written notification should contain a description of the claims made or the circumstances that may give rise to a claim.

The mechanics of providing notice may be worded differently between the insurers and should normally be one of the issues that should be clarified when entering into insurance contracts. The effect of not complying may also differ, but untimely notification often entails the cover being lost.

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

These are similar to the mechanics described under question 8, but as mentioned, here the wording may differ from policy to policy between insurers.

10 When is notice untimely?

The notice will normally be untimely if not given without undue delay, or within one year of the claims made or knowledge of circumstances that later form the basis for the claim.

In addition to the mechanics of providing notice in accordance with the terms and conditions, the insured should be aware of the general time bar limitation rules regulating claims in general, which provide as a starting point a three-year time limit. A claim may thus be time-barred according to this regulation even if it is timely under the insurance contract.

However, a special limitation rule applies if the insurable event is notified according to the agreed mechanics to the insurer before the claim is time-barred according to the Limitation Act (LOV-1979-05-16-18). In this case, the claim will be time-barred no sooner than six months after the insurer has notified the insured that the insurer will invoke the time bar limitation rules.

11 What are the consequences of late notice?

Late notice will often entail the cover being lost. The court may in rare and exceptional cases censor the effect of such clauses.

Insurer's duty to defend

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

The insurance contract will regulate the insurer's rights and obligations to defend the claim.

In general, the insured is required to defend the claim, but may, according to the insurance contract, recover its defence costs within the insured sum.

The insurer may have a contractual right to approve any legal advice retained by the insured in advance, and it is normally stated that the insured may not give any admissions or enter into any settlement agreements with the claimants without prior written consent from the insurer.

In cases where a third party brings a direct action against the insurer under the Insurance Contract Act, which regularly is the situation in liability cases, the insurer will be the defendant and as such have a direct self-interest to defend against the claim.

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

As described in question 12, it will normally be under a direct action against the insurer that the insurer will be the defendant and as such be required to defend. A failure to defend (eg, not responding to a claim filed against the insurer in the city court) will regularly entail the claimant getting a judgment in its favour in line with the claim presented to the court, if it is not clearly incorrect.

Standard commercial general liability policies

14 What constitutes bodily injury under a standard CGL policy?

'Bodily injury' is not defined in the Insurance Act and should thus be clearly defined in the insurance contract.

Bodily injury can (in the terms and conditions, for example) be defined as 'bodily injury, sickness or disease sustained by a person, including death resulting from any of these at any time'.

Bodily injury should without further clarification include all harm to the body, the effect of only minor harm being that no loss may have occurred. In cases where the amount paid under the policy is not linked to incurred expenses or loss of future income, but to the severity of permanent bodily injury, a schedule is normally provided for calculating the cover.

15 What constitutes property damage under a standard CGL policy?

'Property damage' is not defined in the Insurance Act and should thus be clearly defined in the insurance contract.

Property damage typically includes both moveable and immoveable property, and may cover the reduced value of such property or cover replacement cost if the reduced value or cost is caused by the insured peril. The policy may exclude loss or cost of a more indirect nature.

Even though not regulated in the insurance contract, rescue costs will to a certain extent be covered in accordance with the Insurance Act.

16 What constitutes an occurrence under a standard CGL policy?

One definition of 'occurrence' under a standard CGL policy could be 'an accident, including continuous or repeated exposure to substantially the same general harmful conditions'.

In policies covering, for example, 'bodily injury' or 'property damage', the bodily injury and the damage to the property as defined, specified or exhaustively listed will constitute the occurrence under the policy.

17 How is the number of covered occurrences determined?

There is no generally applicable rule to decide the number of covered occurrences. This depends on the terms in the individual insurance contract, and may vary between branches and insurers.

18 What event or events trigger insurance coverage?

This is agreed in insurance contracts as the perils covered, and the insurance coverage is triggered if and when such perils occur and materialise (eg, in property damage) and no exemption or limitation rule applies.

In professional indemnity insurance, the insurance cover is usually triggered when a claim for damages is made against the insured.

19 How is insurance coverage allocated across multiple insurance policies?

If the same loss is covered by more than one policy, the insured may choose which policy or policies to use until the insured has recovered its loss.

If more than one insurer is involved, the respective insurers are liable in proportion to the cover they have granted to the insured.

First-party property insurance

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

As a general limitation, only legal and a party's own economic interest can be insured – both first party and third-party interest. Hence, insurance coverage that includes an illegal interest (eg, such as illegally acquired goods or goods that the policyholder does not hold any economic interest in) is void and not enforceable.

First-party property coverage is otherwise specific and covers regularly named perils such as theft and fire (named peril policies).

Further, the Norwegian natural hazards insurance scheme is a statutory insurance scheme with an equal premium rate (0.07 per cent of the insured amount under the fire insurance). A person who takes out property and household fire insurance will then also have insurance against natural hazards. Natural hazards are, inter alia, storms, avalanches, flooding and earthquakes.

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

This is dependent on the terms in the insurance contract and may be both actual cash value and replacement cost. Replacement or reinstatement costs are usually only covered if the damaged property is replaced or rebuilt, usually within five years.

If the property value will be paid, the amount is left to specialised appraisers to decide. Such appraisers are nominated by the parties in accordance with the insurance contract.

Directors' and officers' insurance

22 What is the scope of D&O coverage?

A D&O policy covers liability that directors and management may face when carrying out their duties as such, and should, up to the insured amount, cover claims made by, for example, shareholders, creditors or other third parties that make a claim for damages against the insured person. Defence costs are normally covered, either as part of the general insured sum or as a specific amount in addition to the insured sum.

These policies are generally claims-made policies and thus cover any claims made against the insured within the policy period, and any claims based on circumstances that occurred prior to the policy period if no retroactive limitations are agreed.

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

Claims are normally made under D&O policies in situations where a company is insolvent and not able to pay damages to the one that has suffered the damage.

However, the factual and legal basis for claiming damages against directors and officers are not (necessarily) the same as the factual and legal basis for claiming damages against the company. Claims for damages against directors and officers must in short be based on their breach of a duty, such as their not sufficiently monitoring the running of the business, and where this breach of duty has caused the specific loss of the claimant. Each director and officer should be assessed individually and not collectively when deciding liability.

Cyber insurance

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

Regarding third-party cyber liability coverage, cover under a cyber insurance policy might typically cover, inter alia:

- third-party liability for:
  - disclosure of data injuries;
  - injury to content; and
  - impaired access injuries; and
- first-party expenses for:
  - crisis management of cyber crime;
  - e-business interruption; and
  - e-theft and e-communication loss.

Cyber insurance should cover direct loss, legal liability and consequential loss resulting from such cyber security breaches.

25 What cyber insurance issues have been litigated?

One difficulty with cyber insurance is for both the insurer and the insured to assess the extent of exposure that should be covered, and to date, there seems to be no public overview regarding the volume of cyber insurance coverage in Norway. A search through the database for Norwegian court rulings involving cyber insurance yielded no data in this regard.

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Preliminary and jurisdictional considerations in insurance litigation

1 In what fora are insurance disputes litigated?

Assuming that local courts have international jurisdiction over insurance-related disputes, they will most probably fall under the competence of common or judicial courts. The procedural rules applied are mainly those contained in the Portuguese Civil Procedure Code approved by Law 41/2013 of 26 June 2013.

In Portugal, insurance disputes may also be litigated in arbitral tribunals. According to article 122 of the Insurance Contract Law approved by Decree-Law 72/2008 of 16 April 2008 (ICL), disputes over the validity, interpretation, performance or breach of an insurance contract may be settled by arbitration. Arbitration is regulated by Law 63/2011 of 14 December 2011. However, arbitration clauses do not bind injured third parties who are allowed a direct right of action in liability insurance, nor do they bind the third-party beneficiaries in personal insurance, according to a ruling of the Portuguese Supreme Court of 27 November 2008.

Arbitration is not yet a very popular choice for insurance-related litigation involving large risks. However, it is an increasingly popular resource for small insurance claims made by consumers due to the availability of specialised institutional arbitration structures, the most important of those being the non-profit association CIMPAS. This arbitration centre hears cases on car insurance, residential and commercial multi-risk insurance claims not exceeding €50,000 per claim, and some types of liability insurance not exceeding €50,000 per claim.

According to article 50 of the ICL, it is also possible for the parties to submit their factual disagreements over the causes, circumstances and consequences of an occurrence to one or more experts appointed by the parties, if this solution is provided for in the contract or in a subsequent agreement. In this case, unless otherwise agreed, the experts' decision is binding upon the insurer, the policyholder and the insured. This possibility is different from that of submitting a dissent to arbitration, as it does not involve issues of law.

2 When do insurance-related causes of action accrue?

In many insurance-related cases, the disputed issue is simply whether, or to what extent, the claimant is entitled to compensation under any class of insurance contract. In this type of case the claimant may be the insured, an injured third party in liability insurance or a third-party beneficiary in personal insurance, the defendant being the insurer.

Often the main cause of action will not be insurance-related, and the insurer will intervene in the proceedings either as a codefendant or join the proceedings at a later stage, also as a co-defendant or as an accessory to the defence. Typically the case will concern the first defendant's alleged liability and the insurer will be the first defendant's liability insurer. The insurer will take the role of co-defendant when the claimant is entitled to sue the insurer directly, and it will take up the role of accessory to the defence when the claimant does not hold that right. In this case the insurer will be called upon to join the action because the defendant – the insured – wishes to enforce the decision as to the facts and its own liability as against the liability insurer at a later stage.

A different type of insurance-related cause of action involves subrogation. In this type of action the insurer who has paid compensation to an insured or on behalf of an insured seeks reimbursement by enforcing the payee's rights as against those liable for the loss. Where compensation has been partial, this action will often be jointly pursued by the recipient of the insurance compensation.

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

In insurance litigation, apart from every other concern that would be common to most other litigation, experience dictates that the following preliminary procedural and strategic considerations should be evaluated:

- gathering and reviewing all relevant policy documentation, as quite often doubts arise as to which documents form part of the policy;
- checking that the insurer has complied with the required information duties, as sometimes failure to do so prevents the insurer from enforcing certain favourable clauses;
- identifying the types of insurance coverage that might be triggered by the loss;
- considering that the insurance requirements may be different from the requirements of the underlying liability claim and taking steps to ensure that adequate evidence is collected in time; and
- giving proper and timely notice to all relevant insurers under all potentially applicable policies or to all significant counterparties, as the case may be.

4 What remedies or damages may apply?

According to article 23 of the ICL, a breach by the insurer of the precontractual information duties set forth in articles 18 to 22 of the ICL or in any other applicable statutory provision may give rise to:

- the obligation to pay damages for loss arising out of such breach, on the basis of the general terms of the law. Such general terms regarding this matter are set out in article 227 of the Portuguese Civil Code (CC), according to which the wilful or negligent breach of precontractual bona fide duties may give rise to civil liability; or
- retroactive termination of the agreement by the policyholder, except in cases where it can be established that the breach of the insurer's duties did not reasonably affect the policyholder's decision to enter into the contract or where a third party has already made a claim under the contract. The right to retroactively terminate the insurance contract must be exercised within 30 days from the date on which the policyholder received the documents that comprise the insurance policy.

Similar remedies are applied whenever the insurer has apparently fulfilled its information duties, but the policy conditions turn out not to be in accordance with the information previously disclosed to the policyholder or to the insured.

Annulment of the contract is the remedy for the wilful breach of the policyholder's duties of disclosure regarding elements able to affect the assessment of risk. In this case the insurer must give proper notice within the specified time limit, as provided for in article 25 of the ICL. In such a case, the general terms regarding the annulment of contracts apply with some adjustments. In particular, the insurer does not have to indemnify a claim arising out of an event taking place before it became aware of the breach of the information duties or during the annulment period. However, if the insurer has not wilfully or with gross negligence contributed to the policyholder's breach, it is entitled to receive the premium regarding the period of annulment or, if the policyholder's breach was fraudulent, the premium corresponding to the entire duration of the contract.

In the case of negligent breach of the same duties, and under the terms and within the period specified in article 26 of the ICL, the insurer is entitled to propose changes to the contract, setting up a time limit for the policyholder's acceptance or counter offer; or to terminate the contract, if it succeeds in demonstrating that it has a policy of not entering into any contracts for the coverage of risks related to the omitted or wrongfully described facts.

The insurer will be liable to pay damages for late performance or for non-performance of the contractual obligations arising from the occurrence of an insured event, according to the general rules on breach of contract set forth in articles 798 et seq of the CC.

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

In Portugal, civil liability is meant to compensate injured parties for their loss, aiming to restore them to situation that would be in existence were it not for the damaging event, as per articles 562 et seq of the CC. Therefore, no punitive damages may be awarded on the basis of either contractual or extracontractual liability. Extracontractual damages may be awarded, but it is rare for an insurer to place itself in a position that would call for an award of extracontractual damages other than for a breach of their legal duties of information and disclosure. As to those, see question 6.

Interpretation of insurance contracts

6 What rules govern interpretation of insurance policies?

Insurance policies should be construed in accordance with the same general rules applicable to all types of contractual statements. Such rules are contained in articles 236 to 238 of the CC. According to such rules, the meaning of a contractual statement is that which an ordinary person, placed in the position of the real addressee, would draw from the behaviour of the issuer. This will be so unless the addressee is aware of the issuer's true intention, in which case the latter will prevail. However, if the contract is made in writing, the meaning of the statement must bear a minimum, albeit imperfect, correspondence to the text, unless a different meaning is shown to correspond to the parties' true intent and the reasons for the contract to have been made in writing do not counter the applicability of the latter meaning.

Since 1 January 2009, insurance contracts must no longer be made in writing so as to be valid, as per article 32 of the ICL. When made in writing, the contract terms must be sought in the wording of the written document that the law calls the insurance policy. When they are not made in writing, the insurer is under a legal duty to put the terms of the parties' agreement in writing and deliver a dated and signed counterpart to the policyholder. According to article 35 of the ICL, the latter has 30 days within which to raise any discrepancies between the parties' agreement and the contents of this written document, after which the contract terms are consolidated as contained in the written document produced by the insurer.

According to article 33 of the ICL, any specific and objective messages contained in advertisements relating to an insurer's product shall be deemed included in the insurance contracts entered into in the year following their broadcasting.

Finally, there are a substantial number of mandatory legal rules governing insurance contracts covering mass risks, most of which are freely disposable by the parties in the case of insurance contracts covering large risks. Such rules may be absolutely mandatory, in which case the parties may not alter them, or relatively mandatory, in which case the parties may only alter them to the benefit of the policyholder, the insured or the beneficiary. Whenever a contract clause goes against such mandatory legal rules it shall be struck out as invalid and of no effect. Other legal rules shall apply to an insurance contract by default; that is to say, they will be included in the contract unless the parties agree otherwise. An example is the provision whereby life insurance contracts are deemed to exclude death by suicide in the year following the contract's conclusion, contained in article 191 of the ICL.

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

An insurance policy provision should be classified as ambiguous when, as a result of the application of the previously mentioned general rules, either two or more equally plausible meanings are detected or no definite plausible meaning may be drawn from the wording of this provision. In either case, the general rule on interpretation of ambiguous contractual statements contained in onerous contracts such as insurance contracts would entail the adoption of the meaning leading to the more balanced contractual solution.

However, a different general rule applies in the case of standard terms. A typical insurance policy will be composed of a document containing terms individually negotiated by the insurer and the policyholder, such as those setting the premium amount and the covered risks, which should also make reference to the documents containing the applicable standard terms: typically, a much larger document or set of documents containing the contract's general and special terms. Whenever a contradiction is detected between a standard term and a term individually negotiated by the insurer and the policyholder, the latter shall prevail, in accordance with article 7 of the Standard Terms Law, Decree-Law 446/85 of 25 October 1985, as amended (STL).

In addition, ambiguities are not resolved pursuant to the general rule that favours the more balanced contractual solution. In accordance with article 11 of the STL, an ambiguous standard term shall have the meaning that is most favourable to the party that adheres to it (ie, the policyholder in the case of insurance contracts).

Notice to insurance companies

8 What are the mechanics of providing notice?

According to article 100 of the ICL, the policyholder, the insured or the beneficiary must communicate an occurrence to the insurer within eight days of the date on which they became aware of its taking place. The insurance contract may, however, stipulate a different term for the notice.

The notice shall mention the causes, circumstances and consequences of the occurrence. The policyholder, the insured or the beneficiary must also provide the insurer with all relevant additional information upon a request being made by the insurer.

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

Claims-made policies generally contain a prompt notice provision. The policyholder must provide notice 'as soon as practicable' or 'immediately' after a claim is made. In addition, many claims-made policies also stipulate a specific reporting requirement, which requires that notice of a claim be reported to the insurer within a specified period, which may be the same as the policy period or slightly longer (ie, an extended reporting period). In some claims-made policies, proper notice has to comply with two requirements: the claim has to be reported both consistently with a prompt notice provision, that is to say 'as soon as practicable' or 'immediately'; and no later than 30 or 60 days after the end of the policy period.

This is to allow the insurer to ascertain its potential obligations under a claims-made policy within a short time after the policy period.

Liability insurance (such as professional, product liability and environmental liability insurance) is normally construed based on the claims-made principle.

10 When is notice untimely?

As mentioned above, proper notice must be given within eight days from the date on which the insured person or the policyholder became aware of the loss-triggering event. The insurance contract may, however, stipulate a different term for the notice.

It should also been taken into consideration that any enforcement rights against the insurer shall cease five years as from the date on which its holder became aware of its existence. The law also sets forth an ordinary limitation period of 20 years as from the date of occurrence of the relevant facts. Thus, these two limitation periods have to be articulated. The person entitled to compensation may only be aware of its right after the expiration of the ordinary limitation period, in which case it may no longer lodge its claim against the insurer.

11 What are the consequences of late notice?

Failure to comply with the duty to provide proper notice does not immediately determine loss of coverage. Such was the decision, for instance, of the Lisbon Court of Appeal on 8 March 2007 and on 23 November 2010.

According to article 101 of the ICL, the consequences of late notice are a reduction of the compensation payable by the insurer, taking into consideration the loss caused by late service of the notice; or preclusion of the right to compensation in the case of an intentionally late service of the notice that caused loss to the insurer. One should bear in mind that the

relevant loss for this purpose is that which could have been avoided if the notice had been served in a timely manner. However, such adverse consequences should not occur if the insurer had knowledge of the claim by other means during the time set for the notice to be served or if the server of the notice is able to demonstrate that earlier notice could not have been served.

Injured third parties are protected against the consequences of late notice in the case of compulsory liability insurance. In such cases, failure to serve notice may not be invoked as against such injured third parties. In such cases, the insurer shall pay the compensation that may be due and shall be entitled to recover it from the defaulting policyholder or insured, unless the insurer had previous knowledge of the claim or the former could not have reasonably have served prior notice.

Insurer's duty to defend

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

In Portugal, no legal provision imposes a general duty to defend upon insurers. According to article 140 of the ICL, a liability insurer is entitled to intervene in any judicial or administrative proceedings in order to participate in the litigation concerning the insured's alleged obligation to pay damages, supporting the associated costs. Insurers will be free to defend or not to defend, as they deem more convenient.

The insurer's duty to defend may be stipulated in the insurance contract as an autonomous insurance coverage, in which case its scope will be contractually determined. This autonomous coverage, called legal protection insurance, is regulated in articles 167 et seq of the ICL. It may include the insurer's duty to defend or be limited to the insurer's obligation to bear the costs of the insured's legal defence.

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

In view of the fact that no generally applicable legal duty to defend applies, the consequences of an insurer's failure to defend, whenever this duty has been contractually stipulated, will be those established in the insurance contract. In liability insurance, insurers have a legal right to defend. If they do not exercise this right they may be prevented from disputing the reasonableness of certain defence costs or the strategy pursued by the insured, as that may be deemed contrary to the principle of good faith.

Standard commercial general liability policies

14 What constitutes bodily injury under a standard CGL policy?

There is no such thing as a standard CGL policy in Portugal. However, there appear to be some common denominators among the standard terms used locally by insurers. A typical CGL standard term's definition of bodily injury will be harm inflicted upon an individual's physical or mental health.

15 What constitutes property damage under a standard CGL policy?

Again, there is no such thing as a standard CGL policy in Portugal. However, there appear to be some common denominators among the standard terms used locally by insurers. A typical CGL standard term's definition of property damage will be harm inflicted upon any tangible asset, whether moveable or immoveable, including animals. This definition naturally excludes pure economic loss.

16 What constitutes an occurrence under a standard CGL policy?

Again, there is no such thing as a standard CGL policy in Portugal. Some degree of diversity may be found among the standard terms used locally by insurers. Generally, an occurrence is a partially or totally developed factual event that is susceptible to triggering the insurance coverage. In some cases the wording will specify that the event must be sudden and unforeseen. In the context of a CGL policy, this event must be imputable to the insured. However, small wording differences may result in different interpretations, especially in the context of more complex successions of facts. Two or more factually separable events may be considered as a single occurrence if the cause from which they originated is one and the same (see question 17). It should be noted that in some cases the occurrence will be the insurance trigger, while in other cases, notably in claims-made policies, the occurrence itself will not give rise to any right to insurance compensation (see question 18).

In complex successions of facts it is important to determine the relevant date of the occurrence for the purpose of enquiring whether it took place within the coverage's temporal limits. The most common standard terms set forth as the relevant date that when the first adverse effect took place. This means that if loss from the same cause accumulates over time it will all be included in the insurance period in force at the time that first consequence arose.

17 How is the number of covered occurrences determined?

In view of the application of the principle of contractual freedom to insurance contracts, the question of how the number of covered occurrences is determined must ultimately be answered on a case-by-case basis through contractual interpretation.

In general, the number of occurrences is calculated according to the cause of the occurrence and not according to the resulting loss. Two or more factually separable events may be considered as a single occurrence if the cause from which they originated is one and the same.

For example, if the insured's vehicle accidentally spilled oil on the road and as a consequence three other vehicles spun out of control, we may usually conclude that there is a single occurrence with multiple adverse consequences. More complex situations may give rise to interpretation difficulties as to what a court of law would consider to be a single cause. The well-known discussion that arose after the events of 9/11 did not lead local insurers to clarify their wording significantly in this respect.

18 What event or events trigger insurance coverage?

Article 99 of the ICL defines a trigger of loss as 'the whole or partial verification of the event which activates the coverage of risk provided for in the contract'. In view of the application of the principle of contractual freedom to insurance contracts, the question of which events may trigger insurance coverage must ultimately be answered on a case-by-case basis through contractual interpretation. Nevertheless, the law does provide for the more usual scope of coverage of the classes of insurance that it specifically regulates.

This is the case in liability insurance, where the default rule is that of an occurrence-basis insurance coverage. Pursuant to article 139 of the ICL, unless otherwise agreed by the parties, liability insurance will cover the insured's liability for liability-generating facts occurring during the policy term, including any claims made after that term. Other types of trigger are allowed and commonly used, the most frequent being the manifestation of the loss and the lodging of a claim by the injured third party.

When a claims-made insurance contract is entered into and a claim is made in the year following the end of coverage with regard to a harmful event occurring during the policy term, no further insurance coverage having been secured by the insured that covers that risk, a mandatory legal provision imposes upon the insurer an obligation to cover that claim. This is known as a mandatory sunset clause.

There are no insurance contract law provisions regulating the degree of causality that must exist between the triggering event and the loss suffered by the injured third party. For such purpose, one should apply the general principles of civil liability law set out in the CC.

19 How is insurance coverage allocated across multiple insurance policies?

The same risk relating to the same interest may, at any one time, be covered by two or more independent insurance contracts concluded with two or more insurers, even when the sum total of all insured capitals exceeds the value of such risks. In such cases, the policyholder or the insured must inform each relevant insurer of the multiple insurance situations as soon as they become aware of them. The insured must disclose the situation in any claim made. Fraudulent breach of the duty to disclose that information to the insurers relieves them from their obligations in relation to the policyholder and the insured under the insurance contracts, but not in relation to the injured third party.

In liability insurance, the rule that compensation is always limited to the amount of the loss will apply. Accordingly, the insured – or the injured third party, as the case may be – is allowed to demand payment under any or all of the relevant insurance contracts. The claimant is free to choose which contract or contracts to claim under.

Unless otherwise agreed, as between insurers each insurer involved in a claim shall be liable for the loss, up to the respective indemnity limit, in proportion to the maximum amount that each might have had to pay if their insurance contract applied.

Special rules may apply if different types of liability insurance are involved. For instance, a motor liability insurer will bear all the loss of an

Update and trends

By far the most relevant topic that is worthy of mention is the recent approval, by Law 147/2015 of 9 September, of the new Legal Framework of the Business of Insurance and Reinsurance. This is an entirely new set of rules regulating the taking-up and pursuit of the business of insurance and reinsurance, which came into force on 1 January 2016. This has come about so as to implement Directive 2009/138/EC of the European Parliament and of the Council of 25 November 2009, as amended (Solvency II Directive).

The next few months will most probably see a time of adjustment by the market to the new set of rules. Partly in anticipation thereof, we have already witnessed a recent surge of insurance mergers and acquisitions, as well as a restructuring of some existing businesses.

occurrence involving a motor accident with a company vehicle, even where the risk is also covered by the general liability insurer.

First-party property insurance

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

Insurance policies for first-party property coverage are designed to provide coverage against the risk of a direct loss to the insured's property. Traditionally, the most widely disseminated classes of first-party property insurance would cover risks related to ownership of several different means of transportation as well as homeowners' policies covering both buildings and their contents, while commercial first-party property coverage would protect industrial and other facilities as well as their inventory.

These classes of insurance policies typically cover material damage to the insured's property. Loss of profit will only be covered if provided for in the insurance contract, in accordance with article 130(2) of the ICL.

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

According to article 49 of the ICL, except as otherwise provided by law, it is for the policyholder to indicate to the insurer, either at the beginning or during the term of the contract, the value of the insured assets. As a general rule, the principle of freedom of contract applies to the determination of property value under first-party insurance policies, thus allowing for the inclusion of different clauses, it being possible to determine, for instance, that the relevant value will be that of a new asset with the characteristics of the insured asset, that the relevant value is that of the insured asset at the time of the occurrence or that the relevant value is that which has been agreed by the parties, as is the case in valued policies. So as not to undermine the nature of this insurance, the parties may not agree on a value that is manifestly unfounded in view of the circumstances of the case.

The valuation of rights over immoveable assets follows a different set of rules. The value of such property rights is automatically set and automatically updated according to the rates published quarterly by the Portuguese Insurance Institute. Thus, the insurer is under a duty to inform the policyholder that this automatic setting and update of the value exists and on what terms, and of the resulting value of the property rights to be considered for the purposes of assessing the amount of compensation in cases of total loss and of the applicable criteria that led to the calculation of such value.

Directors' and officers' insurance

22 What is the scope of D&O coverage?

In Portugal, ordinary D&O policies do not typically contain significant local specificities. Typically, in the local insurance market most insurers will offer D&O coverage that is heavily inspired by the wording of the products generally available on the London market. Often, the original wording in English will be used for the sake of reinsurers, no translation or adaptation being attempted. However, in addition to this international product, another is commonly distributed in the local market, designed to cater for the specific needs of local companies. The most relevant of such needs is derived from article 396 of the Portuguese Companies Code, which sets forth a legal duty upon the directors of a limited liability company to provide a surety to the company regarding their potential liability. Liability insurance is a popular form of surety in this context. As to the scope of its coverage, its most significant characteristic is that it must cover liability for wilful misconduct by a company's directors.

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

The fact that D&O policies are mostly made using original English language wording drafted in the context of a different jurisdiction causes some difficult interpretation issues that are the subject of debate both in and out of court. As to the more specific issues, questions on the extent of the company's own protection as an additional insured sometimes arise, as well as of this product's relationship with a few other liability insurance products, as to which the insurer should bear the loss in the case of multiple insurance coverage of partially the same risk. Finally, and given this product's typical exclusions, when it is ultimately dependent upon the court's final decision about whether or not the occurrence will fall under an exclusion, some debate arises about the extent of the insurer's undertaking to advance interim payments of attorneys' fees.

Cyber insurance

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

Cyber insurance as such is not specifically regulated in Portugal. Such risks are typically excluded from many policies, but the market has responded to the rising public awareness and demand for such a product. Typically, those products currently on offer cover civil liability, loss of profits and a varying range of crisis management expenses.

25 What cyber insurance issues have been litigated?

We are uaware of any litigation involving cyber insurance issues in Portugal.

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Preliminary and jurisdictional considerations in insurance litigation

1 In what fora are insurance disputes litigated?

Insurance disputes related to consumers (mass claims) are normally resolved by litigation in court, although arbitration is also available under certain limitations. Insurance disputes concerning large risks tend to be (but are not always) resolved by arbitration.

'Large risks' is a fundamental category in the framework of Spanish insurance law. We mention this at the outset of this chapter because it permeates the whole system.

As defined by article 11 of Law 20/2015 of 14 July on the regulation, supervision and solvency of insurance and reinsurance entities (Law 20/2015), which abrogated article 107.2 of the Insurance Contract Act 1980 (ICA) and entered into force on 1 January 2016, large risks are the following:

- those relating to railways, aircraft, hulls, goods in transport and civil liability derived from the use of aircraft and vessels;
- credit and surety (insurance) purchased by those carrying out an industrial, commercial or liberal profession when the risk insured relates to such industrial, commercial or liberal professional activity; and
- fire, damage to property, general liability and miscellaneous financial losses where the policyholder has the characteristics of a minimum size defined by reference to a combination of the policyholder's balance sheet, net turnover and number of employees (any two of the following: €6.2 million, €12.8 million and 250 employees, respectively). These thresholds will apply on a consolidated basis if the policyholder forms part of a group of companies presenting consolidated accounts.

The parties to a contract involving a large risk are not bound by the otherwise mandatory provisions of the ICA, and are free to agree as they wish subject to the general limits to party autonomy and to the fundamental principles of insurance. They are also free to choose the governing law and forum. Consequently, there is a divide between consumer risks and large risks, the latter not being subject to the mandatory provisions of the ICA. However, the provisions of the ICA could or would apply to a large risk on a supplementary basis if nothing has been stated in the insurance contract.

2 When do insurance-related causes of action accrue?

Generally speaking, an insurance-related cause of action shall accrue at the time of an occurrence or event that constitutes the risk covered by the insurance (eg, the fire or the burglary). Where civil liability insurance is concerned, it is common opinion that the loss equates to the harmful event.

When the cause of action accrues is key to finding out when the limitation terms start running and hence when the action becomes time-barred.

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

A number of factors need to be considered: from the perspective of insurers, the information provided on the loss, coverage issues, any applicable exclusions, the adjustment process, and last but not least the potential payment of punitive interest, which is a key issue. Under article 20 of the ICA, insurers are required to pay a punitive interest when payment of the indemnity allegedly owed is not made under certain time frames, unless there are sound and justified reasons proven by the insurer for not complying with them, which the courts tend to construe very rigidly. It amounts to the legal interest rate increased by 50 per cent for the first two years the payment is in arrears and no less than 20 per cent per annum thereafter. Obviously, this can increase the amount substantially.

Hence, the insurer must evaluate its position very carefully before denying cover or engaging in a dilatory tactic.

4 What remedies or damages may apply?

In the event of 'inaccuracies' (misrepresentations) or 'reservations' (concealment or non-disclosure) in the information provided when completing the questionnaire or proposal form, the remedies available will depend on when the insurer knows about the inaccuracies or reservations.

If the insurer knows about them before the loss takes place, it will be entitled to rescind the contract within one month of learning about the misrepresentation or reservation. In this event, the insurer may keep the premium for the period in course, except if it acted in bad faith or with gross negligence. If the loss occurs before the rescission is notified or if the misrepresentation or non-disclosure is discovered after the loss takes place, the insurer will no longer be entitled to rescind the contract but solely to reduce the indemnity in the same proportion to that existing between the premium actually collected and the premium that would have been collected had the real risk been disclosed to it. However, if the policyholder acted in bad faith or with gross negligence (which is to be proved by the insurer), the insurer will be released from its obligation to indemnify.

Damages

Damages for monetary debts consist of interest. There are four types of interest rates for late payments in Spain:

- the general legal rate, which compensates for the late (default) payment of debts pursuant to the provisions of article 1,108 of the Civil Code and is fixed annually by the Budget Law (it is 3 per cent for 2016);
- the default interest for late payment of commercial transactions, which is 8.05 per cent per annum for the first six months of 2016;
- the procedural default interest rate, which accrues on any liquid monetary judgment from the moment the first instance judgment is handed down amounting to the legal interest rate increased by two percentage points (article 576, Civil Procedure Act); and
- the punitive interest rate for late payment of insurance claims under section 20 of the ICA (see question 3).

In the matter of insurance claims, punitive interest excludes both the default legal general interest and the procedural default interest (article 20, paragraph 10 of the ICA, noting that the reference to article 921 of the Civil Procedure Act should now be understood to be made to article 576 following the amendment of the Civil Procedure Act in 2000). Commercial interest is not applicable.

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

In Spain, under the general civil rules, damages have a compensatory nature and intend to restore the position of the injured party to that position that he or she had prior to the harmful event. This provides for full redress, but at the same time prevents the injured party from profiting from the harmful event, which would equate to an unjust enrichment. Damages (both the loss actually suffered and the profit lost, if any) must be proved by the plaintiff. Apart from the punitive interest rate that insurers must pay, subject to certain requirements, if they delay payments of claims, the

concept of punitive damages that are awarded to punish or deter an especially malicious conduct or wilful misconduct of the party is not admitted in the Spanish law. Pain and suffering (moral damages) are admitted under Spanish law.

Interpretation of insurance contracts

6 What rules govern interpretation of insurance policies?

The general principle for the interpretation of any contract is good faith. This is particularly true in the case of insurance contracts, which are described as contracts of utmost good faith.

Further, the contract must be construed upon its own terms (ie, literally, provided the terms reflect the intent of the parties). If the terms appear to contradict the evident intent of the parties, the common intent will prevail and should be looked for. In looking for the intent, actions before, during and after the contract can be taken into consideration. In other words, if the intent of the parties flows clearly from the terms of the contract, such terms will be applied and no interpretation will be required (article 1,281 of the Civil Code, article 57 of the Commerce Code and related case law). There are also a number of subsidiary construction rules.

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

An insurance policy provision is ambiguous when its meaning does not come across clearly and it is necessary to interpret it.

Ambiguities are resolved pursuant to the following rules.

Whatever the general terms of a contract may be, things and cases different from those the parties intended to agree upon should not be understood to be included in the contract (article 1,283 of the Civil Code and Decision of the Supreme Court of 23 November 1988).

If a clause admits several meanings, it shall be construed in the more adequate manner so that it produces the desired effects in the context of the contract (article 1,284 of the Civil Code). However, the effects should be inferred from the intention of the parties (Decision of the Supreme Court of 22 April 1959). The purpose of this provision is to exclude those interpretations that would render ineffective, pointless or misleading the clauses of a contract (Decisions of the Supreme Court of 18 April 1941, 21 April 1951 and 2 February 1952).

The clauses of the contract should be construed in connection with each other, assigning to the doubtful clauses the meaning resulting from all of them as a whole (article 1,285 of the Civil Code and Decision of the Supreme Court of 26 February 1985).

Words with different meanings shall be understood in the manner that would better accommodate the nature and purpose of the contract (article 1,286 of the Civil Code).

The usage or custom of the land will be taken into account to interpret any ambiguities in contracts, particularly where certain clauses that are normally included in contracts are omitted. However, more than as a rule of interpretation, this rule serves to integrate or complete the contract (Decision of the Supreme Court of 15 October 1965).

There may be doubts concerning the interpretation of a contract that cannot be resolved under the rules indicated above. If such doubts refer to the 'accidental' elements of the contract (condition, term, mode), how these doubts are resolved will depend on whether the contract is gratuitous (not for a valuable consideration, eg, a pure gift or donation) or onerous (for a valuable consideration, eg, a loan with interest). If it is gratuitous, any doubts on such accidental elements will be construed in such a way that the party benefiting from the gratuitous contract will acquire fewer rights and interests. Assuming the gift is subject to a certain mode (the party receiving it must do something that in proportion to the gift does not turn it into an onerous contract), any doubts on what the beneficiary of the gift should do will be construed in such a way that the beneficiary of the gift acquires fewer rights. On the contrary, if the contract is onerous, any doubts on those accidental elements will be construed in such a way that the party acquires more rights and interests. Assuming, for example, that there are doubts on the term given to the debtor to pay (whether it was 30 or 60 days), the debtor will be given 60 days.

If there are doubts on the essential elements of the contract (cause, object) of such kind that it is impossible to discern the intent of the parties, the contract will be null and void.

In any case, ambiguities are construed against the drafter of the contract (contra proferentem). In consumer insurance, which is characterised as an 'adhesion' contract by case law, any ambiguities will be construed against the insurer.

The law on standard contract terms must also be considered. It applies to both consumers and non-consumers.

Notice to insurance companies

8 What are the mechanics of providing notice?

As a general rule, insurance claims must be reported within seven days from the moment the insured knew about the loss (article 16, ICA). A longer term can be agreed for the benefit of the insured. Shorter terms could be agreed in the case of a large risk. In practice, however, many policies insert imprecise wording of the type 'as soon as possible or practicable' and the like, which conceivably could be longer than the statutory seven days.

The policyholder or the insured have the duty to provide all information available on the circumstances and consequences of the loss. The breach of this duty with gross negligence or bad faith on the part of the insured would release the insurer from its obligation to indemnify.

The foregoing provision is connected with the general duty of salvage in all casualty insurances that is to be understood as the duty to diminish or reduce the loss (article 17, ICA). If the insured breaches that duty, the insurer will be entitled to reduce the indemnity in the relevant proportion taking into account the significance of the damages derived from the breach and the degree of fault of the insured. If the insured had the intent to prejudice the insurer, the latter will be released from its obligation to indemnify.

Once the loss has occurred and within five days of the notification of the loss, the insured or the policyholder is required to notify the insurer in writing of the list of the existing objects at the time of loss, of those saved and the estimate of loss. The insured is required to prove the pre-existence of the objects. However, the policy itself will constitute a presumption in favour of the insured where no further evidence could be reasonably provided. The insured must also provide all relevant information on the circumstances of the loss at the request of the insurer. The insurer is bound to pay the indemnity at the end of the necessary investigations and adjustments in order to establish the existence of the loss and the quantum thereof, if any. If the parties disagree on the quantum, expert adjusters designated by the parties will sort out the issue.

The law provides nothing about a report of the facts and circumstances that could give rise to a claim eventually. Policies usually require for a report of the facts and circumstances, and attach certain legal consequences to such report.

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

Claims-made policies are acceptable within certain conditions under article 73 of the ICA. To be valid and enforceable, these clauses can follow one of two modalities: claims can be made until at least one year after coverage has ceased for losses that occurred during the policy period; or claims can be made during the policy period, but cover should be extended to those losses that occurred at least one year before the inception of the policy provided the insured was not aware of them. Longer terms would be admissible; shorter terms would not, and would render the clause null and void.

The law provides that these clauses limit the rights of the insured. Consequently, to be valid, these clauses must be highlighted and written in bold letters, and the policyholder or the insured must accept them explicitly.

The limitations set out for claims-made clauses would not apply to large risks.

10 When is notice untimely?

Notice is untimely when it is not given within the time frame provided in the contract or after seven days if nothing is said in the contract.

11 What are the consequences of late notice?

Late notice may entitle the insurer to deny cover only if the insured delayed notice wilfully with the intent to prejudice the insurer. Otherwise, the insurer may only request damages for any proven prejudice suffered as a result of the late notice but may not deny cover. The burden of proof lies on the insurer. The parties to a large risk contract can provide for different rules. For example, the parties could make a timely notice a condition precedent to cover.

Insurer's duty to defend

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

As a general rule, the insurer is required to defend the insured against the injured third-party claims, unless the parties agree otherwise. The insurer will also bear the costs of such defence. The insured is required to cooperate with the defence as needed. The defence will encompass both extrajudicial and judicial assistance.

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

A breach of an insurance contract would compel the insurer to indemnify the insured and hold him or her harmless from any and all damages caused by the lack of defence.

Standard commercial general liability policies

14 What constitutes bodily injury under a standard CGL policy?

Bodily injury is bodily lesion or death caused to individuals.

15 What constitutes property damage under a standard CGL policy?

Property damage is destruction, deterioration or loss of things or animals.

16 What constitutes an occurrence under a standard CGL policy?

An occurrence is any event for which the insured may be legally responsible, provided it is the subject matter of the insurance contract and activates the cover under the terms and conditions agreed in the policy.

17 How is the number of covered occurrences determined?

There is no express provision in the law in this regard, although some judgments of the lower courts (courts of appeal) refer to the issue (eg, judgment of the Provincial Court of Madrid dated 30 September 2014). Policies usually provide that it is one single loss event or series of harmful events due to the same original cause, irrespective of the number of claimants and claims lodged and the number of persons whose personal liability may be put into question. The judgment quoted above, while recognising in principle the validity of the insurance clause, questions whether the cause in the case examined was the 'same original cause', and makes a subtle distinction between 'the same original cause' and causes that are objectively similar but autonomous in time, space and damaging effect, hence concluding that in the case examined several losses had occurred. It follows that this clause might be subject to close judicial scrutiny, particularly in the case of consumers' insurance.

18 What event or events trigger insurance coverage?

Those events envisaged in the policy that constitute the risk covered trigger coverage. See question 2.

19 How is insurance coverage allocated across multiple insurance policies?

Where two or more policies taken out by the same policyholder with different insurers cover the effects of the same risk over the same interest and for an identical period of time, the policyholder or the insured must, except as agreed otherwise, communicate to the other insurances that he or she might stipulate to each insurer. If this notice is omitted maliciously, and the loss takes place in a situation of over-insurance, the insurers are not bound to pay the indemnity. Once the loss has occurred, the policyholder or the insured must notify it, in accordance with article 16 of the ICA, to each insurer indicating the name of the others. The insurers will contribute to the payment of the indemnity in proportion to the sum insured by each of them, with the actual amount of damages operating as a cap. Subject to this cap, the insured may claim the indemnity due under the respective contract to each insurer.

The insurer that has paid more than the amount that proportionally corresponds to it may recover the difference from the remaining insurers. If the total amount of the insured sums notably exceeds the value of the interest, the provisions of the ICA on overinsurance shall apply.

There are some points that have arisen in practice that are noteworthy. The policies must have been taken out by the same policyholder. What if one has been purchased by the wholly-owned subsidiary and the other by the parent company? Would the requirement be deemed met? Further, the risk, interest and period of time of both policies need not be identical but should at least coincide partially; and last, all the policies should operate jointly with regard to the loss. What if one or more operate in excess of the other or others (by virtue of other insurance clauses) and with a difference of conditions? Case law has found that this requirement was not met if one of the policies operated on a subsidiary basis (Decision of the Supreme Court of 24 July 2007).

Update and trends

As mentioned in question 1, Law 20/2015 entered into force on 1 January 2016. At the same time, the Regulation and Supervision of Private Insurance Act 2004 was abrogated, except for a few provisions that are still in force. Law 20/2015 transposes into Spanish law the Solvency II Directive, as amended by the Omnibus Directive. According to the Solvency II Directive, Law 20/2015, inter alia, introduces economic risk-based capital requirements, and regulates the corporate governance of insurance and reinsurance entities to provide greater transparency and improve the professionalism and reputation of corporate management.

Law 20/2015 has also amended several provisions of the Insurance Contract Act 1980, namely on the transparency of policies regarding coverage, limitations and exclusions, the aggravation of risk and the timings for policyholders to oppose the extension of a policy.

First-party property insurance

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

The protection of the tangible goods and assets belonging to the insured or regarding which he or she may have an insurable interest, including improvements and renovation works of buildings property of third parties. The protection extends to moveable property of third parties that is in the power or under the custody of the insured or its employees, as well as any other property for which the insured might be responsible.

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

Under normal circumstances, property will be valued for its replacement cost.

Directors' and officers' insurance

22 What is the scope of D&O coverage?

Basically, the scope of D&O coverage extends to side A (liability of the insured person for any negligent wrongful act resulting in loss), side B (reimbursement to the insured entity of any loss paid on behalf of any insured person) and side C (securities claims).

A wrongful act or omission is any act or omission committed, attempted, or allegedly committed or attempted, by an insured in his or her insured capacity. It also includes any matter claimed against him or her solely by reason of his or her serving in such insured capacity.

Loss is the total amount that an insured person is legally liable to pay as a consequence of a claim. Loss shall include, among other items, damages, defence costs, legal representation expenses and public relation expenses.

Regard should be paid to the reform of the rules on directors' liability, which have been in force since 24 December 2014.

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

Some issues that are commonly litigated in the context of D&O policies include:

- disclosure of risk: the questionnaire-proposal form;
- severability of declaration provision;
- severability of conduct provision;
- defence costs, advance and allocation;
- defence costs, return of defence costs;
- fraud exclusion, consequences;
- fines (criminal, regulatory, civil);
- other penalties exclusions;
- late reporting; and
- disgorgement or restitution.

Cyber insurance

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

Cyber insurance policies may provide coverage for, among others, the following types of risks:

- identity theft as a result of security or data breaches;
- illegal access to confidential information;
- transmission of malware, worms, spyware, trojans and other malicious computer code;
- cyber extortion;
- business interruption;
- theft of intellectual property;
- damage to a firm's reputation;
- fines and penalties imposed by regulatory bodies; and
- third-party damages.

25 What cyber insurance issues have been litigated?

Cyber insurance is a relatively new product in the Spanish insurance market. To our knowledge, there have been no court decisions to date in Spain dealing with cyber insurance disputes.

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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 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, since 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 in the same way 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 contactor 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 regards 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, since 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. 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 as a main principle are legally enforceable.

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 moveables 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 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 includes, 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 replaced 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.

Update and trends

M&A insurance has become fairly common, and M&A insurance policies have been subject to major arbitration proceedings in Sweden.

There have been substantial court litigations against auditors and board members related to alleged incorrect annual reports, loss caused by trading activities and loss of licences to conduct banking business. Insurers are heavily involved in these disputes. Legal action against law firms seeking compensation for damages caused by alleged negligence also seem to be on the increase. This development will probably continue.

Moreover, for the past few years insurance companies have been increasingly inclined to subrogate against third parties and other insurers, meaning that the number of disputes between insurance companies has increased. This development is applicable to both court litigation and arbitration.

Directors' and officers' insurance

22 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).

23 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

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officers may be held personally responsible, which in turn triggers the D&O policy.

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

24 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 due to data loss from property damage, hacker attacks or physical sabotage;
- loss of data access;
- disruption damage due to 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.

25 What cyber insurance issues have been litigated?

To date, there have been no public cases in relation to cyber insurance in Sweden.

Switzerland

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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 that courts 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.

Update and trends

Insurers, and in particular life insurers, have stated that they are having great difficulty finding adequate possibilities to invest in in light of the general low interest rates.

The increasingly tough supervision of insurance activities may lead, inter alia, to more inquiries in the sector.

Finally, at this stage it is unclear whether the Swiss parliament will take the up revision of the Private Insurance Act again; this has, for the time being, been rejected.

Directors' and officers' insurance

22 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.

23 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

24 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.

25 What cyber insurance issues have been litigated?

We have no knowledge of any cyber insurance litigation having taken place in Switzerland to date.

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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. It is also possible to initiate international or domestic arbitration proceedings.

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. In order to apply to the tribunal, no arbitration clause is needed provided that the insurer is a member of the Commission. Regarding disputes arising out of mandatory insurances, if the insurer is not a member of the Commission, the insured, beneficiary and policyholder are still entitled to apply to the arbitral tribunal.

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). 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.

In Turkey, it is usually the case that insurers refrain from paying the indemnification; thus, insurance coverage denial is rather common in insurance disputes.

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 competency of the courts or an arbitral tribunal;
- the 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 expenses of the claimant's attorney); 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 as well as the determination of the material facts in relation to loss is particularly important to detect whether the insured has increased the risk of occurrence. 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 insured's recourse actions must be considered carefully since there are conditions to be met in order to initiate litigation for recourse claims. The following should be noted:

- to be entitled to the right of subrogation, firstly, the insurer must pay the indemnity to its insured. The precedents in this regard require the indemnification to be paid to the rightful person;
- the right of subrogation only covers the amount that is paid by the insurer to the insured and the interest applied to such amount starting from when the payment was made. The insured remains the rightful owner of the remaining amount that is not covered by the insurer; and
- the insured should be entitled to ask for indemnification from the third party in order for the insurer to ask for the same; for example, if the insured has committed misconduct that led to the damage, then the insurer, as the subrogee of the insured, shall not have any right of subrogation against the third party, since the third party did not cause the damage.

4 What remedies or damages may apply?

As it is not possible to request specific remedies, monetary damages are claimed in a typical litigation case.

Monetary damages would cover the indemnity 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 2016 being 11.5 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.

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 due to the principle of prohibition of enrichment. It is, however, possible to insert

penalty clauses in agreements where one or more of the parties agrees to pay a certain sum of money or perform an action if he or she 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.

With regards to extracontractual damages, Turkish law provides for indemnification against tortious acts provided that there is a tortious act, damages, causal link between the act and damages, and fault. However, indemnification based on a tortious act is not applicable in insurance litigation, since insurance litigation is not based on conflicts related to tortious acts, but is based on contractual obligations.

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 who formulated the provision, who is usually the insurer.

Other than such, the basic principle of the contract remaining in force and the consensus of the parties are also dominant in the interpretation of insurance policies.

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

As per article 1425 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.

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, those points 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 Appeal ruled a decision of reversal where it determines that the indemnification requested by the insured should have been identified and 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. However, 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 has chosen to use different wordings when stipulating the notice duty of the insured; namely, in the general provisions of the TCC, the notification duty of the insured must be accomplished without delay, whereas in liability insurance it must be pursued immediately.

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 occurrence of the risk.

The only remedy is that, 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. When there is such an alteration, the rules provided in the TCC will directly apply.

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 the insurer 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. However, third-party liability insurance provides coverage for financial damages.

As per the general terms 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 independent auditors' professional liability insurance, motor vehicles liability insurance, professional liability insurance, financial liability insurance, employer's liability insurance and medical injury liability insurance.

In financial 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 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 terms of professional 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 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, 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?

In 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 real estate, establish whether it has adequate fire alarm systems or the real estate's likelihood of burning. Using information from the expert and the insured, the insurer sets the value of the property, and thus the coverage of the policy.

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.

Directors' and officers' insurance

22 What is the scope of D&O coverage?

As per Turkish legislation, there is no standard D&O insurance coverage, since this type of insurance is not specifically regulated under Turkish law and the general terms 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 in 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 the litigation costs, provided that there is a deductable stipulated in the contract and excluding any wilful misconduct and misrepresentation of the D&O.

23 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

24 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.

25 What cyber insurance issues have been litigated?

No cyber insurance issues have been litigated in Turkey to date.

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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.

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 legal entity), or a foreign legal entity with a domicile or place of residence in the UAE (Civil Procedures Law (Federal Law 11 of 1992) 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 is to the 'value of insurance', jurisdiction is vested in the court where the beneficiary has its residence or where its property is located. 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. However, there are certain formalities that an arbitration clause has to comply with in order to be valid. One of these formalities relates specifically to arbitration clauses in respect of insurance contracts and provides that the arbitration clause must be in a 'special agreement separate from the general printed conditions of the policy' (Civil Code (Federal Law 5 of 1985) article 1028(1)(d)).

Fourth, the UAE also has a series of free zones, including the Dubai International Financial Centre (DIFC), which has its own 'civil' (ie, non-criminal) laws and its own court to administer those laws. DIFC law is a common law legal system largely based on English and common law substantive civil law and procedure. Parties are free to choose DIFC law and jurisdiction to govern their contracts.

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 (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 (Commercial Maritime Code (Federal Law 26 of 1981) 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 of Evidence in Civil and Commercial Transactions No. 10 of 1992, article 90 (i)), the court will usually follow the recommendations in the expert's report.

In civil cases, evidence is provided by way of document rather than witness evidence.

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 a party to produce documents, there are no sanctions for failing to do so, although a negative inference may be drawn from a failure to provide them.

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, a small amount in respect of legal fees), UAE courts do not award costs.

There is no pre-action protocol or procedure.

Interest runs generally from the date on which a claim is filed at court (Federal Law 10 of 1993 article 78), or the date upon which the judgment becomes final (at the discretion of the Court), until the claim is settled. Absent agreement in the contract, interest rate is awarded at the discretion of the court up to a maximum of 12 per cent (Federal Law 10 of 1993 article 76).

4 What remedies or damages may apply?

The insured is entitled to an indemnity or the sum specified in the policy (Civil Code articles 1026 and 1034).

No other damages are payable for late payment of the indemnity or specified sum, although interest is payable on claims (see above).

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, article 3 (2) of the Insurance Authority Directive (IA Directive) (Code of Conduct for Insurance Companies issued by the UAE Insurance Authority (Insurance Authority Resolution No. 3 of 2010).

It follows that it may theoretically be possible for the insured to claim 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), to claim damages for consequential losses flowing from the insurer's breach, or both.

However, punitive damages are not generally awarded in the local court, 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 the IA Directive).

A party's obligations under the contract extend beyond what is expressly contained in the contract to include an obligation to do that

which is related to the contract via law, custom or 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 given for any other interpretation (Civil Code article 258(2) and article 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)). In this regard, the court will construe it against the 'obligor' (ie, the debtor) (Civil Code article 266), although this provision does not apply to 'contracts of adhesion' (ie, standard form contracts; Civil Code article 266).

Policies issued in the UAE are to be issued in Arabic (Insurance Law (Federal Law 6 of 2007) article 28), and may be translated. If there is a difference in interpretation between the two, 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 'shown conspicuously' (Civil Code article 1028(c). According to the IA Directive (article 7(2), such clause should be 'clearly shown' (ie, in a different font or colour), while the Insurance Law (Federal Law 6 of 2007) stipulates it should be shown in a prominent manner and a different colour, and must be 'approved' (namely endorsed) by the insured (article 28).

This definition covers warranties, exclusion clauses and conditions precedent.

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?

When construing a contract of insurance, where there is 'scope for interpretation' of the contract, the court will make enquiry into the intentions of the parties, as well as the nature of the transaction with due regard to the current business practice (Civil Code article 265(2)). (See also above: the court will construe it against the 'debtor' (save in contracts of adhesion) (Civil Code article 266)).

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.

The IA Directive provides that the procedures the insured has to follow upon the occurrence of the risk have to be clearly indicated on the policy (IA Directive article 7(5)).

The content of the notice will typically require a summary of the claim or circumstance, quantum information sufficient for insurers to assess coverage together 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, a claim or circumstances under an insurance policy.

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 as regards breach of contract will apply (subject to the comments below). 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 (see below)).

There may be provisions in the policy as regards notification. In that regard, if the insured has a 'reasonable excuse' for the delay, a term that provides that late notification means an insured's rights shall 'lapse' under insurance policy will be void under UAE law (Civil Code article 1028(b)).

Further, 'arbitrary' clauses are void (ie, where a breach 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 Directive of 2010 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?

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 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 will 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?

Compensation is payable under UAE law for 'any harm caused to a person' (Civil Code article 299).

In addition to compensation for bodily injury, pain and suffering (ie, moral damages) are recoverable under UAE law (article 293 Civil Code).

15 What constitutes property damage under a standard CGL policy?

There is no such standard UAE policy, and 'property damage' is not defined in UAE law.

The Civil Code (article 300) 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 case law or development law on this issue in the UAE (unlike, eg, 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 concept 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 a 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?

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 includes cover for business interruption, property damage and fire claims.

Update and trends

The UAE has the biggest insurance market in the Gulf Cooperation Council. It has the following features:

- there is generally low insurance penetration, although motor insurance (and health insurance in certain emirates) are compulsory;
- only licensed insurers can write business 'on shore' in the UAE (there is currently a moratorium on the issuing of new onshore licences). Therefore, significant additional capacity is provided by way of reinsurance. The DIFC is an important reinsurance market, with Lloyd's having opened there in 2015; and
- the Insurance Authority was established in 2007 and is still relatively new. It has started the process of issuing directives, and the insurance market is becoming increasingly regulated.

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 (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).

Directors' and officers' insurance

22 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.

D&O insurance has not been widely purchased in the UAE to date. This may change as a result of the new UAE Commercial Companies Law (Federal Law No. 2 of 2015) widening the duties and liabilities of directors and officers (including managers), and broadening sanctions for breaches of those duties.

As a result of the widening duties and liabilities of directors and officers under 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, which is likely to be the responsive cover.

23 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), whether this is a claim that should be (or can be) notified under D&O.

Cyber insurance

24 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 on Combating Cyber Crimes.

Those cyber insurance policies that are available in the UAE are largely based on London market wordings.

25 What cyber insurance issues have been litigated?

To our knowledge, there have been no reported claims before the UAE courts under cyber insurance policies.

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Preliminary and jurisdictional considerations in insurance litigation

1 In what fora are insurance disputes litigated?

Insurance disputes can be litigated in all the following fora of the civil courts:

- county courts;
- High Courts (for appeals from other courts or for 'first instance' claims exceeding £100,000);
- the Court of Appeal; and
- the UK Supreme Court (appeals only from the High Court or the Court of Appeal).

The High Court has a specialist court, the Commercial Court (part of the Queen's Bench Division), which hears insurance and reinsurance disputes and is highly experienced in complex insurance disputes.

It is important to note that the court views litigation as 'a step of last resort' and encourages parties to resolve their dispute without issuing proceedings by considering an alternative dispute resolution (ADR) mechanism instead. Failure to use ADR (such as mediation) may lead to the refusing party being required by the court to pay more of the other party's costs.

The use of the contractual dispute mechanism of arbitration is very common in insurance disputes and, properly drafted, such a commitment is enforceable in England. Arbitration may be conducted under the rules of an arbitral institution such as the London Court of International Arbitration or may be ad hoc.

A large proportion of consumer cases are dealt with by the Financial Ombudsman service. This hears complaints and will provide a decision that will usually be followed by insurers. There may be regulatory repercussions for any insurer that does not respect a decision of the Financial Ombudsman.

2 When do insurance-related causes of action accrue?

The general position under English law is that claims for breach of contract must be brought (by issue of proceedings – a mere letter will not be sufficient) within six years of the accrual of the cause of action. In general contracts, this is six years from the date of breach, but in insurance matters the issue is rather more complex and requires care.

As to liability policies, the insured's right to be indemnified arises when the liability is ascertained (by agreement, award or judgment) rather than when the underlying event that gave rise to the liability occurred. For other forms of insurance, such as property, marine or life insurances, the cause of action accrues when the event occurs (eg, the relevant death).

The difference in when time begins to run can be a trap for the unwary. Often of greater practical urgency, however, since so many claims are dependent upon notification, is that cover will not be available if notification is not made in accordance with the policy terms (as is explained further below).

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

There are a number of procedural and strategic considerations:

- dispute resolution clause and choice of law: it is important to refer to the policy for the applicable dispute resolution mechanism and choice of law. It is very common in commercial insurance in England and Wales for claims to be arbitrated; it is also not uncommon for large claims to be heard in England under a different law (eg, where the policy is governed by New York law but with provision for arbitration in London – this is typical in 'Bermuda Form' policies);
- other steps: although less common in insurance than in other commercial areas, there may be other steps that the parties would need to take (such as mediation) before issue of any formal proceedings. In any event, the courts will expect the parties to confirm that they have considered mediation;
- time and cost: for disputes to be heard in the English High Court, the Civil Procedure Rules require a front loading of costs to enable the parties to understand each other's cases before proceedings are issued. Once proceedings are issued, at least a year is likely to pass before the court hearing. There are a number of procedural steps to be taken during this time;
- disclosure: in English court procedure, parties have to search for, review and disclose documents on which they rely or that adversely affect their own case or the other side's case. The disclosure process (which relates only to documents; depositions form no part of English procedure) can be invasive, time consuming and very expensive compared with the disclosure process in, for example, civil law jurisdictions;
- witnesses: English court (and indeed typically also arbitral) procedure requires that parties produce witness statements in support of their case. The statements are produced by way of evidence in chief and the witness is then cross-examined on his or her evidence. A potential difficulty can arise if a witness is no longer with the company, does not want to give evidence, or both; witnesses outside the jurisdiction cannot be compelled to attend before the English court;
- statements of truth: parties are required to sign statements of truth to English pleadings. Therefore, even if the instructing party is not a witness, a responsible individual from the insured and insurer will need to certify the truth of key facts that give rise to that party's position. A false statement of truth is a contempt of court and could in certain circumstances expose individuals to potential imprisonment;
- legal costs: the general position in England and Wales is that the losing party pays the legal costs of the winning party. In the past, this has produced a recovery for the winning party of about 60 to 70 per cent of that winning party's costs. The amount of recovery is now less certain in light of new court rules, since more complex court-approved costs budgeting is required in many cases as well as greater court analysis of the costs. A losing party will have to pay its own costs in any event (in addition to a significant proportion of the winning party's costs);
- appeal: this is not permitted as of right. If permission to appeal is given, this will typically add nine months to a year to the litigation process and some further expenses before the litigation is at an end. Arbitration typically carries very limited scope for appeal (which forms part of its attraction for many parties);
- confidentiality: the starting point is that a court hearing (unlike arbitration) will be held in public. In exceptional circumstances, a hearing or a part of it may be conducted in private. Therefore, before starting proceedings, the parties should be aware of the fact that members of the public as well as journalists can attend the hearing. This may bring unwanted publicity;
- relationship with insurers: the insured needs to consider if it has other policies with the same insurer either linked to the same dispute

or covering different risks. Starting proceedings against the insurer (albeit necessary) may be detrimental to the relationship between the parties, and if the relationship is damaged beyond repair, the insured may have the added burden of policy transfer or renegotiation;
- mitigation: the policyholder must usually in practice take steps to mitigate the loss; and
- other insurance: it can happen that the same loss is covered by one or more policies. Care will be needed to understand the priority that applies to the policies or, if there is scope for overlap, to understand how the policies interact. A failure to notify is more than likely to be fatal to a claim.

4 What remedies or damages may apply?

Insured's remedies

The best remedy for the insured will typically be full and timely payment under the policy. An insured will therefore often seek a declaration that the insurer must pay the claim or damages, which amounts to the same result. Even if a declaration is – or damages are – ordered, this may be a partial remedy, since it may prove an inadequate remedy for late payment. English law does not currently permit awards of damages for late payment. Interest on the late payment can be awarded but may fall short of the true loss.

New legislation is currently under review that will permit damages for late payment (see also the Update and trends section). The Enterprise Bill 2015 is intended to amend the Insurance Act 2015 to imply a term in every contract of insurance that insurers must pay any sums within a 'reasonable time'. If the insurer then fails to pay within a reasonable time, the insured would be entitled to pursue a claim for damages. The Bill provides for contracting out of this implied term in non-consumer contracts, provided the insurer satisfies the transparency requirements set out in the Insurance Act and unless the breach is deliberate or reckless.

Insurer's remedies

As noted above, the insured will often seek a declaration that the insurer pay the claim or damages. The insurer can also seek a declaration to the opposite effect, namely that it is not liable for the insured's claim. Under the current legal framework, the insurer's main remedy for breach of the policy is avoidance if a warranty or a condition precedent is breached. Another possible remedy for the insurer is damages. If the insured has not complied with a notification clause that is a condition (rather than condition precedent) and the insurer has suffered loss as a result of this, the insurer can claim damages.

The Insurance Act 2015 will change the framework of remedies when it comes into force in August 2016. For example:
- breach of a warranty will suspend the policy rather than avoiding it. An insurer will only be discharged from liability while the warranty is breached, and will not be discharged if the breach is remedied before a loss occurs;
- if the insured breaches a term that is entirely unconnected to the actual loss, the insurer will not be able to rely on this breach to reduce or extinguish liability. An insurer can only rely on the breach if it could have increased the risk of loss that occurred; and
- a schedule to the Insurance Act 2015 sets out a series of proportionate remedies available to the insurer in the event that the insured breaches its duty of fair presentation of risk. If the insured breaches this duty deliberately or recklessly, the insurer may avoid the contract and retain the premium paid. In the case of innocent breach, the aim is to put the insurer in the position that it would have been in if there had been fair disclosure. If the insurer with the knowledge of the true facts would not have signed the policy, the insurer can avoid the policy. However, if the insurer would have entered into the policy on different terms, the policy is to be treated as if it had been entered into on the basis of the new terms. In the event that the insurer would have charged a higher premium, the insurer may reduce proportionately the payment to the insured. For example, if the actual premium charged is 90 per cent of the higher premium, the insurer will only pay 90 per cent of the value of the claim.

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

Insurance contracts fall within the general rule that extracontractual or punitive damages are not awarded for breach of contract under English law. The court is also restricted to awarding simple interest, at its discretion, under the Supreme Court Act 1981. The court has an equitable jurisdiction to award compound interest, but this is exercised in very limited circumstances, and compound interest is not generally awarded as a penal measure.

Interpretation of insurance contracts

6 What rules govern interpretation of insurance policies?

An insurance policy is a contract, and will therefore be interpreted in accordance with the general principles of contractual construction under English law. There are a number of guiding principles.

Contract interpretation is an objective process whereby the court aims to establish the meaning of the document to a reasonable person having the background knowledge available to the parties at the time of entering the policy. The sources for interpreting an insurance policy are the text of the policy itself; and the factual matrix at the time of the contract – that is, the setting of the transaction excluding the previous negotiations between the parties and their subjective intent.

If the insurance policy is taken out by a consumer, there will be focus on whether a term of the policy is unfair to the insured. The starting point for evaluating this will be the Consumer Rights Act 2015. It should be pointed out that if a consumer or a small business (turnover of less than €2 million and fewer than 10 employees) interprets a term in a policy as unfair and the insurer takes a different view, the insured can bring its complaint to the Financial Ombudsman.

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

An insurance policy is ambiguous if a provision can have more than one meaning or if the policy is silent in relation to a particular situation. Ambiguity is resolved by applying the process of contractual interpretation set out in question 6. The following principles are also relevant:
- the natural meaning of words: it is generally accepted that in the process of interpretation, words should be given their natural meaning. This should be treated with caution in an insurance context. The word 'flood' in a policy listing 'storm, tempest or flood' as loss-causing events may be interpreted as gradual accumulation of water leading to overflow or a violent deluge. Both of these meanings are natural. The Court of Appeal decided that 'flood' is to be taken in context and interpreted it to mean a violent event (*Young v Sun Alliance* [1976] 3 All ER 561);
- previous court decisions: as noted in the preceding paragraph, in the event of policy ambiguity the parties should also consider previous court decisions. Analysis of words and phrases and their meaning by other common law courts can also be of assistance, but it should be noted that they are not binding on the English court;
- contra proferentem rule: the general position is that, if a text is ambiguous, it is interpreted against the person who drafted the text. Usually the insurer 'holds the pen' in policy drafting, and it is easy to assume that an ambiguity in the policy would be resolved in favour of the insured. However, when the policy wording has been drafted by a broker who is the agent of the insured, the words of the policy would be interpreted against the insured;
- extrinsic evidence: as noted in question 6, evidence about the previous negotiations between the parties and their subjective intent is not admissible;
- business common sense: in contractual interpretation, the courts have considered that it is appropriate for them to have regard to considerations of commercial common sense when the meaning of a term is ambiguous. Recently, however, the courts have favoured a literal approach to contractual interpretation despite the fact that this may not yield a commercially sensible outcome. In *Arnold v Britton & Ors* (2015), the Supreme Court emphasised that business common sense should not be used to undervalue the importance of the words used;
- implied term: the courts have the power to imply a term into the policy if the text is silent on a particular point. The party asking for the insertion of an implied term should be able to demonstrate that if the parties had addressed their minds to the circumstances they would have included such a term in the policy. It needs to further spell out the term and show that the implied term is necessary to make the policy work; and
- Consumer Rights Act 2015: if the insurance policy is taken out by a consumer and there is doubt about its meaning, the interpretation most favourable to the consumer prevails (section 69).

Notice to insurance companies

8 What are the mechanics of providing notice?

The insurance policy will usually make specific provision as to the steps that an insured needs to take to notify the insurer of a circumstance likely to give rise to a claim or loss or of an actual claim or loss. A notification provision will specify what needs to be notified, when the notice should be made, the recipient of the notice (the broker or the underwriter, or both), which address to send it to and the manner of providing the notice. There will frequently be a requirement that a loss or event be notified as soon as reasonably practicable. Often, there will also be a specific time period (eg, 30 days). If the policy contains these provisions, they must be carefully considered (see further below). Additional traps for the unwary can be if the policy includes requirements as to the level of detail (eg, as to the loss flowing from an event) or as to the time period for filing a proof of loss. These need to be noted and as far as possible observed. Attempts to make 'blanket notifications' covering as yet unknown losses or events can often be rejected.

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

The policy will require the insured to give notice of a circumstance likely to give rise to a claim or loss or of an actual claim or loss. Careful review of the precise policy obligation is vital, as explained below.

10 When is notice untimely?

Notice about loss or claim

If a notice is of a loss or claim, it should be given upon the occurrence or within a specified period of time. The policy will often be very precise as to what constitutes loss or claim. If a clear loss event has occurred, then notice should be given. A failure to give notice after a specific loss may cause the policyholder to lose cover. (A discovery period in the policy may be an important breathing space to enable notifications to be made after the policy period has expired.) The process of proving actual loss may involve complex analysis, calculations and meetings. It is in the interest of the insured to keep the insurer abreast of such events, as the insurer may have discretion to extend the time period.

Notice about a circumstance likely to give rise to a loss or claim

Again, the insured needs to check the policy wording very carefully. Usually a notice regarding a circumstance that is likely to give rise to a loss or claim is to be given as soon as reasonably practicable or possible. It is important that the notice giver has acted reasonably in the circumstances. A notice provided more than a year after the death of a policyholder was not considered by the courts to be unreasonable because the personal representatives of the deceased were not aware of the existence of the policy (*Verelst's Administratrix v Motor Union Insurance Co* [1925] 2 KB 137). However, if an insured notified an insurer three months after a letter of claim, the notice may be considered to be untimely. Care and diligence in understanding the policy terms are important, and it is usually far better to be prudent and make a notification even if it is difficult to predict how a possible circumstance may develop. Judging whether a circumstance is likely to give rise to a claim often looks very different in hindsight.

11 What are the consequences of late notice?

The consequences of late notice will often be specified in the policy. The consequences frequently depend on whether the notice provision is a condition precedent to payment or a condition. In the case of the former, the insurer will be able to avoid payment under the policy if no notification is made. If the notice provision is a condition, breach would be a breach of contract that would entitle the insurer to damages. To claim these damages, the insurer would have to show loss. The insured in turn will dispute this loss, and it is a balancing act for the insurer as to whether to go down this route.

Ultimately, late notice, even if not objected to by the insurer, could delay assessment of liability and payment of the claim.

Insurer's duty to defend

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

There is no general rule of English law placing the insurer under a duty to defend a claim made against the policyholder. However, an insurer itself may offer the 'duty to defend' as a policy enhancement. This could be subject to the caveat that the insurer is not obliged to defend the claim if there is no reasonable chance of success or if the claim is not covered by the policy, or both.

It is more common practice that a policy will contain subrogation and assignment language. Subrogation entails the substitution of the insured with the insurer upon payment of a claim whereby the insurer assumes the insured's legal rights. The consequences of subrogation are that any claim brought by the insurer against a third party must be in the name of the insured. The insured would receive payment if the claim is successful and the insurer would have a right to recover these proceeds to the extent that they cover the payment that it has made to the insured (plus interest). With assignment, the insurer essentially assumes all the rights and obligations of the insured. For this reason, assignment to the insurer upon payment is not an automatic process, but is usually upon the insurer's request. The benefit of assignment is that the insurer can initiate a claim against a third party in its own name and thus would receive any payment made if the claim is successful, including any surplus above the amount that the insurer paid to the insured under the policy.

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

In the event that the policy incorporates a 'duty to defend' provision and the insurer decides not to defend a claim because it considers that there is no reasonable chance of success, this can lead to a dispute with the insured. Such dispute is to be resolved by applying the dispute resolution mechanism in the policy (if the insured thinks it is worth invoking this and incurring yet more costs in addition to the costs incurred defending the claim brought against it by the third party). In the event that the insured proceeds with the claim and is successful, it would not be obliged to hand over any recoveries to the insurer.

Standard commercial general liability policies

14 What constitutes bodily injury under a standard CGL policy?

'Commercial general liability policies' is not a descriptive term typically used in UK policies, but is usually understood to be of the same nature as public and product liability policies. Such policies cover the liability of insureds to third parties in respect of personal injury and property damage caused by the insureds. Bodily injury is usually defined, but is focused upon injury, sickness, disease and death resulting from such injury.

15 What constitutes property damage under a standard CGL policy?

This is usually defined as loss of or physical damage to material property. Usually, damage to the property of an insured is not included.

16 What constitutes an occurrence under a standard CGL policy?

Public liability policies are 'occurrence' based. Usually the relevant occurrence is the event that triggers the bodily injury or property damage affecting the third party.

Product liability policies can be 'occurrence' (explained above) or 'claims-made' policies. Cover under a claims-made policy is triggered by the policyholder's notification to the insurer of a claim against the insured made by a third party; or a circumstance likely to give rise to a claim or loss.

17 How is the number of covered occurrences determined?

The analysis of what is an occurrence has spawned a large amount of litigation in England. It is very common that a policy will provide that there is cover per claim and that the total cover will be subject to an aggregation of claims. A policy will often also provide that all claims arising out of the same occurrence will be treated as one claim. Whether the aggregation clause is in favour of an insured is highly dependent upon the facts. The analysis of what is an occurrence will be considered by reference to a number of factors, such as time and location.

18 What event or events trigger insurance coverage?

The difference between claims-made and 'losses-occurring' bases of cover is key to an understanding of how claims in English market practice and English law are addressed. Policies written on a losses-occurring basis are triggered by the occurrence of the bodily injury or relevant damage. Claims-made policies are triggered by notification. This is why attention to the notification clauses is vital.

Update and trends

As mentioned above, the Insurance Act 2015 will shortly come into effect and will represent a sea change in the development of English insurance law. It remains unclear how many of the provisions of that Act will be applied, but it is a major rebalancing of rights and obligations between insureds and insurers in favour of insureds.

The debate around the payment of damages for late payment, if introduced, will also represent for the first time a more effective mechanism for insureds to obtain recompense where an insurer has been unjustifiably dilatory in handling a claim.

19 How is insurance coverage allocated across multiple insurance policies?

If more than one insurance policy may be engaged by a given situation, any one insurer may be subject to (and have to pay) the claim and then seek recovery from the other insurers. However, insurers will often include policy wording to exclude the ability to claim 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 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 that, despite its name, often contains numerous exclusions. Insurances such as landlord property cover, home insurance and business interruption offer first-party property coverage.

The goods covered by the property insurance can be specifically listed (eg, a particular painting) and usually are only insured if they stay at the specified location (eg, a gallery). Any removal has to be authorised by the insurer. It is also possible that the policy covers all the items at a particular location, for instance, home contents insurance.

A property insurance will contain a range of exclusion clauses, some of them being wear and tear (this is not a risk, but a natural expectation), mysterious disappearance (there is no identified insured event and cause of the loss), defective design, wilful act of the insured such as arson or fraud (the cause of the loss is not a peril, but a deliberate self-inflicted act and as a general principle a man should not be rewarded for his wrong), terrorism, war and losses recoverable by another insurance.

Property insurance is likely to have a clause stating the amount of money for which the insured will bear its own responsibility, which is a fraction of the claim that the insurer will not pay. For example, if a claim under a car insurance policy is for £200, the insured will not be able to recover the first £50. This is not a specific characteristic of property insurance. It is typical for other insurances as well (eg, health insurance).

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

Unvalued policy

The general principle is that an insurer cannot recover more than the actual loss suffered. For example, under a travel insurance policy, if a pair of old skis is lost, the insured cannot overstate their value and recover as if the skis were new. The property is valued at the date of the loss. Such policies usually have a reference to 'sum insured', which is the maximum that an insurer will pay either per claim or as aggregate.

Valued policy

It is possible to fix the value of an insured item if the insurance product is for a valuable item (eg, jewellery). The value of the item is fixed by a valuator as of the date of the policy. This is also the amount that the insured can recover if a total loss occurs as a result of an insured peril.

Directors' and officers' insurance

22 What is the scope of D&O coverage?

A D&O policy is a liability insurance designed to protect the insured against loss suffered as a result of a claim made by a third party following an alleged wrongful act by the insured. The insured could be a natural person (such as a former, current or future director or officer, or even a spouse), a company or its subsidiaries. The definition of 'wrongful act' is subject to negotiations with the insured, but it usually covers actual or alleged breach of duty, misleading statement, misrepresentation, error and omission. The claim made against the insured could cover a written demand for compensation, court proceedings and investigation by an official body.

A D&O policy is a claims-made policy, which means that it covers claims made during the term of the policy and notified in accordance with policy terms. The practical result of this is that a claim made against a director and notified in 2012 and which is still ongoing in 2015 is covered under the 2012–2013 policy and will normally be excluded from the 2014–2015 policy.

The policy usually covers the following risks:

- loss suffered by a director or officer, or both, as a result of a claim brought against him or her that has not been indemnified by the company because the company is not permitted to do this (side A cover). The insured person is the director;
- indemnifications made by the company to the director or officer, or both (side B cover). The insured person is the company; and
- actions brought against the company itself, by shareholders (side C cover). Again, the insured person is the company.

The policy will also provide the maximum limit of liability and the fraction of the claim that the insured has to cover itself (a deductible). Some typical policy exclusions are fraud and 'insured v insured' claims whereby a director who is a shareholder in the company makes a claim under the policy or the company itself makes a claim against that director.

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

Some of the common litigation issues under a D&O policy are the definitions of a director or officer and wrongful act. Compliance with the notification process is often challenged. Non-disclosure prior to entry into the policy is sometimes challenged.

Cyber insurance

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

The take up of cyber liability insurance in the UK has continued to increase over the past 12 months. Although there is as yet no standard cover, there is increased consistency in terms of both underwriting information requirements and the scope of policy coverage. Importantly, there remains a wide degree of interpretation as to what in fact constitutes a cyber risk.

The main heads of cover under a standard cyber liability policy are now typically:

- network security and privacy liability: cover for third-party claims and defence costs following a security breach or privacy breach;
- privacy breach response costs and security event costs: notification expenses, customer support and credit monitoring, IT forensics and public relations costs following a security breach or privacy breach;
- privacy regulatory defence costs, fines and penalties (where insurable by law);
- non-damage cyber business interruption cover (which is cover for loss of income (net profit) and the increased cost of working as a result of a total or partial interruption or degradation of the insured's IT network following a security breach);
- data and software restoration costs following a security breach; and
- cyber extortion: costs to deal with an extortion threat as well as any ransom payment.

In some cases, reputational risk cover can be provided to address risks such as loss of customers following a cyber event; however, the availability of capacity in this area is limited, not least because it can be extremely challenging to quantify reputational damage.

The definition of a security breach would generally include denial of service attacks, (transmission or receipt of malware and computer viruses, and unauthorised access or unauthorised use.

25 What cyber insurance issues have been litigated?

We are not aware of any cyber issues having been litigated as yet.

* *The authors would like to thank Glyn Thoms of Willis Towers Watson for his contribution to this chapter.*

United States

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Preliminary and jurisdictional considerations in insurance litigation

1 In what fora are insurance disputes litigated?

Parties to insurance litigation must evaluate the proper forum for dispute resolution. 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, the 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 dipositive 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?

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 those 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. 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 the date that the payment was demanded, the date that payments are deemed due under the applicable policy or the date that 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 in which courts 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 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 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 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, 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 timely notice 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 expiration date in which the policyholder may provide notice. Second, a 'savings' clause may provide that claims made during a limited period after the expiration 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 expiration.

10 When is notice untimely?

Notice 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, 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 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 potentially fall 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 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 of insurance law 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 and the manufacture or distribution of harmful products.

18 What event or events trigger insurance coverage?

Litigation that centres on whether an occurrence falls within a given policy period is generally referred to as a 'trigger' 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.

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 implicates 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 in order 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 relate 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 policy. Many states

Update and trends

A number of insurance disputes are expected to be decided this year, including cases involving allocation of damages where multiple layers of insurance and policy years are implicated, insurance coverage when a policyholder's loss is the result of a combination of covered and non-covered causes, and assessment of the number of occurrences in the asbestos liability context. Further, in light of the increasing issuance of cyber insurance policies, it is anticipated that courts will be asked to address coverage issues raised by such policies. In addition, data breaches, inadvertent disclosures of confidential information and other computer system failures are expected to lead to coverage issues under traditional comprehensive general liability policies.

have passed legislation that sets forth certain statutory minimum coverage requirements for first-party property policies.

Directors' and officers' insurance

22 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 due 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, some D&O policies have expanded coverage to include certain limited costs associated with formal investigations, such as costs associated with an interview of an insured person in connection with an investigation. 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.

23 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.

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 an insured organisation or 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. 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.

Cyber insurance

24 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.

25 What cyber insurance issues have been litigated?

Issues relating to the scope of coverage available for cyber-related losses (eg, data breaches, hacking incidents, accidental loss of personal data) under traditional insurance policies have yet to be widely litigated. Decisions issued by the handful of courts that have addressed such claims suggest that courts will uphold insurers' denials of coverage in this context.

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. 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. 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. 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.

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