

THE INSURANCE
DISPUTES LAW
REVIEW

SECOND EDITION

Editor
Joanna Page

THE LAWREVIEWS

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CONTENTS

PREFACE.....	v
<i>Joanna Page</i>	
Chapter 1 AUSTRIA.....	1
<i>Ralph Hofmann-Credner</i>	
Chapter 2 BELGIUM.....	8
<i>Merel van Dongen</i>	
Chapter 3 BRAZIL.....	19
<i>Cassio Amaral, Thomaz Kastrup, Anthony Novaes, Thais Arza and Thales Dominguez</i>	
Chapter 4 DENMARK.....	30
<i>Anne Buhl Bjelke</i>	
Chapter 5 ENGLAND AND WALES.....	41
<i>Joanna Page and Russell Butland</i>	
Chapter 6 FRANCE.....	54
<i>Erwan Poisson and Delphine Dendievel</i>	
Chapter 7 GERMANY.....	63
<i>Marc Zimmerling and Angélique Pfeiffelmann</i>	
Chapter 8 INDIA.....	76
<i>Neeraj Tuli and Rajat Taimni</i>	
Chapter 9 IRELAND.....	85
<i>Sharon Daly, April McClements and Laura Pelly</i>	
Chapter 10 ITALY.....	96
<i>Andrea Atteritano</i>	

Contents

Chapter 11	KOREA	107
	<i>Jin-Hong Kwon, John JungKyum Kim, Jae-Hwan Kim and Yang-Ho Yoon</i>	
Chapter 12	PORTUGAL.....	117
	<i>Pedro Ferreira Malaquias and Hélder Frias</i>	
Chapter 13	SPAIN.....	126
	<i>Julio Iglesias Rodríguez and Francisco Caamaño Rodríguez</i>	
Chapter 14	SWEDEN.....	135
	<i>Johan Gregow</i>	
Chapter 15	UNITED ARAB EMIRATES	142
	<i>Hassan Arab, Mohammad Muhtaseb and Jyothi Venugopal</i>	
Chapter 16	UNITED STATES	149
	<i>Susannah Geltman and Summer Craig</i>	
Appendix 1	ABOUT THE AUTHORS.....	159
Appendix 2	CONTRIBUTORS' CONTACT DETAILS.....	171

PREFACE

This is now the second edition of *The Insurance Disputes Law Review*. I am delighted to be the editor of this excellent and succinct overview of recent developments in insurance disputes across 16 important insurance jurisdictions, including now the United States.

The first edition was very well received and demonstrated both the need and the very active interest, evident across the globe, in the legal frameworks for insurance and, in particular, in the insight that the developing disputes arena provides into this fascinating area.

Insurance is a vital part of the world's economy and critical to risk management in both the commercial and the private worlds. The law that has developed to govern the rights and obligations of those using this essential product can often be complex and challenging, with the legal system of each jurisdiction seeking to strike the right balance between the interests of insurer and insured and also the regulator who seeks to police the market. Perhaps more than any other area of law, insurance law can represent a fusion of traditional concepts that are almost unique to this area of law with entrepreneurial development, as insurers strive to create new products to adapt to our changing world. This makes for a fast-developing area, with many traps for the unwary. Further, as this indispensable book shows, even where the concepts are similar in most jurisdictions, they can be implemented and interpreted with very important differences in different jurisdictions.

To be as user-friendly as possible, each chapter follows the same format – first providing an overview of the key framework for dealing with disputes, and then giving an update of recent developments in disputes.

As editor, I have been impressed by the erudition of each author and the enthusiasm shown for this fascinating area. It has also been particularly interesting to note the trends that are developing in each jurisdiction. An evolving theme in almost every jurisdiction is the increase in protections for policyholders. Much of the special nature of insurance law has developed from an imbalance in knowledge between the policyholder (who had historically been blessed with much greater knowledge of the risk to be insured) and the insurer (who knew less and therefore had to rely on the duties of disclosure of the policyholder). With the increasing use of artificial intelligence to assess data and more detailed scope for analysis across risk portfolios, the balance of knowledge has shifted; it will often now be the insurer who is better placed to assess the risk. This shift has manifested itself in tighter rules requiring insurers to be specific in the questions to be answered by policyholders when they place insurance, and in remedies more targeted at the insurer if full information is not provided. Coupled with these trends, however, is the increasing desire by some jurisdictions to set limits on the questions that can be asked so that, for example in relation to healthcare insurance, policyholders are not denied insurance for historical matters. We can expect that this tussle

between the commercial imperative for insurers to price risk realistically and the need to balance consumer protection, government policy and privacy will increasingly be at the heart of insurance disputes.

It is also fascinating to see how global concerns around climate change and cyber risk are working their way through the legal systems, with jurisdictions, particularly the United States, leading the way in assessing how existing insurance products might respond to these risks.

No matter how carefully formulated, no legal system functions without effective mechanisms to hear and resolve disputes. Each chapter therefore also usefully considers the mechanisms for dispute resolution in each jurisdiction. Courts appear to remain the principal mechanism but arbitration and less formal mechanisms (such as the Financial Ombudsman in the United Kingdom) can be a significant force for efficiency and change when functioning properly. The increasing development of class action mechanisms, particularly among consumer bodies (e.g., in France and Germany) is likely to be an important factor.

I would like to express my gratitude to all the contributing practitioners represented in *The Insurance Disputes Law Review*. Their biographies are to be found in the first appendix and highlight the wealth of experience and learning that the contributors bring to this volume. I must also thank Russell Butland, who is a senior associate with my firm and a highly talented lawyer. He has done much of the hard work in this project, together with Frances Beddow, who has helped enormously in the research.

Finally, I would also like to thank the whole team at Law Business Research, who have excelled at bringing the project to fruition and in adding a professional look and more coherent finish to the contributions.

Joanna Page

Allen & Overy LLP

London

October 2019

AUSTRIA

*Ralph Hofmann-Credner*¹

I OVERVIEW

This chapter provides insight into the legal sources that Austrian courts apply in cases of insurance litigation, the legal framework of the law applicable to insurance agreements, the difficulties seen in cases where an international insurer is the defendant to a claim for coverage and a recent legislative change to the insured's right of withdrawal from an insurance agreement.

II THE LEGAL FRAMEWORK

i Sources of insurance law and regulation

The three main sources of law are legislation, broadly acknowledged templates of general terms and conditions, and precedents.

The substantive insurance law is primarily governed by the Insurance Contract Act.² In addition, certain advice and information obligations of insurers towards insureds are stipulated in the Insurance Supervision Act 2016.³ For certain types of insurance (e.g., motor liability insurance), special statutes exist. Where the insurance statutes do not provide for any special rules, general civil law provisions of the Civil Code apply.

The Insurance Contract Act is, in general, applicable both in consumer and non-consumer contracts without distinction and also to large risks. It aims at protection of the insured as the weaker party, mainly by means of various coercive provisions that cannot be deviated from to the detriment of the insured. However, specific types of insurance either do not fall under the scope of the Insurance Contract Act at all (reinsurance and marine insurance),⁴ or are not subject to its restrictions (transport insurance of goods, credit insurance and insurance against exchange loss).⁵ A legislative change in 2018 concerned a simplification of the several rights of withdrawal from insurance agreements.

In addition, general insurance terms and conditions play a key role. The model insurance terms are developed and published by the Austrian Insurance Association (VVO),⁶

1 Ralph Hofmann-Credner is counsel at Wolf Theiss Rechtsanwälte GmbH & Co KG.

2 Versicherungsvertragsgesetz – VersVG.

3 Versicherungsaufsichtsgesetz 2016 – VAG 2016. An English translation of the VAG 2016 is available online: www.fma.gv.at/download.php?d=825.

4 Section 186 Insurance Contract Act.

5 Section 187 Subsection 1 Insurance Contract Act.

6 Model insurance terms and conditions in German can be found on the website of the VVO: www.vvo.at/vvo/vvo.nsf/sysPages/musterbedingungen.html.

and although these are not binding, they are usually adopted by Austrian insurance companies and incorporated into insurance contracts with minor changes. The most recent model terms developed by the VVO cover cyber risks (see also Section V).

For these reasons, Austrian case law on insurance agreements predominantly deals with legal questions related to the model insurance terms, while case law related to wordings that have an international background, such as directors' and officers' liability insurance, rarely exists. Although court judgments in Austria are, in general, only binding on the parties involved in a dispute, case law plays an important role. Furthermore, the courts of lower instance have to observe and apply the judicature of courts of higher instance, such as the courts of appeal and the Supreme Court of Justice of the Republic of Austria, which is the highest instance in civil and criminal matters. Within the Supreme Court of Justice, a specific senate (i.e., the seventh senate as specialist senate) handles disputed insurance contract cases.⁷

As a side note to this chapter, it should at least be mentioned that as far as insurance regulation is concerned, the Insurance Supervision Act 2016 is the primary source of law, and conducting insurance business in Austria requires the holding of a relevant licence. Depending on whether the applicant is a domestic company or a third-country insurer, the Austrian Financial Market Authority (FMA)⁸ grants a licence upon application and fulfilment of preconditions. A European Economic Area (EEA) insurance company holding a licence and situated outside Austria does not require a further or domestic insurance licence. The EEA insurer may, upon notification of the competent supervisory body, conduct insurance business in Austria on a freedom-of-services basis or freedom-of-establishment basis through a local branch. The ongoing supervision of the insurance market in Austria is also carried out by the FMA.

ii Insurable risk

Austrian law does not define the term 'insurable risk', but international legislative developments such as the Foreign Account Tax Compliance Act and the General Data Protection Regulation have posed again the question of whether insurance can be taken out against a specific (e.g., administrative) fine. The current answer under Austrian law, which dates back to a ruling of the Supreme Court of Justice of 23 January 1917,⁹ is that such fines are deemed to be uninsurable because any agreement between a tortfeasor and a third party concluded before an infringement whereby the third party shall be obliged to compensate the tortfeasor for any future penalty, is an immoral contract.¹⁰

Furthermore, Section 68 of the Insurance Contract Act contains a provision that deals with cases the facts of which are that either no insured interest existed from the beginning or that an insurable interest ceased to exist during the term of a policy. The relationship between the insured and the insured asset is such an interest. An insured interest does not exist if either (1) no insured who carries such an interest exists, or (2) the insured asset or the relationship to this asset does not exist at the outset of the insurance agreement, or it certainly will not

7 The scope of the several senates within the Supreme Court of Justice can be accessed here: www.ogh.gv.at/der-oberste-gerichtshof/geschaeftsverteilung/.

8 The homepage of the FMA is available in English. For a general overview on supervision of insurance undertakings, licensing and notification and other special topics, see www.fma.gv.at/en/insurance.

9 ZBl 1918/348.

10 RIS – Justiz RS0016830.

exist in the future.¹¹ As at 19 July 2019, in the database of the Legal Information System of the Republic of Austria¹² there are nine judgments of the Supreme Court of Justice and one judgment of the highest appellate court in Germany for civil and criminal cases, between the years 1938 and 2013, that relate to Section 68 of the Insurance Contract Act,¹³ and this reflects that this statutory provision is not highly disputed in courts.

iii Fora and dispute resolution mechanisms

Insurance disputes (i.e., disputes over the content or scope of a private insurance agreement), are typically heard by the state courts. Even though arbitration proceedings are recognised, it does not play a key role in Austrian insurance practice. The same is true for mediation proceedings, which are recognised by Austrian courts, but it is not mandatory for a party to go through mediation before filing a lawsuit in a contested insurance matter. As stated in Section II.i, the highest instance in contested insurance matters is typically the seventh senate of the Supreme Court of Justice.

But wordings can contain a stipulation for the parties to go through an expert procedure. The extent to which agreeing on an expert procedure in an insurance contract may be admissible is stipulated in Section 64 of the Insurance Contract Act. In practice, such a procedure is concluded by the parties within the framework of the general terms and conditions, and this is harmonised within the several types of insurance through the VVO model conditions. The following general insurance terms and conditions contain provisions, inter alia, for an expert procedure: non-life insurance,¹⁴ legal expenses insurance¹⁵ and accident insurance.¹⁶

The decision of an expert procedure shall be binding on the parties, except if the decision obviously deviates from actual facts.¹⁷

III RECENT CASES

In 2019, the Supreme Court of Justice released, inter alia, two rulings worth mentioning in this edition of *The Insurance Disputes Law Review* because the Supreme Court modified case law (as explained below) and reaffirmed previous but criticised precedent (as described in the second case below).

The first case, court file No. 7 Ob 137/18z, dated 24 April 2019, deals with the undisputed key facts that an insured informed its insurer to cancel an insurance agreement, which the insurer confirmed to the insured in writing in May 2004. Nevertheless, and without giving reasons for its decision, the insurer collected from its former insured for a further

11 Ertl in Fenyves/Schauer (Editor), VersVG § 68 Rz 5.

12 The Legal Information System of the Republic of Austria is a platform and database providing information on Austrian law.

13 Search result on the website of the Legal Information System of the Republic of Austria: www.ris.bka.gv.at/Ergebnis.wxe?Abfrage=Justiz&Gericht=&Rechtssatznummer=&Rechtssatz=&Fundstelle=&AenderungenSeit=Undefined&SucheNachRechtssatz=True&SucheNachText=True&GZ=&VonDatum=&BisDatum=07.10.2018&Norm=VersVG+%c2%a768&ImRisSeitVonDatum=&ImRisSeitBisDatum=&ImRisSeit=Undefined&ResultPageSize=100&Suchworte=&Position=1.

14 Article 8 of the General Conditions for Property Insurance (ABS 2012).

15 Article 9 of the General Conditions for Legal Expenses Insurance (ARB 2015).

16 Article 16 of the General Conditions for Accident Insurance (AUVB 2008, Version 06/2017).

17 Section 64 Subsection 2 and Section 184 Subsection 2 of the Insurance Contract Act.

12 years (i.e., until August 2016) a monthly amount of €48.25 through the automatic debit transfer system. While the former insured requested repayment of all unjustified collected amounts, the insurer repaid only the amount it had collected in the three most recent years (i.e., during the period 2013–2016). Consequently, the former insured filed a lawsuit for repayment of the remaining unjustified collected amounts during the period 2004–2013. The Supreme Court deviated from existing precedent and dismissed the lawsuit on the basis that the claim was time-barred.

Noting that Section 12 Subsection 1 of the Insurance Contract Act stipulates a three-year respite concerning claims arising from an insurance agreement, the former insured had based its lawsuit seeking repayment from the insurer on the Austrian law of unjust enrichment because Section 1479 of the General Civil Code¹⁸ stipulates a 30-year respite, in general, for reclaiming unjustified payments and, as the insurance agreement at hand had been effectively cancelled, the claim for repayment did not result from an insurance agreement.

In recent years, however, Austrian courts have taken a more diversified approach¹⁹ and, for the respite of a claim for unjust enrichment, they currently also take into consideration the claim that has been substituted by the claim for unjust enrichment. Accordingly, the application of a three-year respite for reclaiming (1) unjustified paid interest,²⁰ (2) unjustified user fees levied by a network operator,²¹ (3) an overpayment of rent,²² and (4) a periodically paid unjustified leasing fee²³ has been established by the Supreme Court (although it has been criticised for this). Where claims for unjust enrichment supersede these types of claims, therefore, the Supreme Court has invoked Section 1480 of the General Civil Code, which stipulates a three-year respite for claiming overdue annual benefits, such as interest and annuities.

The application of this case law was deemed ill-founded in a case where the facts at hand of an unjustified collection of a premium after the cancellation of an insurance agreement were undisputed; as a result, the Supreme Court precedent²⁴ that claims for repayment of mistakenly paid insurance premiums that fall outside the scope of Section 12 of the Insurance Contract Act lapse after 30 years was ruled unsustainable.

A second case (7 Ob 242/18s) of the Supreme Court of Justice, which was made public in April 2019, concerned the legitimacy of two clauses in general conditions for legal expenses insurance. One of the clauses, which will be looked at in more detail, granted the insurer the right to cancel or amend the insurance agreement for an ‘increase in risk’ in the event of new or changing case law whereby an insured’s silence constituted consent.²⁵ The clause was deemed to be unlawful, grossly discriminatory and non-transparent according to the Supreme Court of Justice.²⁶

In its reasoning, the seventh senate of the Supreme Court held that the clause concerned did not contain any restrictions whatsoever regarding a ‘significant circumstance’ that would trigger the legal consequences of the clause, and therefore the clause was in breach

18 Allgemeines Bürgerliches Gesetzbuch – ABGB.

19 Supreme Court of Justice 30.5.2017, 8 Ob 110/16h.

20 Supreme Court of Justice 24.6.2003, 4 Ob 73/03v; RIS – Justiz RS0117773.

21 Supreme Court of Justice 30.3.2009, 7 Ob 269/08x.

22 Supreme Court of Justice 25.8.2015, 5 Ob 25/15k.

23 Supreme Court of Justice 18.5.2016, 3 Ob 47/16g.

24 Supreme Court of Justice 10.9.2003, 7 Ob 191/03v.

25 Allgemeine Bedingungen für die Rechtsschutz-Versicherung (ARB 2005 Art 13.5).

26 Supreme Court of Justice 27.2.2019, 7 Ob 242/18s.

of Section 29 of the Insurance Contract Act, from which an insurer cannot deviate to the detriment of an insured. If a clause stipulates that an insured's silence constitutes consent to an amendment of an insurance agreement without limitation, then that clause violates the transparency requirement because, in general, the legal consequence of such a clause would be the possibility of unilaterally amending the contract.

Finally, an unpublished recent appeal decision of the Higher Regional Court in Innsbruck (4 R 82/19v) dated 5 July 2019 should remind everyone involved in insurance litigation that occasionally legal questions of civil procedure law may determine success or failure in a coverage dispute. An athlete had taken out professional sports insurance and sought coverage for the consequence of incapacity to perform sports after a training accident. The insurer's denial of coverage based on medical evidence that the accident had not caused the termination of the insured's professional career resulted in the insured filing a lawsuit with the Austrian courts in December 2016. After the court-appointed medical expert confirmed in July 2018 the insurer's position that the bodily injury of the insured had healed after the training accident, the insured brought in January 2019 the new arguments that (1) illness triggers the policy as well, (2) incapacity to perform as an athlete results from covered illness, and (3) the insurer is therefore liable under the policy. The court dismissed the case with costs without taking further evidence (i.e., on the insured's alleged illness) on the basis of an objection against an amendment of claim under civil procedure law, and the court of appeal confirmed the decision of the court of first instance. While, in general, civil procedure law allows for an amendment of claim,²⁷ an amendment may be objected to if it goes beyond the scope of the initial lawsuit or if the proceedings are ripe for decision.²⁸ In the case at hand, the claim for insurance proceeds had been based solely on the peril of an accident, with covered illness not being raised by the insured at all until January 2019, almost five years after the insured had stopped practising competitive sports. While one would instantly consider these facts to constitute a late notification of an insured event, thereby releasing the insurer from paying out under the insurance policy, the courts, in view of the insured's objection, had to resolve the case by applying civil procedure law, which finally resulted in the insurer being released from its obligation to perform.

IV THE INTERNATIONAL ARENA

The local standard may be most accurately described as having three principal characteristics: an Austrian insured would expect (1) the policy wording to be in German or, in the case of a bilingual special insurance wording, the German wording prevails, (2) that no arbitration clause exists, and (3) that Austrian law applies.

However, international insurers serving the Austrian and German market sometimes apply German law to their insurance agreements with Austrian insureds. For insurance intermediaries and the Austrian courts, this does not bring much surprise or complications in the application of the law because the Austrian Insurance Contract Act historically stems from the German Insurance Contract Act, with minor linguistic variation.

If foreign law applies and Austrian courts have to decide a dispute under foreign law, then the judge would appoint a foreign law expert to gain an understanding of how the

27 Section 235 of the Code of Civil Procedure (Zivilprozessordnung).

28 RIS – Justiz RS0039594.

legal question would be answered under that foreign law.²⁹ This procedure is not necessary for German law, as the official language is identical in both countries and both insurance contract acts are rather similar.

Furthermore, it should be mentioned that lawsuits against international insurers are on occasion filed incorrectly against a party that is not the risk carrier (e.g., especially if the insurer had delegated underwriting authority or the policy was not issued by the insurer). These situations have resulted in confusion and the wrong defendant being named. In fact, if the affected insurer gains knowledge of such a situation, it depends on its defence strategy on whether it clarifies the shortcoming and commonly agrees with the parties to the insurance dispute to change the defendant, or if it lets the wrong defendant defend the case with the argument that the defendant is not the risk carrier and therefore the claim is to be dismissed. If, however, the claimant only misspelled or wrongly named the correct insurer, the court is entitled to adjust the naming of the defendant, according to Section 235 Subsection 5 of the Code of Civil Procedure.

Since Austria is a member of the EU, jurisdiction in international insurance disputes is determined by the rules of Brussels I Regulation (recast).³⁰ As a general rule (see Articles 11 to 14), the Regulation stipulates that an insurer may bring proceedings only in the courts of the Member State in which the defendant (the policyholder, the insured or a beneficiary) is domiciled. However, the insurer may be sued in the courts of the Member State in which it is domiciled (including where it has a branch, agency or establishment); or in the Member State where the claimant (the policyholder, the insured or a beneficiary) is domiciled; or, if it is a co-insurer, in the courts of a Member State in which proceedings are brought against the leading insurer. For liability insurance, the insurer may, in addition, be sued in the courts of the place where the harmful event occurred and may, in general, be joined in proceedings that the injured party has brought against the insured.

Regarding international insurance litigation falling within the scope of the Rome I Regulation,³¹ the choice of law is limited especially by the restrictions listed in Article 7 Paragraph 3. For contracts covering risks (other than large risks) that are situated in a Member State, the choice of law is limited to:

- a* the law of the Member State where the risk is situated;
- b* the law of the country where the policyholder has his or her habitual residence;
- c* in the case of life insurance, the law of the Member State of which the policyholder is a national;
- d* for insurance contracts covering risks limited to events occurring in one Member State, the law of that Member State; or
- e* where the policyholder pursues a commercial or industrial activity or a liberal profession, and the insurance contract covers two or more risks that relate to those activities and are situated in different Member States, the law of any of the Member States concerned or the law of the country of habitual residence of the policyholder.

For compulsory insurance, special provisions apply.

29 Section 4 of the Private International Law (internationales Privatrecht – IPR–Gesetz).

30 Regulation (EU) No. 1215/2012 of the European Parliament and of the Council of 12 December 2012 on jurisdiction and the recognition and enforcement of judgments in civil and commercial matters.

31 Regulation (EC) No. 593/2008 of the European Parliament and the Council of 17 June 2008 on the law applicable to contractual obligations (Rome I).

Article 7 of the Rome I Regulation provides that if the parties would be entitled to choose Austrian law, and Austrian law allows greater freedom on choice of law in insurance contracts, then the parties are allowed to make use of this freedom. (This is the case in Austria, where, pursuant to Section 35a of the Private International Law, the parties may choose any law as the law applicable to the insurance contract.) However, if the insurer carries out its business or otherwise directs its activities to the state of residence of the insured, then by choice of law the insured may not be deprived of the rights granted under mandatory provisions of the law that would be applicable in the absence of choice. In consumer contracts, further limitations exist.

For arbitration clauses, the general norms of the Code of Civil Procedure stipulate that an arbitration agreement may be concluded between parties for both existing and future civil claims that may arise out of or in connection with a defined legal relationship (insurance matters are not excluded). The arbitration agreement must be in writing and indicate the parties' will to submit to arbitration. In consumer contracts, however, stricter requirements exist.

V TRENDS AND OUTLOOK

As mentioned above, and in more detail in the previous edition of *The Insurance Disputes Law Review*, a legislative change in 2018 concerning the modification of the rights of withdrawal from insurance agreements was ultimately triggered by a decision of the European Court of Justice (ECJ) in 2013, based on a German preliminary ruling procedure.³² In 2018, two Austrian courts filed for a preliminary ruling in relation to an insured's withdrawal right and since then numerous related civil proceedings have been stayed. The ECJ is expected to hand down its preliminary ruling by the end of 2019, thereby providing life insurers with greater clarity in respect of their payment obligations towards insureds who were initially instructed inaccurately about their withdrawal rights.

32 ECJ 19. 12. 2013, C-209/12, Endress/Allianz.

BELGIUM

*Merel van Dongen*¹

I OVERVIEW

In Belgium, insurance and insurance law has become a hot topic in the media. Increasingly, policyholders are dissatisfied with the cost of premiums, refusals by insurers to provide coverage, claims settlements, and alleged violations of legal obligations such as information requirements.

The legislature is continuously working on legal solutions and trying to adapt existing legislation to fit contemporary practices and complaints. For example, life insurers will have to respect certain deadlines in the future when paying out life capital, a tax reduction has been granted for legal expenses insurance, the notice periods for policyholders for the cancellation of an insurance contract can now be shortened, a right to be forgotten has been granted to policyholders when they have been cured of cancer for at least 10 years, and mandatory insurance for fire and water damage has been introduced for tenants and landlords. Moreover, the Insurance Distribution Directive (IDD)² has been implemented into Belgian law and the Belgian legislature has proactively taken measures in case of a Brexit without an agreement with the EU. It is not only legislation that is evolving, but also case law. For example, the Supreme Court has interpreted the forfeiture-of-coverage clause, the burden of proof regarding the right to redress, and the limitation periods for a direct claim by an injured party and the injured party's insurer against the liable person and the liable person's insurer. Furthermore, the Belgian Constitutional Court has asked a preliminary question to the European Court of Justice regarding the insured's free choice of advisers in legal expenses insurance contracts.

In this chapter, I discuss in detail the legal framework of Belgian insurance disputes, interesting recent case law, international insurance disputes and emerging trends in insurance claims.

1 Merel van Dongen is a lawyer at Schuermans advocaten.

2 Directive (EU) 2016/97 of the European Parliament and of the Council of 20 January 2016 on insurance distribution (recast).

II THE LEGAL FRAMEWORK

i Sources of insurance law and regulation

For Belgian law practitioners, the first point of reference regarding insurance law is the Act of 4 April 2014 concerning insurance (the Insurance Act), which contains, among others, provisions on the insurance contract, the obligations of the parties, limitation periods, insurance mediation and distribution, and supervision of insurance companies.

Apart from the rather long Insurance Act, Belgium has a number of relevant specific acts (e.g., for motor vehicle insurance, damage caused by terrorism, and the status and supervision of insurance companies) and countless royal decrees (e.g., for life insurance and fire insurance for simple risks).

Although the law changes constantly, the following key developments from the past 12 to 18 months are worth mentioning:

- a First and foremost, the IDD has been implemented into Belgian law by five measures. Of these, the most noteworthy for this chapter are the Act of 6 December 2018 and the Royal Decree of 18 June 2019. Even though it intended to implement the IDD as literally as possible, Belgium did introduce certain differences. For example, the monetary limitation for the exemption for ancillary intermediaries from the strict requirements for distribution activities introduced by the IDD has been set at premiums of €200 per year.³ Furthermore, some provisions regarding insurance-based investment products are applicable to all insurance products. Some information requirements are not applicable to professional clients. Moreover, Belgian law still makes a distinction between brokers, agents and tied agents, and introduces some additional conditions for intermediaries. Finally, some provisions introduced by the Act of 6 December 2018 are not based on the IDD, such as those concerning data storage and liability for tied agents. The Royal Decree of 18 June 2019 concerns the registration of intermediaries, the number of persons responsible for distribution, professional liability insurance, the professional and organisational requirements for intermediaries, and the definition of a professional client.
- b Second, the Act of 9 May 2019 concerning Mandatory Civil Professional Liability Insurance in the Construction Industry introduces mandatory insurance for architects, expert land surveyors, health and safety coordinators and other service providers in the construction sector. The coverage cannot be less than €1.5 million for damage resulting from bodily injuries, €500,000 for material and non-material damage and €10,000 for objects that were entrusted to the insured by the constructor.
- c Third, the Act of 2 May 2019 concerning Diverse Provisions regarding Economics adds new provisions to the Insurance Act⁴ regarding the pay-out period of life insurance contracts. In accordance with this Act, the insurer has to respect certain deadlines. For example, if it receives a request to pay out on a life insurance policy, the insurer has to state within two weeks which documents and information it requires. Any necessary additional documents or information must then be requested by the insurer within one month of receiving the original documents and information. After receiving all necessary documents and information, it has to pay out the life insurance within one month. There are, of course, exceptions, but these are too extensive to treat exhaustively

³ Article 258 Section 1 Insurance Act.

⁴ Article 197/1 to 197/3 Insurance Act.

in this chapter. If the insurer does not respect these deadlines, it has to pay interest, counted from the expiration of the deadline at issue, until the relevant requirement has been complied with. Furthermore, the documents and information requested by the insurer have to be reasonable and relevant for the payment of the life insurance. These provisions will take effect on 22 May 2020.

- d* Fourth, the Act of 22 April 2019 on Making Legal Expenses Insurance More Accessible introduces a tax reduction of 40 per cent for legal expenses insurance that complies with certain requirements. The coverage is limited for different kinds of disputes, namely €13,000 for civil disputes, €13,500 for criminal proceedings, €3,375 for divorces and €6,750 for construction and labour disputes. A royal decree will identify the maximum amount of lawyers' fees that will be covered by these insurance contracts.
- e* Fifth, the Act of 22 April 2019 amending the Act of 4 April 2014 concerning Insurance, to Adapt the Requirement regarding the Cancellation of Insurance Contracts to Better Protect Consumers amends Article 85 Section 1 of the Insurance Act. Normally, the parties to an insurance contract have to cancel the contract three months before the expiry date. If they do not, the contract is tacitly renewed for one year. By royal decree, for certain types of insurance contracts, the king can introduce shorter notice periods for policyholders when they do not want the insurance contract to be tacitly renewed. This royal decree has yet to be published.
- f* Sixth, the Act of 4 April 2019 amending the Act of 4 April 2014 concerning Insurance Introducing a Right to Be Forgotten for Certain Types of Personal Insurance forbids an insurer assessing the current health of a potential policyholder to take into account cancer when the prospective client has been cured for 10 years. The insurer cannot exclude cancer, nor refuse to provide insurance nor charge an additional premium because of the previous illness. This Act will take effect on 1 February 2020. In the future, a royal decree will define certain types of cancer for which the 10-year period will be shortened, as well as other chronic diseases to which this Act will apply.
- g* Seventh, the Act of 3 April 2019 concerning the Withdrawal of the United Kingdom from the EU, or the Brexit Act, among other things, prepares the insurance sector for a Brexit without an agreement with the EU. For this reason, a new type of insurance intermediary has been introduced into Belgian law, namely underwriting agents. Moreover, measures will be taken to secure the execution of existing insurance contracts concluded by insurers who lose their European passport as a result of such a Brexit.
- h* Eighth, the Flemish Decree of 9 November 2018 concerning the Rent of Goods or Parts of Goods Intended for Habitation, in its Article 29, introduced mandatory insurance for fire and water damage for tenants and landlords.⁵

ii Insurable risk

In theory, almost every risk is insurable. However, a few exceptions exist.

First and foremost, fines and settlements in criminal matters are not insurable.⁶ Nevertheless, the person who is legally liable for the perpetrator can conclude an insurance contract covering such fines and settlements unless the insurance relates to road traffic or road transport.

5 The Walloon decree of 15 March 2018 already obliged tenants and landlords to conclude fire insurance. The Flemish Region goes further by also requiring insurance for water damage.

6 Article 155 Insurance Act.

Second, no insurer can be obliged to provide coverage for intentional damage.⁷ After all, when damage is induced intentionally, the parties to the insurance contract have not been confronted with any risk, which is one of the key components of insurance.

Third, some legal statutes or codes provide for general exclusions, such as Article 127 of the Insurance Act, which excludes harvest that has not been gathered, cattle living outside a building, soil, crops and forest plantations from natural disaster insurance coverage. However, the insurance contract can deviate from this provision.

Fourth, some insurers might refuse to insure a certain risk because, following a cost–benefit analysis, it proves to be too costly or too risky for the insurer. For example, a health insurer for pets always refuses to cover hereditary diseases. Generally, no insurer covers damage caused by war or similar circumstances.⁸ The same applies to the life insurer who, in principle, does not cover suicide or death immediately and directly caused by a crime intentionally committed by the insured as perpetrator or co-perpetrator, if the consequences were foreseeable.⁹

Another distinction can be made between compulsory insurance and non-compulsory insurance. Belgium has introduced compulsory insurance for no fewer than 33 categories of risks. These categories are:

- a* occupational accidents;
- b* architects, expert land surveyors, health and safety coordinators, contractors and other service providers in the construction sector in real estate;
- c* tenants and landlords (fire and water insurance);
- d* investments;
- e* mediation;
- f* payment institutions and collective investment undertakings;
- g* surveillance companies, internal surveillance services and security companies;
- h* accounting and tax professions, insolvency practitioners and temporary administrators;
- i* civil security;
- j* audit agency;
- k* service providers;
- l* animals;
- m* healthcare;
- n* hunting;
- o* fairground activities;
- p* nuclear installations;
- q* surveyor experts;
- r* environment;
- s* local public institutions;
- t* notaries;
- u* education, training and childminders;
- v* public procurement;
- w* publicly accessible institutions;
- x* care homes;
- y* social developments;

7 Articles 62 and 240 Insurance Act.

8 Article 63 Insurance Act.

9 Article 164 Insurance Act.

- z* sports;
- aa* mine waste;
- ab* trustees of real estate;
- ac* tourism;
- ad* employment;
- ae* transport;
- af* volunteers; and
- ag* health.

iii Fora and dispute resolution mechanisms

Insurance disputes are dealt with at various levels. Frequently, the general conditions of the insurance company advise the policyholder to file a complaint with the internal ombudsman service. If this step is unsuccessful, the policyholder often contacts the Insurance Ombudsman, established by the Federal Public Service Economy.¹⁰ The Insurance Ombudsman tries to settle the dispute and to obtain a favourable solution for every party.

Increasingly, parties try to resolve their disputes amicably, not only through the Insurance Ombudsman, but also through binding third-party decisions¹¹ and mediation.¹²

A policyholder or the insurance company can also subpoena the other party before regular courts. Which court depends on the amount of the claim, the nature of the claim and the capacity of the parties. If the amount of the claim does not exceed €5,000, the claim can be brought before a justice of the peace.¹³

Generally, claims have to be brought before courts that hold special or exclusive competence. For example, claims for damages resulting from a traffic accident have to be brought before a police court, unless the dispute has a purely civil nature.¹⁴ The labour courts are competent for occupational accidents and group insurance (supplementary pensions).¹⁵ If an insurer files a subrogation claim against a tenant, the claim has to be brought before a justice of the peace. In most cases, however, the parties refer insurance disputes to the court of first instance.

If the parties are both enterprises or if the defendant is an enterprise, the claim has to be brought before a commercial court.

10 Royal Decree of 21 June 2006 modifying the handling of complaints in the insurance sector defined in the Royal Decree of 22 February 1991 containing general regulations concerning the supervision of insurance companies and of the Royal Decree of 25 March 1996 implementing the Act of 27 March 1995 relating to insurance mediation and the distribution of insurance; Articles 302 and 303 Insurance Act of 4 April 2014.

11 The parties agree that a third party will make a binding decision about their dispute. This third party is no judge or arbitrator. For example, in legal expenses insurance: Article 157 Insurance Act and Article 7-8 Royal Decree of 12 October 1990 concerning the legal expenses insurance. For example, in fire insurance: Article 121 Insurance Act.

12 Articles 1730-1737 Judicial Code.

13 Article 590 Judicial Code.

14 Article 601 *bis* Judicial Code.

15 Article 578, 22-24° and Article 578 *bis* Judicial Code.

The Belgian legislature is not very fond of arbitration in the insurance sector. According to Article 90 Section 1 of the Insurance Act, insurance contracts cannot include an arbitration clause. However, the Royal Decree of 24 December 1992 makes an exception for certain types of insurance.¹⁶

III RECENT CASES

i Forfeiture of coverage

Article 141 of the Insurance Act states that liability insurance aims to provide cover to the insured against all claims for damages arising from the occurrence of damage described in the contract, and to safeguard the insured's property within the coverage limits against all debts arising from a certain liability. Article 65 of the Insurance Act provides that no full or partial forfeiture of the right to the performance of the insurance can be stipulated except for the non-performance of a certain obligation imposed by the contract where there is a causal link between the non-performance and the insured event.

A dispute arose between a civil liability insurer for business operations and the insured. The insurer covered 'the laying of underground cables and pipelines – horizontal drilling'. The general conditions included an exclusion for damage that directly and exclusively arose from the choice of the modalities of the execution of the work or a lack of elementary precautions. The special conditions stated (under a special 'cables and pipelines' clause, clause E00012) that 'compensation for damage to underground cables and pipelines is only guaranteed if the policyholder requested, before the beginning of the work, the plans of the aforementioned cables and pipelines within the periods prescribed by the laws and regulations and if he consulted them on the construction site and carried out the necessary surveys if he had the slightest doubt about their location'.

The Court of Appeal had ruled that clause E00012 was null as this clause rendered the insurance cover devoid of purpose.

The Supreme Court did not agree. According to the Supreme Court, Articles 141 and 65 of the Insurance Act, as quoted above, imply that a provision regarding the forfeiture of the coverage is null when it eliminates any coverage of the risk described in the insurance contract.¹⁷ This annulment has to be interpreted strictly. Only when a forfeiture of coverage eliminates any coverage can the clause be annulled. If a court does not examine whether any coverage remains standing, it cannot annul the forfeiture clause.

16 The excepted types of insurance are (1) insurance contracts other than non-marine insurance; (2) fire insurance for industrial risks; (3) civil liability insurance other than motor vehicle insurance, private life insurance and fire insurance for simple risks; (4) insurance contracts that cover monetary losses for industrial risks; (5) construction all-risk insurance other than goods that meet the criteria of simple risks; (6) the risks covered in an additional or complementary manner in the agreements concluded in accordance with the Act of 3 July 1967 concerning the compensation for occupational accidents, accidents on the way to and from work and occupational diseases in the public sector and the Act of 10 April 1971 concerning occupational accidents; (7) insurance contracts the duration of which are shorter than one year; and (8) credit and bail insurance.

17 Supreme Court 19 October 2018, C.18.0082.N/3, T.Verz. 2019, 1, 76-77.

ii Burden of proof: right to redress

According to Article 152 Section 2 of the Insurance Act, the liability insurer has the obligation to notify the policyholder or, if applicable, the insured who is not the policyholder, that it wants to exercise its right to redress. The liability insurer has to do this the moment it learns of the fact on which it bases that decision. If the insurer does not comply with this obligation, it loses its right to redress. Article 870 of the Judicial Code stipulates that the person who states something has to prove it. Furthermore, Article 1315 Section 2 of the Civil Code obliges the person who claims to be liberated to prove that his commitment has been extinguished.¹⁸

An insurer had notified its insured by registered letter. However, this letter was sent to the wrong address. The insurer tried to argue that it had complied with its notification requirement since the registered letter was not returned to it. According to the insurer, if a letter is not returned to the sender, it has reached its destination.

The Court of Appeal had agreed with this argument. However, when the Supreme Court had to assess the situation, it ruled that the insurer had the burden of proof regarding its notification requirement.¹⁹ By agreeing with the aforementioned argument, the Court of Appeal had reversed the burden of proof.

Following this judgment, insurers have to make sure they have the correct address for insureds when they want to notify them of the insurers' intention to exercise the right to redress.

iii Limitation period: direct claim against insurer

In Belgium, the injured person can file a claim against the liability insurer of the liable person directly, in what is called the injured party's 'own right'.²⁰ That right can also be exercised by the insurer of the injured person if that insurer has provided coverage to the injured person; because of this, the insurer is subrogated in the rights of the injured person against the liable person and can file a direct claim against the insurer as well.

There are specific limitation periods for the direct action against the insurer of the liable person. According to Article 88 Section 2 of the Insurance Act, the claim resulting from the injured party's own right against the insurer is time-barred by five years, counting from the damage-causing event or, in the case of a crime, from the day the crime was committed. However, if the injured person proves that he or she has only learned of his or her right against the insurer at a later date, the limitation period will only start from that time, but it will in any case expire after 10 years from the damage-causing event or from the day the crime was committed. This means that the limitation period does not start until the moment that the injured party knows who the insurer of the liable person is.

The facts that led to the judgment of the Supreme Court of 14 March 2019²¹ were as follows. An explosion had caused damage to the buildings owned by the insureds of Generali and AXA on 31 January 2005. The explosion originated from the building owned by the AXA insured (i.e., the liable person).

18 Note that the Belgian Civil Code of 1804 will be replaced by a new Civil Code, published in the Belgian Official Journal on 14 May 2019. This new Civil Code will take effect on 1 November 2020. The principle of the 'old' Article 1315 Section 2 will be formulated in Article 8.4: 'he who claims to be liberated, has to prove the legal acts or facts that support his claim'.

19 Supreme Court 14 March 2019, C.18.0056.F/1, available on www.cass.be.

20 Article 150 Insurance Act.

21 C.18.0307.F.

On 28 February 2005, Generali (the injured party's insurer) became aware of the identity of the liable person. On 12 September 2005, Generali paid damages to its insured, the injured party, whereby Generali became subrogated in the insured's rights. On 6 September 2010, Generali subpoenaed AXA, the liable person's fire insurer, which also covered fire damage to third parties. Generali's insured, namely the injured party, took advantage of this subpoena and filed a claim against AXA and its insured on 18 March and 3 May 2011.

The court of appeal ruled that Generali's claim was time-barred. However, the claim of its insured was not time-barred.

According to the court of appeal, Generali, when it became aware of the identity of the liable person, should also have known the identity of his insurer. Generali should at least have asked the liable person who his insurer was. Therefore, the limitation period for Generali started on 28 February 2005. On the other hand, the injured party himself became aware of the identity of the insurer, AXA, on 15 June 2010. Unlike Generali, the injured party could not have been expected to know the identity of the insurer of the liable person. Furthermore, the injured party did not have the same investigative obligation as Generali. Therefore, the limitation period for that injured party started on 15 June 2010.

The Supreme Court did not agree with this argument. The Supreme Court found that the court of appeal judgment – which held that the limitation period for Generali started before the limitation period for Generali's insured (the injured party) and before Generali was subrogated in the insured's rights – did not legally justify the decision to declare the claim of Generali against AXA time-barred. In other words, if the limitation period for Generali's insured had not started, the limitation period for Generali, which was subrogated in the rights of its insured, had also not started. The claim of the subrogated insurer could not be time-barred if the claim of its insured was not time-barred.

IV THE INTERNATIONAL ARENA

For matters concerning international and European areas, Belgium and other Member States often look to the European Court of Justice for guidance. For example, the Belgian Constitutional Court has asked a preliminary question to the European Court of Justice regarding free choice in respect of advisers in legal expenses insurance contracts.

The Act of 9 April 2017 amended Article 156(1) of the Insurance Act regarding the free choice of advisers in legal expenses insurance contracts. Every legal expenses insurance contract has to state that the insured has a free choice of lawyer or any other person who is qualified to defend, represent or promote the insured's interests when judicial, administrative or arbitration proceedings have to be initiated. Moreover, the insured can freely choose any person who has the required qualifications and is appointed to do so in the event of arbitration, mediation or any other acknowledged extrajudicial form of dispute resolution. The amendment to Article 156(1) of the Insurance Act now extends that free choice of advisers to alternative forms of dispute resolution such as mediation.

This Act makes a distinction between, on the one hand, a free choice of lawyer in the event of a judicial, administrative or arbitration procedure and, on the other hand, a free choice of the person who leads the arbitration, mediation or other extrajudicial dispute resolution procedure. For example, in the case of mediation, the insured does not have a free choice of lawyer, but does have a free choice of mediator. According to the legislature, the

reason for introducing this distinction was that the presence of a lawyer is not beneficial for mediation and the agreement reached through mediation is not necessarily based on legal reasoning.

The Belgian Bars asked the Constitutional Court to annul this Act.²² According to them, this Act introduced an unconstitutional difference between, on the one hand, the insured who wants to introduce an arbitration procedure and, on the other hand, the insured who wants to solve a dispute through mediation.

In Belgium, there is a distinction between extrajudicial mediation and judicial mediation. An extrajudicial mediation can be initiated by the parties before, during or after judicial proceedings. The agreement reached by the mediator and the parties can be accredited by a judge if the mediator is acknowledged. A judicial mediation occurs when the judge ruling on a dispute orders mediation at the parties' request, or if the judge proposes mediation and the parties agree to this. The dispute remains pending and the judge can take other measures. The agreement reached by the parties through judicial mediation can be accredited by that judge. If no agreement is reached, the judicial proceedings continue. The difference between these two types of mediation and arbitration is that arbitration leads to a decision made by arbitrators.

According to the Constitutional Court, arbitration and mediation are comparable situations, meaning that no discrimination between the two may arise. The Court refers to case law of the European Court of Justice to rule that the free choice of a lawyer cannot be restricted.²³ However, European law does not extend this right to extrajudicial proceedings. Therefore, the Constitutional Court decided to ask this preliminary question to the European Court of Justice: 'Should the term "proceedings" in Article 201(1)(a) of Directive 2009/138/EC of the European Parliament and of the Council of 25 November 2009 on the taking-up and pursuit of the business of Insurance and Reinsurance be interpreted as including extrajudicial and judicial mediation proceedings, as provided for in Articles 1723/1 to 1737 of the Belgian *Gerechtelijk Wetboek* (Judicial Code)?'²⁴

We will have to wait and see what the opinion of the European Court of Justice is on this subject.

V TRENDS AND OUTLOOK

i Busiest areas of claims

It is very difficult to assess the busiest areas of insurance claims in Belgium. Belgium does not have an overview of all claims that were referred to the different courts. However, one can investigate all insurance disputes of the highest courts of Belgium, since their judgments are published. Here it becomes apparent that most disputes involve mandatory liability insurance for motor vehicles. Of course, this is very understandable since every person who owns or drives a motor vehicle is obliged to take out liability insurance.

22 Constitutional Court 11 October 2018, case 6752, Belgian Official Journal 26 October 2018, 81857.

23 European Court of Justice 10 September 2009, *Enschig*, C-199/08, 38-58, European Court of Justice 7 April 2016, *Büyüktipi*, C-5/15, 16-23 and European Court of Justice 7 April 2016, *Massar*, C-460/14, 18-25.

24 European Court of Justice, C-667/18, pending.

The same conclusion can be made for all complaints filed with the Insurance Ombudsman.²⁵ In 2018, 1,285 complaints involved motor vehicle insurance, 1,130 life insurance, 980 health insurance, 973 fire insurance and 580 legal expenses insurance. The remaining complaints were about various insurance contracts (transport, credit and complaints not clearly defined (510), other civil liability insurance (265), assistance insurance (194), all-risks insurance, such as for mobile phones (173), occupational accidents (86) and individual accidents (43). Compared to complaints in 2017, there has been a clear increase in complaints regarding life and health insurance, mostly because of alleged long settlement periods. There has also been an increase in complaints regarding legal expenses insurance because of allegedly insufficient communication being provided to the consumer.²⁶

More than one in four questions (28 per cent) related to response time, especially in relation to life and health insurance.²⁷ In this digital age, consumers expect quicker answers and are less understanding regarding waiting periods and delays. The Insurance Ombudsman recommends clear agreements concerning the communication between the various parties; for example, the policyholder, the intermediary and the insurance company. Moreover, an administrative simplification could prevent a lot of complaints.²⁸

Insurance intermediaries are often confronted with complaints about claims management by the insurance company (27 per cent), non-compliance with deadlines (19 per cent) and the lack of information at the moment of the conclusion or adaptation of the insurance contract (18 per cent). The policyholder is often of the opinion that the insurance product does not comply with his or her needs and that he or she was not correctly informed about the conditions of the contract.²⁹

ii Areas that are likely to evolve and become more important in the future

First, new or changed legislation always results in new disputes and case law. Two noteworthy examples are the General Data Protection Regulation (GDPR) and the IDD.

Since the entry into force of the GDPR, insurers have had to change their privacy policy.³⁰ One of the most important changes is the protection against data breaches. Cyberattacks occur increasingly and, as a result, insurance against these is becoming more vital for businesses. One can see more and more insurers introducing these new kinds of policies. Since they are relatively new, they might become a hot topic in the near future.

Furthermore, courts are often confronted with claims concerning life insurance policies without a guaranteed return (known as Branch 23 policies). In the years before the global financial crisis, these insurance policies were promoted by and concluded with the help of

25 Insurance Ombudsman, Annual Report 2018, available at: <http://www.ombudsman-insurance-annualreport.be/2018-ombudsman-verzekeringen-jaarverslag/>.

26 Insurance Ombudsman, Annual Report 2018, available at: <http://www.ombudsman-insurance-annualreport.be/2018-ombudsman-verzekeringen-jaarverslag/>. p. 6.

27 Insurance Ombudsman, Annual Report 2018, available at: <http://www.ombudsman-insurance-annualreport.be/2018-ombudsman-verzekeringen-jaarverslag/>. p. 8.

28 Insurance Ombudsman, Annual Report 2018, available at: <http://www.ombudsman-insurance-annualreport.be/2018-ombudsman-verzekeringen-jaarverslag/>. p. 13.

29 Insurance Ombudsman, Annual Report 2018, available at: <http://www.ombudsman-insurance-annualreport.be/2018-ombudsman-verzekeringen-jaarverslag/>. p. 17.

30 Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data, and repealing Directive 95/46/EC (General Data Protection Regulation).

insurance intermediaries who were, at the time, not extensively regulated. The clients for these policies are now starting proceedings because rather recently it became clear that all the money invested in these policies is now lost. The clients often claim in these proceedings that the insurance intermediaries or the insurer withheld information, and had the clients received that information they would have invested in another product.

Obviously, the European and Belgian legislatures have now started to regulate the activities of insurance companies and intermediaries, and clients are increasingly aware of the behaviour that the insurance companies and intermediaries have to adopt.

One of the most recent pieces of European legislation is the IDD. This instrument is not only relevant for compliance officers, but also for clients, who can now expect certain behaviour on the part of their contracting parties.

In the context of evolving areas, a general awareness of global problems, such as climate change, can result in new insurance policies. Currently, the insurance sector is reluctant to provide coverage for weather disasters because of high costs and risks; for example, in the agricultural sector, the renewable energy sector, the transport sector or the tourism sector. However, these kinds of insurance policies are becoming more essential than ever. Reliance on the Belgian Agricultural Disaster Fund might not be sufficient. Therefore, the Belgian government has promoted insurance for weather disasters since the autumn of 2017 and together with several agricultural organisations continues to negotiate in favour of affordable premiums.³¹ For example, the Decree of 5 April 2019 of the Flemish Region further simplifies administrative procedures, updates the reimbursement process and introduces an aid scheme for farmers who have concluded a comprehensive weather insurance contract.³²

In addition, technological and scientific progress sparks new insurance policies. As mentioned above, the first cyber insurance policy was concluded in 2010.³³ Vanbreda Risk & Benefits, a Belgian independent insurance broker and risk consultant, predicts that drone insurance will become common in 2020 and that the first insurance policy for robotics and automated guided vehicles will appear in 2030.³⁴

Insurance law is an ongoing process of trial and error and a constant interaction between the legislature, the judiciary and the executive. When new legislation is published, case law will evolve. When case law evolves, legislation has to be changed. When certain insurance problems receive media attention, both case law and legislation are to an extent forced into taking a certain direction. Therefore, it is fairly possible that new topics will arise in the future and we, as law practitioners, look forward to any evolution of insurance law.

31 www.demorgen.be/binnenland/boeren-kunnen-zich-binnenkort-verzekeren-tegen-klimaatrisico-s-b4dfa421/.

32 Decree of 15 April 2019 regarding the compensation of damage caused by disasters in the Flemish region, Belgian Official Journal 23 April 2019, 39955.

33 www.vanbreda.be/nl/nieuws/elk-decennium-een-nieuw-risico-van-cyber-naar-drones-en-zelfrijdende-wagens/.

34 www.vanbreda.be/nl/nieuws/elk-decennium-een-nieuw-risico-van-cyber-naar-drones-en-zelfrijdende-wagens/.

BRAZIL

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I OVERVIEW

Brazil is the fifth most densely populated country in the world² and among the biggest in terms of territory. These facts speak for themselves, making Brazil one of the most promising insurance markets globally, especially given the percentage of the national gross domestic product (GDP) accounted for by the Brazilian insurance market (close to 4 per cent, according to recent surveys conducted by the Brazilian Private Insurance Authority (SUSEP)).³

Hence, there is plenty of room for growth when compared to other markets. In addition to the above, new legislation enacted by the National Congress, such as the Brazilian Data Protection Law (BDPL),⁴ the Brazilian Code of Civil Procedure of 2015 (the Code of Civil Procedure),⁵ Bill of Law No. 29/2017 (designated the New Brazilian Insurance Law by market experts and scholars) and Provisional Measure No. 881/2019, certainly anticipate significant changes in the manner in which local and foreign accredited players in the Brazilian insurance market do business.

II THE LEGAL FRAMEWORK

i Sources of insurance law and regulation

Unlike some other countries in Latin America, Brazil has a highly regulated insurance sector. Basic insurance legislation is composed of several laws, as well as regulations enacted by the following federal authorities: the National Council of Private Insurance (CNSP) and SUSEP.

Decree-Law No. 73/1966, known as the Brazilian Insurance Law, created the Brazilian Private Insurance System (SNSP), which is formed by CNSP, SUSEP, accredited reinsurance and insurance companies, open private pension entities and capitalisation entities, as well as insurance and reinsurance brokers. Open private pension entities are subject to the provisions of Supplementary Law No. 109/2001, whereas capitalisation entities are governed by Decree-Law No. 261/1967.

The SNSP is composed of two governmental authorities, both of which are part of the Ministry of Finance. While CNSP has the authority to set out the general guidelines

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2 US Census Bureau, 2018.

3 6th Analysis and Monitoring of Supervised Markets Report, SUSEP, 2018.

4 Law No. 13709/18.

5 Law No. 13105/2015.

and rules of the Brazilian local insurance and reinsurance market, SUSEP has oversight over the activities of all players in this market, monitoring their respective businesses and, when applicable, giving prior approval to certain transactions involving regulated entities.

Reinsurers are classified into: (1) local (headquartered in Brazil), such as IRB Brasil Resseguros SA (IRB); (2) admitted (headquartered abroad but with a representative office in Brazil); and (3) occasional (headquartered abroad, without any representative office in Brazil). Insurance companies must be duly authorised to operate by SUSEP.

Insurance and reinsurance brokers must be duly enrolled as such with SUSEP before intermediating the sale of any insurance policy or conducting the intermediation of reinsurance treaties or contracts. In addition, reinsurance brokers' corporate purpose must be exclusive, meaning that they cannot conduct any activity other than acting as a reinsurance broker.

It is also worth stressing the following laws, which – in one way or another – either apply directly to the entities that are part of the SNSP or otherwise have an impact on them:

- a* Supplementary Law No. 126/2007, which dismantled the IRB's monopoly in the reinsurance market, sets out the ground rules that must be met by each type of reinsurer (as previously explained), and rules for residents in Brazil and companies headquartered in the country taking out insurance abroad.
- b* the Brazilian Civil Code (BCC),⁶ which dedicates an entire chapter to insurance contracts and the main principles that regulate the insured–insurer relationship;
- c* the Brazilian Consumer Protection Code,⁷ since the insured is considered a 'consumer' for legal purposes;
- d* The Code of Civil Procedure, which attempts to make litigation less time-consuming by developing and enhancing the rules related to alternative dispute resolution mechanisms (especially arbitration and mediation), rendering former court decisions by the superior courts binding and making a decision in a single case the model or precedent for other similar cases. Its rules are starting to be tested now, since it only became effective in March 2016.
- e* The BDPL, which regulates the commercial use of personal data by legal entities, adopting similar regulatory standards to those set by the European General Data Protection Regulation. In July 2019, the National Congress enacted an amendment to the BDPL to create the National Data Protection Authority, in charge of supervising and regulating the enforcement of the terms and conditions of the BDPL. The Authority will have powers to, among others, (1) request information regarding the processing of personal data by companies; (2) receive and process data breach notifications; and (3) impose administrative penalties for violations of the BDPL. Penalties or fines arising from breaches to the BDPL might reach 50 million Brazilian reais per violation.
- f* Bill of Law No. 29/2017, which sets out a whole new legal framework for SNSP players, triggering the need for new legislation to be enacted by the CNSP and SUSEP. Scrutiny of this bill by the National Congress continues during this year. (See Section V.iii.)
- g* Provisional Measure No. 881/2019, which significantly reduces bureaucracy for setting up businesses in Brazil, as well as state interference in this process. Experts understand that, whenever this provisional measure is converted into law, the relationship between market players and regulators and governmental authorities will change dramatically, improving the environment for doing business in Brazil. (See Section V.iv.)

6 Law No. 10406/2002.

7 Law No. 8078/1990.

- b* Bill of Law No. 1292/1995, which changes public procurement in Brazil and directly affects performance bonds in public works. (See Section V.v.)

ii Insurable risk

Section 757 of the BCC defines insurable risk as the legitimate interest of the insured in protecting a given asset, object or right against predetermined risks.

The legitimate interest must: (1) be licit, since the BCC prohibits any transaction concerning illicit purposes (including, but not limited to, agreements of any nature);⁸ (2) be economic, since a given value must be attributed to the object of the insurance coverage by the person retaining insurance, either limited to the sum of the value of the insured object, asset or right (when dealing with non-life insurance), or freely established pursuant to the will of the insured (when dealing with life insurance);⁹ and (3) precede the contract and remain effective throughout its term of effectiveness.¹⁰

As a result of the requirements pending over the legitimate interest, illicit activities are not insurable and, as such, wilful misconduct or unlawful enrichment are standard excluded risks to all life and non-life products (BCC, Section 762). Regarding liability insurance, there is no concept of punitive damages in Brazil, since the BCC limits compensation in tort to the extent of actual damages inflicted on the victim (BCC, Section 944).

In terms of the regulation of insurable risk, in spite of legislation prohibiting coverage for illicit purposes, SUSEP allows coverage of civil and administrative sanctions in directors and officers (D&O) insurance (SUSEP Circular No. 553/2017). The term ‘civil and administrative sanctions’ means any penalty except for those arising from criminal offences (such as imprisonment). In this type of insurance, there is no restriction on anticipating defence costs, given that litigation in criminal cases is common and widely used. SUSEP has also stated that coverage for ransoms does not breach applicable law, as long as the insurance product has previously been approved by SUSEP (pursuant to SUSEP DETEC Letter No. 07/2008).

iii Fora and dispute resolution mechanisms

Insurance disputes in Brazil are heard before ordinary courts of the judiciary system or arbitration courts.

The judiciary system is divided into specialised courts and ordinary courts. Specialised courts include military, electoral and labour courts, while ordinary courts have jurisdiction to adjudicate all other issues. Since specialised courts do not exist for insurance matters, ordinary courts have jurisdiction over insurance disputes.

The ordinary courts are subdivided into federal and state courts. The jurisdiction to hear insurance disputes depends on the parties involved: federal courts have jurisdiction to hear cases involving the government and government-controlled corporations, and state courts adjudicate cases that do not fall within the jurisdiction of federal courts.

8 Brazilian Civil Code, Article 104: ‘The requirements for the validity of a legal transaction are: I – a capable agent; II – a licit, possible and determined or determinable object; III – a form that is prescribed (or not prohibited) by law.’

9 Tzirulnik, Ernesto. *The Insurance Contract According to the Brazilian Civil Code*. 3rd Edition. São Paulo. Roncarati, 2016, p. 53.

10 Franco, Vera Helena de Mello. *Contracts: Civil and Corporate Law*. 5th Edition. São Paulo. Revista dos Tribunais. 2014, p. 340.

It is important to consider that both federal and state courts have two levels: (1) trial, where cases are filed and ruled by a single judge; and (2) appellate, where appeals are taken by panels usually comprising up to three justices, who are free to assess matters of fact and law.

Trial judges take office after passing a public examination. Justices are appointed to appellate courts based on criteria such as merit and length of service. One-fifth of appellate court seats are mandatorily fulfilled by members of the public prosecutor's office and practising attorneys.

There are 27 state appellate courts (one for each state and the federal district) and five federal appellate courts in Brazil. Appeals against appellate court decisions may be filed with the Superior Court of Justice or the Federal Supreme Court, or both. If an appellate court decision arguably violates the federal law or the Federal Constitution, it may be challenged by appeals filed before the Superior Court of Justice or the Supreme Court.

The Superior Court of Justice is restricted to evaluating matters of law and it rules appeals against appellate court decisions that have arguably violated federal law or have given federal law an interpretation that differs from that handed down by another appellate court.

The Superior Court of Justice comprises 33 justices who are appointed by the President upon approval by the Senate, observing the following rules: (1) one-third of the justices must come from federal appellate courts; (2) one-third of the justices must come from state appellate courts; and (3) one-third of the justices must be private practitioners or public prosecutors.

The Supreme Court rules appeals against appellate court decisions that have arguably violated the Federal Constitution and to be given leave to appeal the appellant is required to provide evidence that the constitutional issues addressed in the appeal would have widespread repercussions.

The Supreme Court comprises 11 justices appointed by the President upon approval by the Senate.

It should be noted that Brazilian civil courts do not hold jury trials, as juries are only permitted in specific criminal proceedings, so insurance disputes are not subject to juries. Insurance disputes may be also subject to arbitration procedures, as they involve rights that can be the object of a transaction (see Section 1 of the Brazilian Arbitration Law).

The Brazilian Arbitration Law was inspired by the UNCITRAL Model Law, adopting a regime favourable to arbitration and following international standards, such as the separability of the arbitration agreement, the *Kompetenz-Kompetenz* principle and the impossibility of reviewing the arbitral award on the merits. Also, Brazilian courts have been very supportive to arbitration, offering a safe and favourable environment to its adoption. Domestic arbitral awards are considered final and binding on the parties and do not require recognition or confirmation by a court to be immediately enforced by the parties.

The annulment of domestic awards may be sought under very limited circumstances, within 90 days of the receipt of an award or a decision clarifying the award. Among the reasons for annulment or setting aside an arbitral award, we highlight the following:

- a* the arbitration agreement is null and void;
- b* the award was rendered by a biased arbitrator;
- c* the award exceeds the limits of the arbitration agreement;
- d* the award was rendered under nonfeasance, extortion or corruption;
- e* the award was rendered after the time limit; and
- f* due process was not observed during the arbitral proceedings.

Therefore, arbitration has been increasingly adopted in Brazil as a dispute resolution method compatible with insurance disputes.

Besides the judicial claims, there are administrative insurance disputes pending before regulatory agencies, such as SUSEP, the Consumer Protection Office (PROCON) and the National Supplementary Health Agency (ANS), which is the regulatory agency for private health insurance and private health plans. These agencies are responsible for reviewing administrative procedures concerning breaches of their respective regulations by insurers, reinsurers and brokers, triggering the imposition of penalties and other sanctions, as the case may be.

III RECENT CASES

One of the most relevant recent insurance disputes in Brazil involves (1) the attachment of the shares of a major airline company to guarantee the reimbursement of a hefty indemnification, and (2) the debate about the subrogation of the insurer to the arbitration clause in the insured's contract.

A performance bond was issued to insure the losses arising from the failure of a company in complying with its obligations under shipbuilding contracts. After the payment of the indemnification, the insurers filed a collection lawsuit with the State Court of São Paulo against the principal and guarantors, who are the shareholders of a famous airline company.

Owing to the proof of commingling of assets and misuse of legal entities, the State Court of São Paulo granted a request to pierce the guarantors' corporate veil and for the provisional attachment of their respective assets to ensure the reimbursement of the indemnification. As a result, around 200 million shares of the famous airline were attached.

In response to the attachment, the guarantors argued that the State Court of São Paulo lacked jurisdiction to adjudicate the dispute between the insurers, principals and guarantors owing to the parties' subrogation in the arbitration clause, established only in the secured contracts entered into between the policyholder and the insured.

According to the guarantors, the insurers were subrogated to all obligations provided in the agreement entered into by the insured. As a result, the insurers would be obligated to comply with all clauses established in the contracts between the policyholder and the insured, including the arbitration clause.

Furthermore, in order to defend this argument, the guarantors brought an action before the State Court of Rio de Janeiro requesting a provisional injunction to revoke the attachment order granted by the State Court of São Paulo, based on the latter's lack of jurisdiction. Subsequently, the guarantors filed a statement of claim requiring the commencement of arbitration based on the arbitration clause established solely in the secured contracts between the policyholder and the insured.

The injunction was granted by the State Court of Rio de Janeiro and, subsequently, the guarantors raised a conflict-of-jurisdiction lawsuit before the Superior Court of Justice. However, in a preliminary decision, the Superior Court of Justice recognised that the insurers were not subject to the arbitration clause and, therefore, the State Court of São Paulo maintained jurisdiction to decide the case. Although a final and binding decision has not yet been issued, the state courts and the judge-rapporteur for the proceedings have issued statements recognising that under Section 786 of the Brazilian Civil Code the insurer's subrogation is limited to the right of reimbursement and is not subject to procedural issues such as the arbitration clause or the forum-selection clause of the agreements entered into

by and between the parties. Therefore, unless there is a specific provision in the insurance bond subjecting the principal policyholder, guarantors and insurers to arbitration, conflicts between the parties must be ruled on by the judiciary system.

In addition, the State Court of Rio de Janeiro granted an interlocutory appeal filed by the insurers, overcoming the injunction that had been granted and dismissing the argument that the State Court of Rio de Janeiro had jurisdiction. In turn, the arbitral court dismissed the guarantors' claim for lack of jurisdiction, meaning that the judiciary system has the jurisdiction to decide the case.

Although there has been no final decision by the Superior Court of Justice on the conflict of jurisdiction, all the courts involved have already decided that the insurers are not subject to the arbitration clause.

Another recent relevant dispute involves the discussion concerning judicial bonds and judicial reorganisation. Judicial bonds were issued on behalf of one of the largest telecommunication operators in Brazil to insure the payment of labour and civil debts collected in court. In the course of these lawsuits, the policyholder filed for a judicial reorganisation before a bankruptcy court and, under the Brazilian Bankruptcy Law,¹¹ the enforcement procedures against the telecommunication company for collection of the debts were immediately stayed for 180 days (tax credits are not subject to these procedures).

Furthermore, the bankruptcy court issued an order suspending any payment under the judicial bonds presented in labour and civil lawsuits, as the credits would be paid according to the company's reorganisation plan. However, the bankruptcy court decision was not taken into consideration and the courts in charge of the enforcement procedures determined that payment of the indemnities was in order.

Because of the conflicting decisions, the insurer filed for proceedings before the Superior Court of Justice to decide the conflict of jurisdiction between the labour and civil courts, and the bankruptcy court. The Supreme Court of Justice has not decided the conflict of jurisdiction yet, but the judge-rapporteur for the proceedings granted a preliminary order recognising the bankruptcy court's jurisdiction to decide on the payment of the bonds until a final decision is rendered.

The issues under discussion may be summarised as follows: (1) after the approval of the reorganisation plan the debts are novated and the judicial bonds cannot be enforced, as the creditors must be paid under the reorganisation plan terms; and (2) the judicial bonds are a distinct payment obligation and are not subject to the novation effects, and as a result they cannot be enforced and must be terminated.

The judge-rapporteur ratified the preliminary injunction and no further appeal was filed. Therefore, this decision has become *res judicata*. Despite the fact that there are still two jurisdiction conflict lawsuits to be decided by the Superior Court of Justice, which can be analysed by the judge-rapporteur or a panel of justices, it is unlikely that a different outcome could be expected.

11 Law No. 11101/2005.

IV THE INTERNATIONAL ARENA

Two main issues stand out in the international arena: (1) the application of foreign law to insurance disputes in Brazil and (2) the enforcement of foreign arbitral awards in Brazil.

i Application of foreign law to insurance disputes in Brazil

First, it is worth stressing that Brazilian insurance law and regulation have a very paternalistic approach when it comes to the possibility of residents in Brazil or companies headquartered in the country reaching out to the international insurance market for the purposes of taking out insurance products. The general tendency was to restrict this practice as much as possible to prevent the local market being overrun by foreign competitors.

This was the principal justification for IRB's monopoly in the reinsurance market between 1939 and 2007. Even though this monopoly ceased to exist upon the enactment of Supplementary Law No. 126/2007, there still are numerous restrictions on taking out insurance abroad, which ultimately significantly reduce the chances of any controversy regarding the application of foreign law to insurance disputes that take place in Brazil, since insurance policies issued locally are governed by Brazilian law.

This matter becomes more debatable in relation to reinsurance agreements and treaties. According to the Law of Introduction to the Norms of Brazilian Law,¹² the main statute on conflicts of laws, obligations to be met in Brazil are subject to Brazilian law and therefore reinsurance obligations would be subject to Brazilian law. On the other hand, CNSP Resolution No. 168/2007 provides that reinsurance contracts related to risks in Brazil must establish a clause granting jurisdiction to Brazilian courts to decide disputes under Brazilian law, except when the parties to the contract agree to submit the dispute to arbitration.

It is worth mentioning that if Bill of Law No. 29/2017 is enacted, the insurance market in Brazil will be governed by a new law requiring the application of Brazilian law to all contracts (including, but not limited to, reinsurance contracts) and disputes (in the judiciary system or arbitration courts) related to insurance in Brazil.

Many scholars and experts argue that reinsurance agreements or treaties have to be governed by Brazilian law, since all undertakings set out in such agreements are bound to insurance policies or bonds issued by a local accredited insurer and governed by local law. The scale of this debacle will only increase upon the enactment of Bill of Law No. 29/2017, the progress of which is being closely followed by many reinsurers that do business in Brazil.

ii Enforcement of foreign arbitral awards

Regarding the enforcement of foreign arbitral awards, the Brazilian Arbitration Law distinguishes between two types of arbitral awards: domestic and foreign.

Foreign arbitral awards are those rendered outside Brazil that require recognition before enforcement in Brazil. Domestic arbitral awards are those rendered in Brazil that can be enforced as a domestic court judgment without any need for court confirmation. Therefore, for the purposes of recognition of foreign awards, the seat of arbitration plays an important role in defining where the award is rendered and whether it needs confirmation before enforcement.

12 Decree-Law No. 4657/1942.

To enforce a foreign arbitral award in Brazil, it must first be submitted to a recognition procedure before the Superior Court of Justice. Furthermore, the applicant must present evidence that the award:

- a* was issued by a competent authority;
- b* was issued only after the parties to the proceedings had been duly summoned, or with proof that a default judgment was the only option; and
- c* has become final and definitive, and not subject to any appeal.

Brazilian law limits the grounds that can be raised by a respondent against whom recognition is sought. The respondent will only be able to raise a limited range of defence arguments to object recognition and prevent it from being granted.

The defence arguments that can be raised do not include whether the merits of the arbitral award are correct. The Superior Court of Justice will not discuss whether the arbitral tribunal has reached an adequate decision on matters of law and facts. In fact, the Superior Court of Justice has been very careful in not making an analysis or revision of the merits of the decision.

Therefore, the arbitral award may be challenged only if:

- a* there is a lack of standing of the parties to the arbitration agreement;
- b* the arbitration agreement is not valid;
- c* the respondent was not given notice of the appointment of the arbitrator or of the arbitral proceedings;
- d* the respondent was not able to present its case;
- e* the award deals with a dispute outside the scope agreed by the parties;
- f* the arbitral tribunal was not composed according to the parties' agreement or the applicable law;
- g* the arbitral procedure did not observe the parties' agreement or the applicable law;
- h* the arbitral award is not binding on the parties, or it was set aside or suspended;
- i* the subject matter of the dispute cannot be resolved by arbitration under Brazilian law; or
- j* recognition or enforcement of the arbitral award is contrary to national sovereignty, human dignity or Brazilian public policy.

If the application for recognition is presented with all the required documents and no objection is raised, the recognition procedure should take from six months to a year. If an objection is raised, or there are missing documents, this could be expanded to more than two years, depending on the complexity of the case and the Superior Court of Justice's agenda.

Once recognised by the Superior Court of Justice, the award becomes a judgment with enforceable title in Brazil. After that, any party may seek enforcement with the competent federal court, which, as a general rule, is the court with jurisdiction over the place where the award debtor has its place of business.

An enforcement procedure typically takes up to two years if there is opposition to it. This may vary a great deal depending on the difficulties in summoning the debtor and finding enough assets to satisfy the debt if the debtor does not respond immediately.

V TRENDS AND OUTLOOK

Among the trends of the local insurance market, we highlight the following.

i D&O demand and increasing loss ratios

Law No. 13506, enacted on 13 November 2017, significantly increased the limit of the sum of fines that may be applied by the Central Bank of Brazil (BCB) and the Securities and Exchange Commission (CVM). Now the BCB may impose fines of up to 2 billion reais on financial institutions (and their officers and directors), and the CVM may impose fines of up to 50 million reais on publicly held companies (and other entities the CVM regulates, and their respective officers and directors).

This automatically triggered a steep increase in the demand for D&O coverage (taking out such coverage has become, in some cases, a condition for individuals being invested as directors and officers of certain companies), since local products of this nature can cover the payments of fines imposed on directors and officers by governmental authorities, with due regard to the limitations set out by each insurer offering such coverage.

In recent years, D&O insurance claims have risen as a result of a significant increase in federal investigations scrutinising public contracts, which led to an unprecedented increase in the public auditing of public administration activities and tenders. Most of the large corporations operating in energy, civil construction and engineering in Brazil have been retained in public bids to deliver infrastructure works in recent events such as the 2014 FIFA World Cup, the 2016 Summer Olympics in Rio de Janeiro, besides regular projected works in all administration levels (federal, state and municipal).

Public contracts are scrutinised by federal and state audit courts, the Public Prosecutor's Office and civil associations, which may bring claims against the private counterparties involved in the bids in respect of any irregularities. As a result of large federal probes over corruption in public bids (among which, Operation Car Wash is the most prominent), D&O insurance claims amounted to over 500 million reais in 2017, and these claims stemmed from matters ranging from investigations by public bodies to judicial claims associated with securities litigation, tax debts, corporate disputes, contractual breaches and bankruptcy law.

ii Surety bond demand and increasing loss ratios

The Code of Civil Procedure has expressly established the right to offer judicial bonds to secure payments of judicial debts. As a result, judicial bonds have become widely accepted by courts and the market is experiencing a vertiginous expansion. Consequently, some local insurance businesses are totally dedicated to surety and judicial bonds.

The surety business has also been a frequent source of claims owing to the economic recession Brazil has experienced since late 2015, which has led to the suspension of many public contracts. Payments in these contracts were stalled while corruption and money laundering investigations were carried out, ensuing a steep increase in the number of claims associated with performance bonds.

Petrobras, the Brazilian state-owned oil giant, was at the centre of the corruption investigations of Operation Car Wash and the interruption of payments within its contracts triggered low liquidity in construction and oil sectors, leading many contractors to submit requests for judicial reorganisation or even bankruptcy. This in turn resulted in numerous claims in the sureties market for breach of contract, contributing to the demand for performance bonds and construction-related insurance.

iii Bill of Law No. 29/2017

Intended to become the 'New Brazilian Insurance Law', Bill of Law No. 29/2017 introduced various innovations that will significantly alter the way insurers do business, leading to adaptations to operational aspects (e.g., the requirement to obtain the insureds' prior consent to implement certain transactions, such as portfolio transfers), changes in the wording of insurance policies and modification of loss adjustment procedures. In February 2019, the Bill of Law was submitted for scrutiny by the Senate's Constitution, Justice and Citizenship Committee.

iv Provisional Measure No. 881/2019

On 30 April 2019, the Brazilian President executed and published Provisional Measure No. 881/2019, also dubbed the 'Provisional Measure of Economic Freedom'. Applicable to entrepreneurs who do (or would like to do) business in Brazil, and in relation to contracts and civil and business obligations, the Provisional Measure establishes principles and general guidelines that are mandatory for the government regarding economic activities, namely (1) the presumption of freedom in the exercise of economic activities; (2) the presumption of good faith on the part of private enterprises; (3) subsidiary, minimum and exceptional intervention of the state in the exercise of economic activities; and (4) vulnerability of people before the state. As regards its impact in the insurance sector, this Provisional Measure (1) ensures equal treatment by public administration bodies; (2) reinforces the prevalence of the free will of the parties and the principle of *venire contra factum proprium*; (3) encourages innovation if regulation is outdated in relation to technology being used in the market; (4) forbids governmental authorities from adopting contradictory approaches on issues or with different players in the same regulated markets, ensuring equal treatment for local and foreign players; (5) sets forth a fixed term for public authorities to approve or deny a specific request made by private parties (whenever law or regulation has not already established a fixed term) and that such request will be deemed approved if the public authority has not positioned itself within such term; and (6) allows digital storage of documents. The Provisional Measure was approved, with some amendments thereto, by the National Congress and was sanctioned by the President on 20 September 2019, becoming Law No. 13874/2019.

v Bill of Law No. 1292/1995

Currently, in Brazil, performance bond limits range from 5 per cent to 10 per cent of the contract amount and there is lack of a legal framework for step-in rights, in view of a scenario where more than 14,000 public works are paralysed. If approved, this Bill of Law, regarded as the 'New Public Procurement Law', would change the guarantee limits as follows:

- a* public works, services and supply contracts of up to 100 million reais (guarantees are not mandatory): a guarantee limit of 5 per cent of the initial contract amount, which may be increased to a maximum of 10 per cent depending on the complexity of the project and the risks involved;
- b* public works, services and supply contracts above 100 million reais (guarantees are not mandatory): a guarantee limit of 10 per cent of the initial contract amount, which may be increased to a maximum of 20 per cent depending on the complexity of the project and the risks involved;

- c* engineering contracts ranging in value from 100 million to 200 million reais (guarantees are mandatory): a guarantee limit of 10 per cent of the initial contract amount, which may be increased to a maximum of 20 per cent depending on the complexity of the project and the risks involved; and
- d* engineering contracts of over 200 million reais, or 'contratos de grande vulto' (major contracts) (performance bonds are mandatory): a guarantee limit of 30 per cent of the initial contract amount, which may be reduced to a minimum of 10 per cent (as a minimum mandatory percentage) if the 30 per cent requirement (1) unreasonably restricts the competitiveness of the bid, (2) leads to an unjustified increase in the constructor's profit, or (3) allows the constructor to abuse its dominant market position.

If the bidding documents establish that in the event of default the insurer must take over and finish the project (step-in obligation), the insurer shall execute the underlying contract and relevant amendments, as intervening party, and will be able to:

- a* freely access the construction facilities;
- b* supervise the performance of the underlying contract;
- c* have access to technical and accounting audits; and
- d* request clarifications from the technical team responsible for the works.

In the event of breach by the principal (triggering the bond), the following alternatives will be available for the insurer:

- a* the insurer may step in, exempted from the obligation to indemnify losses and penalties arising from the principal's default; or
- b* the insurer may decide not to step in, and will have to (1) pay contractual penalties of up to 15 per cent of the contract's value, and (2) pay for losses and damages or excess costs (overcharges) resulting from the contracting of a new player, provided, however, that the sum of items (1) and (2) above is capped at the policy limit.

In the step-in scenario, the insurer will be able to subcontract, in whole or in part, third parties to finish the works.

The Bill of Law is currently under scrutiny by the National Congress and does not apply to concessions of public services. The next steps are approval by the House of Representatives (Câmara dos Deputados) and subsequently ratification by the Senate (Senado); following approval by the Senate, the Bill of Law may be enacted by the President, who has the power to veto provisions.

vi Regulatory flexibility

In March 2019, SUSEP's chairman and main internal decision-making team were replaced by more business-oriented individuals who seek to make the regulatory environment less bureaucratic and time-consuming, to harmonise legislation with technological advances, and to stimulate growth of the insurance, reinsurance, private pensions and capitalisation market and its participation in the Brazilian GDP. This new administration is working together with the BCB and the CVM to innovate within the securities market, and an example is the Special Committee on Innovation and Insurtech. The federal government has already stated its intention to merge SUSEP with the Brazilian Public Pension Plan Authority (PREVIC), which regulates closed-end pension plans. Nevertheless, to date, no specific bill of law or provisional measure has been issued in this regard.

DENMARK

*Anne Buhl Bjelke*¹

I OVERVIEW

In Denmark, insurance litigation usually comprises coverage disputes (i.e., disputes between the insurers and the insured) and defence instructions (i.e., disputes where the insurers instruct the counsel to defend the interests of an insured or claim recourse from potential liable tortfeasors, who may very well be insured themselves). These have been the bulk of the insurance disputes in Denmark for years. Any disputes about mis-selling of insurance have been isolated occurrences. Recent case law has, however, cast light over subjects of general interest, such as limitation, direct actions and choice of law.

In this chapter we focus on insurance disputes relating to coverage, illustrating the general principles of Danish insurance law and recent case law of interest.

II THE LEGAL FRAMEWORK

i Sources of insurance law and regulation

Danish insurance law primarily consists of the protective mandatory Insurance Contracts Act² governing insurance contracts.³ Like any other contract, insurance contracts are subject to the Contracts Act governing general rules of formation of contracts, as well as general principles and doctrines of contract law. Reinsurance contracts are not subject to the Insurance Contracts Act but are governed by general contract law.

No statutory law provides rules specifically designed to resolve insurance disputes in the courts. In Denmark, insurance dispute resolution is subject to the same procedural rules applicable to any other civil law proceedings by way of the statutory provisions following from the Administration of Justice Act⁴ or rules on arbitration. Many commercial insurance policies adopt arbitration. Arbitration taking place in Denmark is governed by the Arbitration Act,⁵ which is partly mandatory. Arbitral decisions are not usually published.

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2 Consolidated Act No. 1237 of 9 November 2015 ('Forsikringsaftaleloven').

3 Furthermore, the financial and prudential regime (the Financial Business Act, Consolidated Act No. 1140 of 26 September 2017, and the Insurance Distribution Act, Consolidated Act No. 1065 of 22 August 2013, including executive orders) governs insurance business and insurance distribution activities. This regime is often relevant in connection with insurance disputes (i.e., if the disputes relate to mis-selling, consumer insurance or distribution). As from 1 October 2018, the new EU Insurance Distribution Directive is implemented in Denmark; see Act No. 41 of 22 January 2018.

4 Consolidated Act No. 1101 of 22 September 2017 ('Retsplejeloven').

5 Act No. 553 of 24 June 2005 ('Voldgiftsloven').

Interpretation of insurance contracts and the burden of proof

As the Insurance Contracts Act mandatorily protects the insured, interpretation of an insurance policy is made in favour of the insured whether the insured is a consumer or a commercial party. Because of this, the burden of proof is on the insurer in many circumstances.

Trigger of coverage under an insurance policy – the insurance event

In terms of triggering coverage, the burden of proof is on the insured, meaning that the insured must substantiate that the occurrence is recoverable under the policy. On the other hand, the burden of proof is on the insurer in terms of substantiating that the occurrence and subsequent damages are not recoverable under the insurance.

General grounds for refusal of cover under an insurance policy

In addition to the contractual limitations of cover, insurance cover may be refused or limited based on the Insurance Contracts Act in cases of:

- a* the insurance event being caused by the policyholder either deliberately or by gross negligence;
- b* fraud or misrepresentation;
- c* increase in risk or the insured's failure to comply with safety instructions; and
- d* disregard of the insured's duty to mitigate losses.

Insurance event caused by the policyholder deliberately or by gross negligence

According to the Insurance Contracts Act Section 18(1), the insurer is entitled to refuse cover if the insurance event was caused by the insured's intent.⁶ In cases of gross negligence, Article 18(2) coverage may be refused in part or in full, depending on the degree of gross negligence.⁷

As in most jurisdictions, the construction of the term 'gross negligence' has given rise to numerous disputes, but generally the term is construed as acts or omissions of the insured that implicitly presented 'an obvious danger' in respect of the occurrence of the insurance event.⁸

On 30 September 1998, the Danish Supreme Court handed down a fundamental decision further elaborating on the understanding of the term 'gross negligence'.⁹ The matter concerned storage of a key to a safety box at an auction house. The auction house experienced a burglary and suffered a total loss of 1.7 million Danish kroner. There were no signs of forced entry and the key was found sitting in the lock. At the time of the burglary, the key was stored behind books in a bookshelf in the same building as the safety box, as it had for years, according to information received from several former employees. The Supreme Court found

6 Section 18(1)–(2) of Consolidated Act No. 1237 of 9 November 2015 ('Forsikringsaftaleloven').

7 In respect of life insurance and liability insurance, the policy shall cover in full even in cases of gross negligence (Article 18(2)), but not in the case of the insured's intention (Article 18(1)).

8 Supreme Court decision made on 22 June 1995 (U 1995.737 H). All judgments rendered by the Supreme Court and decisions rendered by either the High Courts of Eastern or Western Denmark specifically selected are published and made publicly available on the courts' respective websites. Judgments are subsequently published on a privately owned platform ('Karnov') and the references marked with an initial 'U'; these references will be cited in the footnotes of this chapter.

9 U 1998.1693 H.

that storing the key under these circumstances, leaving it highly accessible, entailed such an obvious danger in respect of the burglary that the insured had acted with gross negligence in doing so, and thus cover was rejected in full.

The burden of proof with regard to refusing or limiting cover in respect of establishing intent and gross negligence is always on the insurer and, according to case law, the requirements in terms of discharging the burden of proof are generally very strict.

Fraud or misrepresentation

Fraud and misrepresentation are strong grounds for refusal of cover and may deem the insurance contract void, although these grounds are not the most frequently used grounds for dismissal of an insurance claim.

According to Section 4 of the Insurance Contracts Act, the insurer is under no obligation to perform the insurance contract if the insured, when concluding the insurance contract, fraudulently gave untrue statements or concealed circumstances material to the insurer. Similarly, if the act or omission was of such a nature that it would infringe the general principles of good faith to rely on the contract, the insurer is also entitled to refuse cover.

Refusing cover, however, presupposes that the insured deliberately gave false information or concealed important information to cause a statement of will.¹⁰ The nullification of the insurance contract also applies if the insured deliberately maintains a state of ignorance that the information given was false.¹¹

The burden of proof with regard to misrepresentation is on the insurer. Generally, any false or concealed information provided to the insurer as answers to the insurer's questions in the insurance proposal is likely to be assumed to be of importance to the insurer.¹²

However, if the insured at the time of concluding the contract was in good faith of any statements being untrue, he, she or it is entitled to cover under the policy pursuant to Section 5.¹³

In cases falling outside the scope of Section 4 (fraud) and Section 5 (good faith) but where the insured nevertheless has presented the insurer with incorrect information before the issuance of the policy, the insurer is further free from liability in the event that it is established that the insurer would not have assumed liability had the information provided been correct. Vice versa, if the insurer is deemed likely to have been willing to assume the risk, albeit on different terms, had the information provided been correct, coverage attaches to the same extent as it would have had the insurer assumed the risk against payment of a true and fair premium fixed on the basis of having received correct information.

Increase in risk or insured's failure to comply with safety instructions

Another fairly common ground for refusal of cover giving rise to disputes is where the insured has participated in increasing the risk of the insurance event occurring.

In cases of this kind, the insurer is entitled to refuse cover pursuant to Section 45 of the Insurance Contracts Act. Section 45 provides that cover may be refused if actions committed by the insured after the conclusion of the insurance contract increase the risk of a certain

10 Jønsson, Henning, Kjærgaard, Lisbeth, *Dansk forsikringsret (Danish Insurance Law)*, 9th edition, page 452 and page 181.

11 *ibid.*, page 181.

12 *ibid.*, page 182.

13 Consolidated Act No. 1237 of 9 November 2015 ('Forsikringsaftaleloven') Section 5.

insurance event occurring. The right to refuse cover is, however, conditional upon the specific risk stated in the insurance contract and the insurer establishing not to have wanted to insure the risk under the given terms if the insurer had known about the circumstances leading to the increase in risk at the time the policy was concluded.

Consequently, coverage may be refused only if four cumulative criteria are met:

- a the risk must be specified in the policy;
- b the risk assumed by the insurer must have been increased as a result of the subsequent events referred to;
- c the increase in risk must exceed what the insurer could have foreseen and taken into consideration when assuming the risk; and
- d the increase in risk must wilfully have been caused by the insured.

Notably in this context, Section 46 of the Insurance Contracts Act states that if the insured becomes aware of such an increase in risk and does not inform the insurer thereof, it is to be considered that the increase in risk was wilfully caused by the insured.

Insurance policies may furthermore impose obligations on the insured to observe certain safety instructions to prevent or limit certain risks or events from occurring. In the event that the insured negligently fails to observe the obligations, cover may be refused or limited, unless it is found that the occurrence of the insurance event and subsequent damage were not caused by any such failure.¹⁴

The burden of proof in respect of refusing cover because of an increase in risk or the insured's failure to comply with safety requirements rests with the insurer. Refusal of cover is conditional upon the wording of the policy imposing the obligation on the insured being both unambiguous and clear.¹⁵

Disregard of the insured's duty to mitigate losses

The insured has a general obligation to prevent or mitigate losses claimed under the policy. Furthermore, Section 51(1) of the Insurance Contracts Act imposes obligations on the insured to limit the extent of the insurance event. In the event of failure to fulfil this obligation the insurer's liability may diminish or cease entirely. Consequently, the insured must to the best of his or her ability take steps to prevent or limit the loss resulting from an insurance event. The loss prevention measures are to be instigated when the incident has occurred or when imminent risk of the incident exists.¹⁶ If the insured wilfully or grossly negligently fails to fulfil his or her obligations, the insurer is relieved from its liability in respect of covering the part of the damage caused by the insured's omission.¹⁷

Vice versa, if expenses are associated with fulfilling the insured's duty to mitigate the loss, the expenses will be recoverable under the policy.¹⁸

14 Consolidated Act No. 1237 of 9 November 2015 ('Forsikringsaftaleloven') Section 51.

15 Jønsson, Henning, Kjærgaard, Lisbeth, *Dansk forsikringsret (Danish Insurance Law)*, 9th edition, page 396.

16 *ibid.*, page 416.

17 Consolidated Act No. 1237 of 9 November 2015 ('Forsikringsaftaleloven') Section 52(2).

18 *ibid.*, Section 53.

Limitation in respect of insurance claims and direct claims

Insurance claims are subject to the statutory provisions of the Limitation Act,¹⁹ according to which claims are time-barred after three years, unless otherwise specified in other mandatory provisions. Insurance claims are furthermore subject to the specific rules on limitation provided for in Section 29 of the Insurance Contracts Act, which provides exceptions to the general rule applying specifically to insurance claims.²⁰ In particular, Section 29(5), which implies an extension of the limitation period of notified insurance claims, has recently been subject to interpretation by the courts (relevant case law is considered below in Section III.ii, 'Limitation according to the Insurance Contracts Act').

ii Insurable risk

According to Section 35 of the Insurance Contracts Act, any legal interest capable of being financially estimated may be made subject to indemnification by insurance. Danish law does not elaborate on or define when an interest may be deemed insurable. Therefore, general moral principles are often applied as guidance providing that it is, for instance, not possible to insure losses resulting from own criminal offences, payment of fines, etc., just as sentimental value cannot be made subject to insurance.

iii Fora and dispute resolution mechanisms

As briefly touched upon in the introduction to this chapter, insurance disputes are subject to the same provisions as other civil lawsuits. The relevant provisions are found in the Administration of Justice Act containing, inter alia, rules on court structure and venue. Accordingly, insurance disputes are settled in the same way as other civil disputes.

Rules on court procedure in Denmark

The Danish court system consists of 24 city courts, the Maritime and Commercial High Court, the High Courts of Eastern and Western Denmark and the Supreme Court. Provided that the claimant possesses procedural capacity, legal proceedings may be instituted by the filing of a writ of summons with the relevant competent court. Generally, the first court of instance will be the competent city court, unless the case, at the request of either of the parties or the city court itself, is referred to one of the two high courts. Referral is possible if the dispute in question is of fundamental legal importance and of general importance to the application and interpretation of the relevant law, or has significant societal implications in general.²¹ The Maritime and Commercial High Court is also regarded as a common court aligned with the city courts, albeit the only court in Denmark that specialises in and therefore only deals with certain types of commercial cases, typically involving foreign parties, which are commonly seen in insurance disputes.

The legal system is based upon a two-tier principle entailing that a party dissatisfied with a first instance ruling may appeal the decision to a higher court for a second hearing. Consequently, the judgments delivered by the city courts and the Maritime and Commercial High Court may be appealed to one of the two high courts, whereas judgments delivered by

19 Consolidated Act No. 1238 of 9 November 2015 ('Forældelsesloven').

20 Consolidated Act No. 1237 of 9 November 2015 ('Forsikringsaftaleloven') Section 29(2)–(6).

21 Consolidated Act No. 1101 of 22 September 2017 ('Retsplejeloven') Section 226(1).

the high court may be appealed to the Supreme Court. Permission to appeal a case to the Supreme Court as a third-instance court requires permission from the Appeals Permission Board and may be obtained only if certain material requirements are met.²²

Principles of publicity, immediacy, contradiction and disposal

Disputes brought before a Danish court are subject to the principles of orality and publicity.²³ These principles imply that legal proceedings are mainly carried out orally²⁴ in hearings open to the public.²⁵ Danish procedural rules are furthermore based upon a principle of immediacy of evidence and the parties' right to dispose of the matter in dispute. The parties preserve the right to decide which evidence to submit or witnesses to hear, etc., and only limited means in respect of disclosure of evidence are provided for (as opposed to the full discovery principles applicable in other jurisdictions).

Subsequently, the court is, in general, restricted to base its decision solely on the specific legal submissions and evidence presented by the parties.²⁶ Furthermore, the parties may also decide to settle a dispute pending before the courts before the court proceedings are concluded.

Submission of evidence and use of expert opinions

Expert opinions may be obtained unilaterally by one of the parties, or at the request of one of the parties to the court. In the latter circumstance, the court appoints an expert to perform an expert opinion based on the parties' mutual questionnaire to be submitted to the court. The use of expert opinions in court cases has until recently been limited to the use of court-appointed expert opinion as provided for in the Administration of Justice Act.²⁷ The courts put great emphasis and very often rely exclusively upon such court-appointed expert opinions to assess the facts when rendering decisions.

On 1 July 2017, changes to the regime of expert opinions came into effect. The aim of the amendments was to make the rules more flexible, implying that a party may now request the court to commission an expert opinion based on a set of questions provided solely by one of the parties. The other party may then present its own set of questions to the expert.²⁸ Furthermore, the material matter may be made subject to more than one expert opinion if the court finds it justified. With the amendments, extended access was introduced to request a new expert opinion (second opinion). The assignment can either be carried out by the same expert or another court-appointed expert. In addition, the parties may under certain circumstances submit expert opinions to the court on technical matters commissioned unilaterally by a party.²⁹ Such expert opinions may, however, be dismissed by the court if deemed factually or scientifically unreliable or of no practical relevance to the case.

22 *ibid.*, Section 371(1).

23 Act No. 169 of 5 June 1953 the Constitution of the Kingdom of Denmark ('Grundloven') Section 65.

24 Consolidated Act No. 1101 of 22 September 2017 ('Retsplejeloven') Section 148(1).

25 *ibid.*, Section 28a.

26 *ibid.*, Section 338(1).

27 *ibid.*, Chapter 19.

28 *ibid.*, Section 196(1).

29 *ibid.*, Section 209a(1).

Time frames for court hearings

In 2018⁷, the average processing time of court hearings at the City Court of Copenhagen, including preparatory work, was 10 months.³⁰ For appeal cases pending before the high courts, the average processing time was approximately 12.5 months.³¹ For disputes pending before the Supreme Court, the average processing time was approximately nine months. Notwithstanding the above, more recent cases show that owing to the increasing complexity of insurance disputes, often involving foreign parties and substantial amounts of evidence, etc., these cases tend to take several years before the courts are able to hand down a decision.

In 2016, a digital forum was introduced as a tool to legal court proceedings with the aim of, *inter alia*, conducting legal proceedings in a more efficient manner and thereby further reducing the average processing time of court proceedings. It is mandatory to use the digital forum when litigating before Danish courts. Furthermore, witness statements and participation in court hearings may take place by means of telecommunication (i.e., by video), depending on the decision made by the court.

Arbitration

If agreed upon between the parties, insurance disputes may be made subject to arbitration proceedings. Arbitration clauses concluded between an insurer and an insured consumer will, however, only be given legal effect if concluded after the occurrence of the event leading to the dispute. If the arbitration clause has been adopted into the insurance contract, any legal proceedings instituted before the courts will be dismissed.

III RECENT CASES

i The SIRI appeal case regarding the insurance event

This case³² concerned interpretation of principle of insurance cover applicable to damage sustained on a platform situated in the Danish part of the North Sea. Further, the ruling concerned interpretation of the insured's right of cost coverage for loss mitigation in cases of an imminent damage (sue and labour coverage). The insured had taken out an all risk property insurance policy. In 2009, cracks were discovered in the structure of the platform situated at the oil tank located on the seabed, and a claim of US\$383 million was filed against the insurers that issued the policies in force in the period from 1 January 2006 to 2009, when the cracks were first detected.

Coverage was rejected by the insurers in full for several reasons. The main reason was that the claim had been filed against the wrong insurers, as the relevant point in time with respect to triggering cover was the occurrence of the initial root cause of the damage. This implied that the time of the first manifestation of the cracks was not the relevant point in time when determining cover under the policies. In 2014, the insured instituted legal proceedings against all the insurers before the Danish Maritime and Commercial High Court in Copenhagen maintaining the view that the insurance was an all risks insurance policy

30 www.domstol.dk/om/talogfakta/statistik/Pages/civilesager.aspx.

31 Cases transferred to the high courts pursuant to Section 226(1) of the Administration of Justice Act had an average processing time of 22–36 months.

32 The Maritime and Commercial High Court decision in Case S-2-14 of 15 December 2016.

providing cover ‘for loss of or physical damage . . . during the period’, implying that the insured’s burden of proof with respect to triggering cover was restricted to demonstrating that physical damage had occurred within the policy period in question.

In November 2016, the Maritime and Commercial High Court in Copenhagen agreed that the principle of damage causation was the general main principle of cover of Danish insurance law (as argued by the insurers). This principle had, however, deviated from the wording of the insuring clause of the insured’s policy to the effect that it was the occurrence and manifestation of the damage that was the relevant trigger of cover under the policy. The agreed wording of the policy therefore took precedence over Danish default legal principles concerning the allocation of damage to a particular policy period.

The insurers filed an appeal with the High Court of Eastern Denmark, which overturned the decision of the Maritime and Commercial High Court in spring 2018. The High Court held that the relevant point in time triggering cover under the policy was the occurrence of the initial root cause of the damage regardless of the wording of the insuring clause, and that the claim should consequently have been pursued under previous policies. Thus, the Eastern High Court ruled in favour of the insurers.

ii Limitation according to the Insurance Contracts Act

Section 29(2)–(6) of the Insurance Contracts Act deviates from the general statutory provisions of the Limitation Act. Section 29(5) provides that claims filed against an insurer are forfeited at the earliest of either: (1) one year after the insurer has notified the insured of its refusal of cover; or (2) three years after the insurer accepts cover and requests more information to assess the claim. Consequently, the general three-year limitation period is suspended when filing the claim with the insurer (as opposed to when legal proceedings are instigated). Recently the Supreme Court elaborated on the interpretation of the provision in question by way of two cases. Both cases were heard by the Supreme Court as a third-instance court upon permission from the Appeals Permission Board.

The Supreme Court rendered its first ruling on the interpretation of Section 29(5) in 2016.³³ The Supreme Court found that the insurer under statutory law was obliged to indemnify the injured party directly (because of statutory third-party access), and thus that Section 29(5) was applicable to the injured third party’s claim against the insurer, thereby extending the limitation period for the injured third party’s claim. Recently, the Supreme Court advanced this interpretation further in the two following cases.

Judgment in Case 223/2017 rendered by the Supreme Court on 29 May 2018

This case³⁴ concerned two claimants who had sued a real estate agent for negligence when facilitating the claimants’ purchase of a house. The question brought before the Supreme Court was whether Section 29(5) applied between the claimants and the real estate agent (the tortfeasor) if a claim had initially been notified with the insurer. Under Danish law, real estate agents are under an obligation to take out insurance stipulating that the insurer can be subject to a direct third-party action. However, as the lawsuit had been filed against the agents (and not the insurers), the Supreme Court found that the wording of Section 29(5) and its *travaux préparatoires* did not contain any grounds implying that a notice of a claim to an

33 U 2016.133/2 H.

34 U 2018.100 H.

insurer should suspend the limitation period between a claimant and the insured tortfeasors. Although the claimants had notified the claim to the insurer, Section 29(5) applied only in the relation between the claimants and the insurer. Since the court proceedings had been instituted against the real estate agents and not the insurer, the Supreme Court held that Section 29(5) did not apply.

Judgment in Case BS-12529/2018-HJR rendered by the Supreme Court on 18 December 2018

In 1996, the claimant was involved in an accident causing head injury, and insurance cover was subsequently paid. In 2011, the injuries reappeared and, in 2011, 2012 and 2013, the claimant requested that the file was reopened. The insurer declined on the grounds that no causality was proven. The dispute was admitted as a third-instance appeal and brought before the Supreme Court.³⁵

The Supreme Court was asked to decide whether Section 29(5) applied when resuming a matter and, if so, when the claim must be deemed obsolete. The Supreme Court held that Section 29(5) did apply when resuming previously settled matters. Furthermore, since the insurer had, as late as 2013, requested the claimant to provide additional information for a subsequent medical assessment, the claim was not obsolete at the time court proceedings had been instigated.

iii Assens Havn v. Navigators Management (UK) Ltd

On 13 July 2017, the Court of Justice of the European Union (CJEU) handed down its decision in Case C-368/16, *Assens Havn v. Navigators Management (UK) Ltd (Assens Havn)*. The CJEU held that a direct action can be brought against an insurer in Denmark if Danish national law so allows, despite an express jurisdiction clause in the contract referring disputes to the English High Court and an express choice of English law. Subsequently, the matter was brought before the Supreme Court. The Supreme Court stated that, according to Section 95(2) of the Insurance Contracts Act,³⁶ an injured party is entitled to direct a claim against the insurer in Denmark if the insured tortfeasor is insolvent.

iv British American Tobacco v. Gerling Verzekeringen NV

The Supreme Court's decision was followed by a ruling of the Maritime and Commercial High Court on 10 November 2017.³⁷

The case brought before the Maritime and Commercial High Court concerned a Danish branch of British American Tobacco (BAT) that entered into a contract of carriage with Exel Europe LTD (Exel) for the transport of a shipment of cigarettes from Hungary to Denmark. The carriage was performed by Kazemier Transport BV (Kazemier). In Denmark, the goods were stolen during transport. Kazemier went bankrupt and BAT filed a lawsuit against Exel and Kazemier in England. The English courts dismissed the claim against Kazemier owing to lack of jurisdiction. BAT consequently brought a direct claim against Kazemier's liability

35 U 2019.1093 H.

36 Consolidated Act No. 1237 of 9 November 2015 ('Forsikringsaftaleloven').

37 The Maritime and Commercial High Court decision on 10 November 2017 in Case H-93-16.

insurer, Gerling Verzekeringen NV (HDI), in Denmark. The insurance contract contained a choice of venue and law clause stipulating Dutch law and courts. There is no legal basis for a direct action according to Dutch law.

As in the *Assens Havn* case, the injured party relied upon Section 95(2) of the Insurance Contracts Act, which in some circumstances allows the injured party to bring a direct action against the insurer of the insolvent tortfeasor.

The Court decided that Danish law was to apply in respect of the question of jurisdiction and found that Section 95(2) of the Insurance Contracts Act allowed BAT to bring its direct action suit against HDI, in accordance with Article 13(2) and Article 12 of the Council Regulation.³⁸ The Court referred to the CJEU's ruling in the *Assens Havn* case and the fact that the jurisdiction agreement between the insurer and insured did not apply to the injured party. Thus, the injured party was entitled to bring proceedings against insurers in Denmark according to national (Danish) law. The Maritime and Commercial High Court noted, in line with the Supreme Court, that the CJEU's decision to set aside the jurisdiction agreement was not conditional upon the injured party being financially or legally a weaker party. The fact that the injured parties were large international corporations had no bearing on the assessment. The decision is currently under appeal awaiting the Supreme Court's decision on admitting a direct appeal to the Supreme Court as a matter of principle and public interest.

IV THE INTERNATIONAL ARENA

i Venue

The jurisdiction of the Danish courts to settle insurance disputes involving an insurer situated in an EU Member State is regulated by the Brussels I Regulation,³⁹ whereas the jurisdiction of the Danish courts to decide on the matter is regulated by the Administration of Justice Act,⁴⁰ provided that the company is situated outside the EU.

ii Choice of law

Insurance disputes often involve parties from different jurisdictions. However, the Insurance Contracts Act does not contain any provisions stating the extent to which the law applies to insurance contracts entered into with companies in foreign jurisdictions. Therefore, Danish private international law on insurance contracts is applicable.

Choice of law clauses in contracts are usually governed by the Rome Convention.⁴¹ However, insurance contracts are governed by EU directives.⁴² The directives have been implemented by a ministerial order⁴³ providing that the rules of the EU directives precede

38 EU Regulation No. 1215/2012 of the European Parliament and of the Council of 12 December 2012 on jurisdiction and the recognition and enforcement of judgments in civil and commercial matters.

39 EU Regulation No. 1215/2012 of the European Parliament and of the Council of 12 December 2012 on jurisdiction and the recognition and enforcement of judgments in civil and commercial matters, Article 11(1)(b) and Article 10; cf. Article 7(5).

40 Consolidated Act No. 1101 of 22 September 2017 ('Retsplejeloven') Section 246(1).

41 Convention No. 80/934 of 19 June 1980 on the law applicable to contractual obligations.

42 Directive 88/357/EEC of 22 June 1988, Directive 92/49/EEC of 18 June 1992, Directive 90/619/EEC of 8 November 1990, Directive 92/96/EEC of 10 November 1992.

43 Ministerial order No. 560 of 27 June 1994.

the choice of law rules laid down in the Rome Convention.⁴⁴ Consequently, if the insurance company is situated in another EU Member State, the choice of law is governed by EU Directives, whereas the choice of law in respect of companies situated outside the EU is governed by the Rome Convention.

iii Enforcement of foreign judgments and arbitral awards

Denmark has ratified the Convention on the Recognition and Enforcement of Foreign Arbitral Awards from 1958 (the New York Convention), which renders it possible to enforce foreign arbitral awards in Denmark.

As of 1 September 2018, the new Hague Convention of 30 June 2005 on Choice of Court Agreements has been in force in Denmark. It matches the main structure of the New York Convention to the effect that foreign judgments rendered in countries that have ratified the new Hague Convention may also be enforced in Denmark. Because of the rules in the Brussels I Regulation regarding insurance contracts, Denmark and the rest of the European Union have agreed to issue a declaration⁴⁵ in which they exclude cases concerning insurance contracts to ensure that the Brussels I Regulation will not be circumvented.

V TRENDS AND OUTLOOK

As it appears from the above, recent cases have revolved around choice of law and jurisdiction clauses in insurance contracts and whether these apply to third-party actions. Owing to the bankruptcy of Gable Insurance AG and a Danish political agreement to intervene and protect 26,000 homeowners from being left without insurance coverage, the Guarantee Fund for Non-life Insurance has initiated legal proceedings before the City Court of Copenhagen against the estate of Gable Insurance AG and others in a claim announced to be for 96 million kroner.⁴⁶ The Eastern High Court has accepted the matter as a matter of principle and public interest and the case is now pending before the Eastern High Court. These proceedings will comprise issues in respect of choice of law and how to apply international private and procedural law in cases where the insurance company is bankrupt. Thus, insurance litigation in Denmark will continue to explore the field of insurance law.

44 Convention No. 80/934/EC of 19 June 1980 regarding choice of law, Article 4(1).

45 Hague Convention of 30 June 2005 on choice of venue agreement, Article 21.

46 <http://skadesgarantifonden.dk/> Press release of 12 January 2018.

ENGLAND AND WALES

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I OVERVIEW

English insurance law has traditionally been perceived as insurer-friendly and, as a result, England and Wales has been viewed as an insurer-friendly jurisdiction for insurance disputes. To a large extent this is the product of English legal history, with many of the most significant developments in English insurance law taking place in the context of marine insurance or similar overseas risks.² Until as recently as 2015, the leading statute in English insurance law was the Marine Insurance Act 1906 (much of which also applied to non-marine insurance). In risks from that period of history, the informational asymmetry between the insured and the insurer was especially acute. To resolve that asymmetry, English insurance law placed onerous duties of disclosure and compliance with warranties on the insured, with potentially drastic consequences for failure, even if entirely innocent.

However, that historic imbalance has since been partly redressed by the Insurance Act 2015, the most important development in English insurance law since the Marine Insurance Act 1906. The Insurance Act recasts the insured's duty of disclosure, the ability of insurers to convert pre-contractual representations into warranties, and sets out a new regime of proportionate remedies for insurers. At the time of writing there have been very few disputes under the 2015 Act, and so it remains to be seen precisely how it will be applied. There are also indications that insurers are seeking to contract out of many of the provisions of the Act where possible in commercial policies. The first significant disputes to test the new regime are anticipated in the next couple of years.

II THE LEGAL FRAMEWORK

i Sources of insurance law and regulation

English insurance law is a mixture of common law (drawn from cases before the courts) and statute. Many of the principles developed during early insurance disputes, including the duty of 'utmost good faith' were codified in the Marine Insurance Act 1906 (the 1906 Act), which continues to influence insurance law in the United Kingdom, the United States and the Commonwealth jurisdictions. Although the 1906 Act expressly governs marine insurance,

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2 Lord Mansfield's celebrated judgment in *Carter v. Boehm* (1746) 3 Burr 1905, 96 ER 342, which established the concept of utmost good faith in English insurance law, concerned an insurance policy taken out on a fort in what is now Indonesia.

many of its sections and principles are also applicable to non-marine insurance contracts, and it was the most significant statute in English insurance law until the Insurance Act 2015 came into force on 12 August 2016.

Other key statutes regulate risk-specific insurance contracts. For example, the development of life and fire insurance contracts led to the Life Assurance Act 1774 and the Fire Insurance Duty Act 1782, key parts of which remain in force today. General consumer legislation, such as the Consumer Rights Act 2015, also applies to consumer insurance contracts.

Firms providing insurance, reinsurance services or insurance intermediation must be authorised to do so under the Financial Services and Markets Act 2000. The Prudential Regulation Authority is responsible for the authorisation of such firms. The Financial Conduct Authority (FCA) regulates the conduct of authorised firms and the FCA's Insurance Conduct of Business Sourcebook applies to the sale of general and protection insurance products, outlining expected standards for insurers such as the maintenance of suitable customer information, appropriate product disclosure and fair claims handling. Commercial parties are not required to take out insurance with local providers, although any entities wishing to sell insurance products in England and Wales must be FCA-authorised.

We cover the recent developments in the common law in Section III below, but English insurance law has also seen substantial statutory revision (or restatement) in recent years. The four significant recent statutes are:

- a* The Enterprise Act 2016, which for the first time provides policyholders with a potential right to claim damages in the event of a late payment of a claim by an insurer. Before the Enterprise Act 2016, policyholders could not recover any additional losses they suffered as a result of undue delay in payment of a claim by an insurer.
- b* The Third Party (Rights against Insurers) Act 2010 (updating the 1930 legislation with the same name) updated and strengthened the regime whereby a third party with a claim against an insolvent insured can, following the insolvency, pursue that claim directly against the insolvent insured's insurers. The insurer continues to have any defences available to the insured in the third party's claim, and any defences that the insurers may itself have under the terms of the relevant policy.
- c* The Consumer Insurance (Disclosure and Representations) Act 2012 (or CIDRA), which applies only to consumer insurance contracts, limits the consumer's duty of disclosure, establishing that an insurer must ask appropriate questions to which the consumer must answer honestly and carefully.
- d* The Insurance Act 2015 (the Insurance Act) applies to both consumer and business insurance contracts entered into from 12 August 2016. The most significant developments to English insurance law now codified in the Insurance Act are:
 - The Insurance Act alters the policyholder's duty of disclosure in non-consumer insurance. Before the Insurance Act, the insured was under an onerous duty to disclose all known material facts about the risk to be insured. A failure to disclose any material fact would entitle the insurer to avoid the policy (and so avoid paying any claims), if the insurer could show that, if that fact had been disclosed, it would not have written the policy on the terms it in fact did (or not written it at all). The ability to avoid arose whether the non-disclosure was fraudulent, negligent or indeed innocent. As a result, insurance disputes in England were often characterised by searches for, and arguments over, alleged non-disclosures.

The Insurance Act replaces that duty with a new duty on the insured to make a fair presentation of the risk to be insured. The insured must now disclose all material circumstances that it knows or ought to know, or provide sufficient information to place a prudent insurer on notice to make further enquiries. Thus the burden is shifted in part onto the insurer. For policies entered into after 12 August 2016, it will be enough for an insured to disclose sufficient information to place a prudent insurer on notice to make further enquiries. If the prudent insurer's enquiries would have revealed a material circumstance that was not disclosed, but the actual insurer made no such enquiries, the insurer may no longer be able to avoid the policy for non-disclosure. Further, if the insurer can establish a breach of the duty to make a fair presentation of the risk that induced it to write the policy, it will no longer automatically be entitled to avoid the policy. To do so the insurer will now need to show either that the breach was deliberate or reckless, or that if a fair presentation had been made it would not have insured the risk at all. If the breach is not deliberate or reckless, and the insurer can only show that it would have insured the risk on different terms (e.g., for a higher premium), the insurer's remedy is to treat the policy as though it were written on those different terms.

- The Insurance Act includes new provisions relevant to breach of warranties in insurance policies. Whereas a breach of warranty previously discharged an insurer from liability under a policy from the date of breach, the Insurance Act introduces proportionate remedies, abolishing any rule of law that maintains a breach of an express or implied warranty results in automatic discharge of the insurer's liability. For example, if the breach is neither deliberate nor reckless and the insurer would still have entered into the contract, the insurer is only able to reduce cover on a proportionate basis; if breach is neither deliberate nor reckless but the insurer would not have contracted, the insurer is able to avoid the contract but must return the premiums to the insured. Any policy terms purporting to convert pre-contractual representations made by the insured into a warranty (known as 'basis-of-contract' clauses) will no longer have effect.
- The Insurance Act clarifies the remedies available to an insurer in the event an insured makes a fraudulent claim. If a fraudulent claim is made, the insurer is not liable for any part of that claim, and can terminate the policy from the date of the fraud. However, the insurer cannot avoid the policy altogether, and remains liable for genuine pre-fraud claims.

ii Insurable interest

English law has historically maintained that for an insurance contract to be valid the insured must have an insurable interest in the subject matter of the policy. An insurable interest is a legal or equitable interest in the subject matter of the insurance, or some interest short of a legal or equitable interest that means the insured would suffer disadvantage or be deprived of an advantage should the risk manifest.

The historic centrality of insurable interest to the concept of insurance in English law means that certain types of derivative contracts, such as credit default swaps, which in many ways economically mirror an insurance arrangement, are not considered (or regulated) as insurance contracts in English law.

Following recent legislative reform there is uncertainty as to whether an insurable interest is a common law requirement or an indirect statutory requirement. Before the Gambling Act 2005, there was a clear statutory basis for insurable interest. The 1906 Act codified the general rule of law (for marine insurance) into a statutory requirement; the Life Assurance Act 1774 rendered life and contingent insurance contracts void without an insurable interest; and the Gaming Act 1845 created an indirect requirement for an insurable interest in all other contracts of insurance.

The Gambling Act 2005, which was intended to regulate new types of gambling activities, removed the 1845 Act's indirect requirement for insurable interest. As the Act did not intend to affect insurance, the impact of the 2005 Act on insurable interest may be limited. However, uncertainty now exists as to the exact legal basis of insurable interest, and proposals by the Law Commission of England and Wales to include a statutory definition of insurable interest in the Insurance Act were rejected. Nevertheless, the English and Welsh and Scottish Law Commissions are currently consulting on a draft Insurable Interest Bill to introduce a statutory definition of insurable interest.

iii Fora and dispute resolution mechanisms

Insurance disputes with a value greater than £100,000 will generally be heard at first instance in the High Court. The Commercial Court, a specialist court within the Business and Property division of the High Court, has specialist judges with insurance experience and will be the most common forum for large insurance disputes. If a claim is greater than £50 million and raises issues of general importance to financial markets, it may be heard on the Financial List, a specialist cross-jurisdictional list established to handle claims related to the financial markets. At first instance the dispute will be heard by a single judge.

Appeals from the High Court are heard in the Court of Appeal, usually by a panel of three Lord Justices of Appeal. To appeal to the Court of Appeal the appellant will need to obtain the court's permission, and to obtain this he or she will need to show that, where the appeal is a first appeal (i.e., the decision being appealed is not itself an appeal from a lower court), the appeal would have a real prospect of success or there is some other compelling reason for it to be heard. Where the appeal to the Court of Appeal is a second appeal (i.e., the decision being appealed is itself an appeal from a lower court) the appellant will need to show that the appeal would have a real prospect of success and there is some other compelling reason for it to be heard.

Appeals from decisions of the Court of Appeal are heard in the UK Supreme Court (the United Kingdom's highest court), usually by a panel of five Justices of the Supreme Court. Again, the appellant will need to obtain permission to appeal, which will only be granted if it can be shown that the appeal raises an arguable point of law of general public importance that ought to be considered by the Supreme Court.

Claims with a value less than £100,000 will be heard in the relevant county court (which is usually the local county court of the defendant). The Financial Ombudsman Service (FOS) can also independently review and settle non-contentious complaints between an insured and insurer. The FOS is primarily designed to deal with complaints by individual consumers, but complaints can also be brought by, or on behalf of, small businesses who, as customers, use financial services. To qualify, the business making the complaint must have an annual turnover of no more than €2 million and fewer than 10 employees. Decisions of the FOS are binding on insurers, and can only be challenged by judicial review.

The English courts encourage alternative dispute resolution (such as mediation) both before and during arbitral or litigation proceedings. An unreasonable failure to engage in alternative dispute resolution may lead to the refusing party being required by the court to pay more of the other party's legal and other costs of pursuing the claim (or receiving less of their own costs if successful). Mediation is the most widely used form of alternative dispute resolution in insurance disputes, but other alternatives include expert determination, adjudication and early neutral evaluation.

It is common for English law-governed insurance contracts to contain a London-seated arbitration clause. The QMUL 2018 International Arbitration Survey identified London as the most popular choice of seat for arbitration and the London Court of International Arbitration as the most popular institution after the International Chamber of Commerce's International Court of Arbitration. London also remains a popular choice of seat for arbitrations arising out of Bermuda Form excess liability insurance policies. Bermuda Form policies often achieve a transatlantic balance between the perceived insurer-friendly laws of England, and the perceived insured-friendly laws of New York, by providing for the policy to be governed by New York law but for disputes to be resolved in London-seated arbitrations (and thus in accordance with English procedural law).

Under the Arbitration Act 1996, an arbitral award issued by a London-seated tribunal can only be challenged in the English courts on the basis:

- a* that the arbitral tribunal did not have substantive jurisdiction (Section 67);
- b* of a serious irregularity affecting the tribunal, the proceedings or the award, and which has caused or will cause substantial injustice (Section 68). The types of serious irregularity are set out in Section 68(2) and range from the tribunal exceeding its powers to the failure of the tribunal to deal with the issues that were put to it; and
- c* of a question of law (Section 69). To challenge an award on this basis requires leave to appeal from the court (which is not required for a challenge under Sections 67 or 68), which will only be given if the decision of the tribunal on the question of law is obviously wrong, or the question is one of general public importance and the decision of the tribunal is at least open to serious doubt.

While it is common for London-seated arbitral agreements to exclude appeals on the grounds of a question of law, it is not possible to exclude appeals regarding substantive jurisdiction or serious irregularity.

III RECENT CASES

There have been a number of significant cases in the English courts since the previous edition of *The Insurance Disputes Law Review*, including three recent decisions of the Supreme Court on matters as diverse as the interpretation of the scope of cover of a standard form motor vehicle policy, and the rights of third parties to access documents held by the courts. We summarise below the key recent cases in the order of the life of an insurance policy and claim, with recent cases extending or clarifying English law in areas including the interpretation of policy terms, notification, the parties to and jurisdiction over a claim, and the quantum of an insured's loss. In addition, there have been two significant judgments in the field of claims under employers' liability insurance arising out of asbestos-related diseases, where English law has evolved a bespoke set of principles to deal with the unusual causation problems that

those claims raise. We also cover a case in the Scottish Court of Session, which is the first case in the United Kingdom to consider aspects of the new duty of fair presentation of the risk in the Insurance Act.

i Fair presentation of the risk

The Insurance Act replaced the insured's duty to disclose all known material facts about the risk to be insured with a new duty to make a fair presentation of that risk. The scope of this new duty has yet to be considered by the higher English courts. However the Insurance Act applies to the entirety of the United Kingdom and, in *Young v. Royal and Sun Alliance Plc*,³ the Scottish Court of Session (Outer House) considered the effect of a question on a proposal form on the insured's duty to disclose facts related to but not sought by the question in the context of the new duty to make a fair presentation of the risk. The Court of Session concluded that the Insurance Act had not altered the common law position that an insurer will only waive compliance by the insured with its duty to disclose where:

- a* the insured disclosed information that would prompt a reasonably careful insurer to make further inquiries and the insurer failed to do so;⁴ or
- b* the insurer asked a limiting question from which a prospective insured might reasonably infer that the insurer had no interest in knowing, and had waived, information falling outside the scope of that question.⁵

In *Young*, the Court of Session rejected the argument that a question in a proposal form seeking information on the insolvency history of the proposed insured company amounted to a waiver of the requirement on the proposed insured to disclose the insolvency history of other companies in which its principals had also been involved.

ii Interpretation of policy terms

The terms of an English law-governed insurance policy are to be interpreted in accordance with the ordinary principles of the English law of contractual interpretation, which require the words used in the contract to be given the meaning they would convey to a reasonable person with all the background knowledge available to the parties. Those principles were most recently restated in *Wood v. Capita*,⁶ which emphasised that contractual interpretation is a unitary exercise, in which the court must engage in an iterative process of balancing the indications given by the factual background and a close examination of the relevant language.

Two recent cases illustrate the flexibility that the English law of contractual interpretation still gives the English courts to resolve cases where a policy term cannot sensibly be given its literal meaning. In *Re S Pilling t/a Phoenix Engineering v. UK Insurance Ltd*,⁷ the Supreme Court was prepared to read an entire additional phrase into the coverage clause in a motor vehicle insurance policy so that it met the compulsory requirements of the Road Traffic Act 1988. The Supreme Court restated the principle in *Chartbrook Ltd v. Persimmon Homes Ltd*⁸ that a court may construe a different meaning to a commercial contract where it is clear

3 [2019] CSOH 32.

4 *WISE Underwriting Agency Ltd v. Grupo Nacional Provincial SA* [2004] EWCA Civ 962.

5 *Doheny v. New India Assurance Co Ltd* [2004] EWCA Civ 1705.

6 [2017] UKSC 24.

7 [2019] UKSC 16.

8 [2009] UKHL 38.

that the parties could not reasonably have intended the meaning of the existing language. However, the Court reiterated that such a corrective construction will be a rare event and requires both the mistake and the intended meaning to be clear.

In *Susan Plevin v. DAS Legal Expenses Insurance Company Limited and Miller Gardner Limited (in administration)*,⁹ in the context of an after-the-event legal expenses insurance policy, the High Court held that where standard-form policy terms and a policyholder-specific schedule contained contradictory terms, the more individualised term in the schedule should prevail over the standard-form policy wording. In doing so, the High Court considered that where policy terms are truly contradictory, rather than ambiguous, and contained in different policy documents, the *contra proferentem* principle of construction¹⁰ did not assist the Court in resolving the inconsistency. However, the Court acknowledged that where contradictory terms are contained in the same policy document, the principle may be applicable.

iii Notification of circumstances

In *Euro Pools v. RSA*,¹¹ the Court of Appeal provided guidance on the approach to a claim where the court must determine under which policy a claim falls for cover following multiple notifications of circumstances. Euro Pools had two professional indemnity policies with RSA covering two consecutive years, and made notifications under both policy years in respect of certain faults with its installation of boom systems in swimming pools. Euro Pools subsequently claimed for the costs of mitigation works carried out on the boom systems under the later policy. RSA maintained that the mitigation works all fell for cover under the earlier policy, whose limits had been exhausted by other claims. In finding that the claims were notified to the first policy year, the Court summarised and synthesised the existing legal principles applicable to the determination of whether there has been a valid notification of a circumstance, and whether a particular claim is within the scope of that notification, as follows:

- a provisions that deem claims to arise from notified circumstances are to be construed and applied with a view to their commercial purpose, namely to provide an extension of cover for all claims in the future that flow from the notified circumstance;¹²
- b a provision that refers to circumstances that ‘may’ give rise to claims sets a deliberately undemanding test, which only requires a possibility of claims in the future, not a likelihood;¹³
- c a notification need not be limited to particular events; insureds can give ‘can-of-worms’ or ‘hornet’s-nests’ notifications.¹⁴ The ambit of such notifications and the claims that are covered by them will depend on the particular facts and terms of the notification in each case;

9 [2019] EWHC 1339 (Comm).

10 That where there are two competing constructions of a term, the construction least favourable to the party who drafted the contract should be preferred.

11 [2019] EWCA Civ 808.

12 *Euro Pools v. RSA* at [39], citing Gloster J in *HLB Kidsons (A Firm) v. Lloyds Underwriters Subscribing to Lloyds Policy No. 621/PKID00101 & Ors* [2007] EWHC 1951 (Comm) at [21].

13 *Euro Pools v. RSA* at [39], citing Rix J in *J Rothschild Assurance Plc v. Collyear* [1999] 1 Lloyds Rep IR 6 at [22].

14 *Euro Pools v. RSA* at [39], citing Gloster J in *HLB Kidsons (A Firm) v. Lloyds Underwriters Subscribing to Lloyds Policy No. 621/PKID00101 & Ors* [2007] EWHC 1951 (Comm) at [76].

- d while an insured must be aware of the circumstance that it purports to notify, it does not have to know the cause of problem that has arisen, or the potential consequences thereof;¹⁵
- e for a claim to arise out of a properly notified circumstance, there must be some causal link between the notified circumstance and the claim, rather than a purely coincidental connection;¹⁶
- f in determining whether a particular communication is a notification, and its scope as such, the court applies conventional principles of interpretation;¹⁷ and
- g whether a particular matter or event meets the threshold for notification as a circumstance in the relevant policy is not only a matter of the insured's subjective knowledge, but also involves the objective estimation of the likelihood of a claim given that subjective knowledge.¹⁸

iv The parties and jurisdiction

The English courts have recently considered a number of cases where the parties to the case were themselves at issue.

In *Cameron v. Liverpool Victoria Insurance Co Ltd*,¹⁹ the Supreme Court determined that a victim of a road traffic accident could not issue proceedings against an unknown defendant to access a motor insurance policy. The vehicle in question was insured under a policy issued to a fictitious person, which covered neither the registered keeper of the vehicle, nor the driver, who was never identified. Consequently, the victim had sought to issue proceedings against 'the person unknown driving vehicle registration number Y598 SPS'. The Supreme Court held that the requirements in the English civil procedure rules for service of a claim reflected a fundamental principle of natural justice that a person cannot be made subject to the jurisdiction of the court without having sufficient notice of the proceedings to enable them to be heard. The Supreme Court identified limited (exceptional) circumstances to this principle, but held that an unidentifiable negligent driver was not one of them, as victims had alternative rights of recovery against the Motor Insurers' Bureau.

The decisions in *Zagora Management Ltd v. Zurich Insurance Plc*²⁰ and *Aspen Underwriting Ltd v. Credit Europe Bank NV*²¹ both concerned third parties to the relevant policies. In *Zagora Management*, the judge held that a party was not entitled to claim under a buildings policy simply because it had a freehold interest in the insured development. The High Court held that a contract of insurance is only a contract between the insurer and the named insureds, and that for a policy to extend to unnamed persons an express provision would be required making the intended extension clear.

15 *Euro Pools v. RSA* at [39], citing Vivien Rose QC in *McManus v. European Risk Insurance Co* [2013] Lloyd's Rep IR 533 at [39] to [43].

16 *Euro Pools v. RSA* at [39], citing Akenhead J in *Kajima UK Engineering Limited v. The Underwriter Insurance Company Limited* [2008] EWHC 83 (TCC) at [99(f)].

17 *Euro Pools v. RSA* at [39], citing Gloster J in *HLB Kidsons (A Firm) v. Lloyds Underwriters Subscribing to Lloyds Policy No. 621/PKID00101 & Ors* [2007] EWHC 1951 (Comm) at [76].

18 *Euro Pools v. RSA* at [39], citing *Toulson LJ in HLB Kidsons v. Lloyds* [2008] EWCA Civ 1206 at [134]-[142].

19 [2019] UKSC 6.

20 [2019] EWHC 140 (TCC) (30 January 2019).

21 [2018] EWCA Civ 2590.

In *Aspen Underwriting* a marine insurer sued a Dutch-domiciled assignee of, and loss payee under, the issued marine insurance policy for misrepresentation in relation to a settlement of a claim under the policy between the insurer and the insured assignor. The Court of Appeal held that the insurer could not rely on the English court jurisdiction clauses in either the policy or the settlement agreement to found jurisdiction in England, as the Dutch assignee was not a party to nor seeking to assert third-party rights under either contract. However, the Court of Appeal held that the English courts nevertheless had jurisdiction. While the Court held that the dispute was a ‘matter relating to insurance’ within the meaning of Chapter II of Section 3 of the Recast Brussels Regulation, which would otherwise require the insurer to sue the assignee in the Netherlands, it also held that, as professional ship financier, the assignee was not within a class of persons that merited the protection of those special rules such as to preclude the English Court taking jurisdiction. Instead, the Court of Appeal also characterised the misrepresentation claim as a matter relating to tort, delict or quasi-delict under Article 7(2) of the Recast Brussels Regulation and, as the settlement agreement was signed in England, held that the English courts had jurisdiction under that Article.

v Quantum of loss

In *Sartex Quilts and Textiles Ltd v. Endurance Corporate Capital Ltd*,²² the High Court clarified the principles applicable to the relevance of the insured’s intentions as to the insured property in considering the appropriate measure of indemnity under a property loss or damage policy. The High Court held that the court should look to all the circumstances, including the insured’s intentions not only at the date of loss but up to the date of trial. An insured cannot recover more than the actual loss arising from the insured peril, and thus the court is concerned to identify what available measure (reinstatement or market value) fairly and fully indemnifies the insured for his or her loss. The primary focus will be on its intentions for the property at the time of the loss. However, subsequent events, even those unforeseeable at the time of the loss, may show that the measure identified would overcompensate the insured, making an alternative measure more appropriate.

The Court also clarified the decision in *Western Trading Ltd v. Great Lakes Reinsurance (UK) Plc*,²³ explaining that it does not indicate that an indemnity on a reinstatement basis cannot be given if the remedial works are not in fact carried out. The Great Lakes judgment simply envisages that the appropriate measure of indemnity will depend on all the circumstances of the case (of which an absence of remedial works will be one circumstance).²⁴

In a second judgment in the *Zagora Management* case referred to above,²⁵ the High Court reiterated that interest will be awarded under the Senior Courts Act 1981 on a successful insurance claim only from the date by which a sufficiently reasonable period of time has elapsed to allow for investigation of the claim by the insurer, rather than from the date on which the insured’s cause of action under the policy accrued.²⁶ This dispute pre-dated the coming into force of the Enterprise Act 2016, and so questions as to the insured’s right to also claim damages for late payment were not considered.

22 [2019] EWHC 1103 (Comm).

23 [2016] EWCA Civ 1003.

24 That the correct measure of indemnity is a matter of fact was also held in *Reynolds v. Phoenix Assurance Co Ltd* [1978] 2 LLR 440.

25 [2019] EWHC 205 (TCC).

26 Following the decision in *Kuwait Airways Corporation v. Kuwait Insurance Company* [2001] CP Rep 60.

vi Asbestos litigation

English law has developed bespoke principles to deal with the insurance of claims by employees who were exposed to asbestos by their employers and contracted mesothelioma as a result. In particular, the ‘trigger’ principle²⁷ provides that employers’ liability insurers are liable to fully indemnify their insureds for claims for asbestos exposure (and thus fully compensate employees) provided there was some exposure during the relevant policy year, and even if the dates of the exposure encompassed multiple other policy years.²⁸ The employee does not have to demonstrate a causal link between the exposure in a particular year and the mesothelioma to sue the insurer covering that year; the employee merely has to demonstrate an exposure to asbestos. In *Equitas Insurance Ltd v. Municipal Mutual Insurance Ltd*²⁹ the Court of Appeal considered whether this bespoke principle should extend to the reinsurance of employers’ liability risks such that an insurer writing multiple years of employers’ liability insurance can elect to allocate a reinsurance claim to a single year, or whether the insurer is obliged to allocate the reinsured losses pro rata across the relevant years. The Court of Appeal held that the trigger principle was created for policy reasons – to ensure that victims were fully compensated without having to make multiple claims and prove causation – and those policy reasons did not extend to the reinsurance market, therefore the law could return to more orthodox principles. The result of those principles was that the insurer cannot elect to claim under a single year’s reinsurance, but must allocate the reinsured losses pro rata across the relevant years.

In *Cape Intermediate Holdings Ltd v. Dring*,³⁰ the Supreme Court provided guidance on third parties’ rights of access to court documents. The Asbestos Victims Support Groups Forum applied under Rule 5.4C of the English Civil Procedure Rules for the disclosure of court documents, including bundles of evidence, in two sets of proceedings brought by employers’ liability insurers against an asbestos manufacturer. The Supreme Court held that there was no automatic right of access for non-parties to copies of documents held by the court unless provided for by the particular court’s rules. However, the court had an inherent jurisdiction to permit third parties to obtain copies of documents placed before the court if the court considers that to do so is consistent with of the constitutional principle of open justice. In considering that question, the court will take into account the reasons for the third party seeking the documents and the risk of harm that the disclosure may cause to the maintenance of effective judicial process or the legitimate interests of others. The court may also take into account the practicality and proportionality of satisfying the request.

IV THE INTERNATIONAL ARENA

The rules that will be applied by the English courts to determine where insurance disputes between international parties are heard depend on where the insurer and the insured are domiciled. If both are domiciled in EU Member States, jurisdiction is determined in accordance with the European Parliament and Council Regulation 1215/2012 (the Recast Brussels Regulation). If one party is domiciled in an EU Member State and another in an EEA Member State, then jurisdiction is determined in accordance with the Lugano Convention.

27 Articulated in *Durham v. BAI (Run off) Ltd* [2012] UKSC, [2012] 1 WLR 867 and *International Energy Group Ltd v. Zurich Insurance Plc UK Branch* [2015] UKSC 33.

28 Although the insurer itself would have a contribution claim against insurers on the other policy years.

29 [2019] EWCA Civ 718.

30 [2019] UKSC 38.

Finally, in cases where the defendant is domiciled outside the EEA, the jurisdiction of the English courts is determined by Part 6 of the Civil Procedure Rules (the CPR). Domicile is determined as at the date of issue of the proceedings.

The Recast Brussels Regulation contains specific, insured-friendly rules (in Articles 10 to 16) on the determination of jurisdiction over insurance disputes (though these rules do not also apply to reinsurance disputes or contribution claims). Those rules provide that:

- a* the insured has the option of suing in the jurisdiction where they are domiciled (Article 11(1)(b)) or in the jurisdiction where the insurer is domiciled (Article 10); but
- b* insurers are restricted to suing an insured in its country of domicile (Article 14). However, Article 14.2 clarifies that this rule does not affect the insurer's ability to bring a counterclaim if sued by the insured in a country other than that of its domicile.

There are also specific rules for insurance of real property and liability insurance (Article 12), which allow the insured also to sue in the place where the harmful event to the property occurred or the harmful act resulting in liability occurred. Articles 15 and 16 of the Recast Brussels Regulation restrict the ability of insurers to remove the benefit of the rules in Articles 10 to 14 by including exclusive jurisdiction clauses in policies. However, those restrictions do not apply to large commercial risks, which encompass most risks insured by any company with a balance sheet total of at least €6.2 million, a net turnover of at least €12.8 million, and an average 250 or more employees. For any company that equals or exceeds these metrics, an exclusive jurisdiction clause in an insurance policy will still be effective to determine where any disputes are heard.

The position under the Lugano Convention is materially the same as that under the Recast Brussels Regulation. The United Kingdom is also currently party to the Hague Convention on Choice of Court Agreements 2005 (the Hague Convention) in its capacity as an EU Member State. The Hague Convention requires contracting state courts (including all EU Member State courts) to respect exclusive jurisdiction clauses in favour of other contracting state courts and to enforce related judgments.

Where the defendant (which in insurance disputes is usually, though not always, the insurer) is domiciled outside the EEA, Part 6 of the CPR provides that the English court will have jurisdiction over a dispute if the claimant has the right to serve the claim form on the defendant, and the English court is satisfied that it is appropriate for the case to be heard in England. A claimant will have the right to serve the claim form on a non-EEA defendant without the court's permission if the defendant is present in England (even if only temporarily and habitually resident overseas), or has nominated a solicitor or process agent in England who is authorised to receive service. Often in insurance policies with an English jurisdiction clause, the broker will be nominated as the process agent for service for all the insurers, and so service issues are relatively uncommon in insurance disputes.

However, if the defendant cannot be served in the jurisdiction, then the permission of the English court is needed to serve proceedings on the defendant where it is domiciled out of the jurisdiction. To obtain permission, the claimant needs to satisfy the court that: (1) it has a good arguable case that one of jurisdictional 'gateways' in CPR Practice Direction 6B apply; (2) there is a serious issue to be tried; and (3) England is the forum where the case should properly be tried. The jurisdictional gateways of most relevance to insurance disputes are the gateway for a claim for an injunction (which is the relevant gateway for commencing proceedings for an anti-suit injunction if one party is threatening or commences proceedings in breach of the policy's jurisdiction or arbitration clause), and the gateway for a claim made

in respect of a contract that is governed by English law or contains a jurisdiction clause in favour of the English courts. In practice, where an insurance policy contains an English court jurisdiction clause, the English courts are highly likely to assert jurisdiction. Conversely, if an insurance policy contains a jurisdiction clause in favour of another jurisdiction, the English courts are likely to respect that choice and decline jurisdiction.

The English courts will also respect the parties' choice of arbitration as their chosen dispute resolution mechanism and decline jurisdiction where there is a validly incorporated arbitration clause in a policy. It is not uncommon for an insurance policy to contain both an English court jurisdiction clause and a London-seated arbitration clause. Although those clauses are on their face inconsistent, the settled approach of the English courts is to interpret the clauses as providing for disputes to be resolved by arbitration, subject only to the supervisory jurisdiction of the English court.

For all insurance policies entered into after 17 December 2009, the English courts will determine the applicable law in accordance with European Parliament and Council Regulation 593/2008 (the Rome I Regulation).

At the time of writing there remains considerable uncertainty over the timing and nature of the United Kingdom's exit from the European Union and its future relationship with the remaining 27 Member States. The position following the United Kingdom's exit with respect to jurisdiction and governing law will depend on the manner of the exit. Should the United Kingdom leave on agreed terms substantially in the format of the withdrawal agreement agreed on 25 November 2018,³¹ then the Recast Brussels Regulation would continue to apply during the proposed transition period. If there is a no-deal exit, then the Civil Jurisdiction and Judgments (Amendment) (EU Exit) Regulations 2019 provide that the Recast Brussels Regulation and the Lugano Convention will continue to apply to cases commenced prior to exit day, but revoke the application to any cases commenced after exit day. For cases commenced after exit day, the jurisdictional rules in Part 6 of the CPR and the common law that currently apply to defendants domiciled outside the EEA will also apply to defendants domiciled within the EEA. The Law Applicable to Contractual Obligations and Non-Contractual Obligations (Amendment, etc.) (EU Exit) Regulations 2019 implements the Rome I Regulation into English law on the United Kingdom's exit date in the event of a no-deal exit. On 28 December 2018, the United Kingdom deposited its instrument of accession to the Hague Convention, which will take effect on the date the United Kingdom exits the EU, ensuring continuity of the application of the Hague Convention by the UK courts.

In addition to where the dispute will be heard, and under what law, one further issue of importance for the arbitration of international insurance disputes is which arbitrators will hear the dispute. This is a matter of choice for the parties, with a mechanism usually provided either by the arbitration clause or a set of institutional rules to determine a sole or third arbitrator in the event of disagreement. In *Halliburton v. Chubb*³² the Court of Appeal recently considered whether an arbitrator may accept appointment in multiple arbitrations in relation to the same subject matter but with only one common party, or whether doing so gave rise to an appearance of bias. Both Halliburton Company and Transocean Holdings LLC commenced separate arbitration proceedings against Chubb Bermuda Insurance Limited to recover losses arising out of the explosion on the Deepwater Horizon oil rig in the Gulf of Mexico. The

31 Agreement on the withdrawal of the United Kingdom of Great Britain and Northern Ireland from the European Union and the European Atomic Energy Community.

32 [2018] EWCA Civ 817.

same arbitrator was appointed to both tribunals, but the appointment in the Transocean arbitration was not disclosed to Halliburton. Under the Arbitration Act 1996, an arbitrator can be removed by the court for a lack of independence if it gives rise to justifiable doubts of impartiality. The test for whether justifiable doubts of impartiality are present is the same as the test for apparent bias in a judge in the English courts, namely whether the fair-minded and informed observer, having considered the facts, would conclude that there was a real possibility of bias. The Court of Appeal held that the fact that the arbitrator would likely have knowledge from their other appointment of which one party would be unaware was of legitimate concern, but did not alone justify an inference of apparent bias from the mere fact of multiple overlapping appointments. However, non-disclosure of the parallel appointment was also a factor to be taken into account in considering apparent bias. The circumstances of and explanation for the non-disclosure will determine whether the non-disclosure justifies an inference of apparent bias. On the facts of this case, no inference of apparent bias was justified. The Court of Appeal's decision is currently under appeal to the Supreme Court.

V TRENDS AND OUTLOOK

The Insurance Act 2015 has now come into force, but it remains to be seen precisely how its provisions will be applied. The Act potentially represents a major rebalancing of rights and obligations between insureds and insurers (in favour of insureds), but early indications are that insurers are seeking to contract out of many of the provisions of the Act where possible in commercial policies.

There also remains a good deal of uncertainty as to how damages for late payment of insurance claims will be approached by the courts, and the first case in which an insured claims such damages is awaited with interest.

Warranty and indemnity insurance and cyber-insurance are two of the fastest-developing policy markets in England, and the terms of both types of policy are becoming increasingly standardised. There have only been a limited number of significant disputes in relation to these types of policies, although we anticipate that to change in the next few years, especially as cyberattacks becoming an increasingly common experience for businesses.

The coming into force of the General Data Protection Regulation has also generated interest in the extent to which the risks of failing to comply with the Regulation are insurable. The position is likely to be that insurance will not be available for any fines imposed under the Regulation or under the related Data Protection Act 2018 (either because English law prohibits the insurance of fines, or because policies will specifically exclude them). However, insurance may be available for the costs of participating in an investigation by the Information Commissioner's Office and defending any subsequent proceedings. Insurance disputes arising out of data protection breaches may also be a developing area in the coming years. Disputes relating to a failure to appreciate the effects of artificial intelligence also look likely to be a developing area.

The use of 'after-the-event' insurance to cover costs risks in English litigation has also increased significantly in recent years, both as a result of reduction in availability of legal aid at one end of the scale, and the increased importance of litigation funding in English disputes at the other end.

In addition to these areas of potential development, climate change remains an area where claims must surely begin to rise. There are no claims in this area as yet, but all eyes are on that space.

FRANCE

*Erwan Poisson and Delphine Dendievel*¹

I OVERVIEW

New legal developments have not resulted in major changes this year. Most of the changes provide clarifications about well-established rules of insurance disputes in substantive and procedural terms that are helpful for practitioners. However, the evolution of the insurance market and recent trends within insurance litigation raise many thorny issues that remain unresolved.

II THE LEGAL FRAMEWORK

i Sources of insurance law and regulation

France has a specific code dedicated to insurance law. This code provides very precise rules that derogate from the law usually applicable in contractual matters. For instance, the limitation period is two years for insurance claims, whereas it is five years for contractual claims.² In addition to the specific law applicable to the insurance contracts, different regimes are set out according to the nature of the insurance policy (car insurance, life insurance, liability insurance, etc.). As a result, numerous solutions under French law are specific to a particular kind of insurance and cannot be generalised to all insurance policies.

The French Civil Code may also come into play in insurance disputes. It applies in all matters related to the insurance policy that are not governed by a specific provision under the Insurance Code. Other specific provisions may also come into play, such as the Consumer Code when the dispute is between a professional and a consumer.

Finally, European directives on insurance hold considerable sway over insurance law. As noted below, the European influence was again recently demonstrated as it resulted in rendering ineffective some provisions of the Insurance Code related to car insurance.

ii Insurable risk

Under French law, the subscriber does not have to show any interest to conclude an insurance policy. As a result, the subscriber can issue an insurance policy not only on his or her own behalf but also on behalf of a third-party beneficiary.

Under French law, insurability of the risk is determined with regard to the nature of the insurance contract. Insurance is considered as a 'contingent contract' under the French

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2 Article L.114-1 of the Insurance Code.

classification of contracts.³ It implies the risk must exist to be insurable. Thus, an event that already occurred cannot be covered. Moreover, if the event occurred as a result of the policyholder's intentional conduct, the insurer can reject the claim.⁴

In addition, a risk cannot be underwritten by an insurer if it contradicts public policy. Notably, criminal offences are not insurable. Therefore, a company cannot ask its insurer to pay a fine for which the company is liable.

Finally, some risks are excluded by law, such as the risk of riots or civil war.⁵

iii **Fora and dispute resolution mechanisms**

French law does not provide for a specific court to deal with insurance-related claims. Depending on the nature of the parties, the claim can be brought before the civil courts, the commercial courts and even the administrative courts when it involves public entities.

III RECENT CASES

i **Significant cases in procedural terms**

Bringing an action in insurance litigation

The special limitation period must be mentioned in some insurance policies pursuant to Article R.112-1 of the French Insurance Code.

In addition, in a recent decision, the Court of Cassation held that an insurer who fails to fulfil this obligation cannot rely on either the special limitation period or the general limitation period (five years).⁶ Also, the burden of proof regarding the communication of the limitation period lies with the insurer.⁷

Practitioners must also be aware that certain actions arising from the insurance relationship are not subject to the two-year limitation period.⁸

Conducting insurance litigation

Under French law, the insurer can conduct proceedings on behalf of the policyholder against a third party. By doing so, the insurer waives raising certain defences accruing from the insurance relationship in any concurrent or subsequent claims against the policyholder (except when specifically otherwise provided by the insurer).⁹ It is, however, well established under case law that the waived defences are only related to the 'guarantee' and do not concern the 'nature of the risk covered, nor the amount of compensation'.¹⁰

3 Article 1108 of the Civil Code.

4 Article L.113-1 of the Insurance Code.

5 Article L.121-8 of the Insurance Code.

6 Decision of the Court of Cassation (civ. 2nd), No. 17-28021, 21 March 2019.

7 Decision of the Court of Cassation (civ. 2nd), No. 18-13938, 18 April 2019.

8 For example: *Nielsen & Cie International v. AGIPI*, Decision of the Court of Cassation (civ. 2nd), No. 16-17754, 18 May 2017.

9 Article L.113-17 of the Insurance Code.

10 Decision of the Court of Cassation (civ. 1st), No. 95-12817, 8 July 1997.

This distinction can be very hard to make in practice and requires frequent clarifications from courts. For instance, in *Perron company and others v. Allianz IARD*,¹¹ it was ruled that the clause that limited the guarantee to certain circumstances in which a risk occurred did not concern ‘the nature of the risk covered’.

Settlements in insurance proceedings

In *National Military Security Found and Benoit X v. Crédit Mutuel and Guillaume Y*,¹² the Court of Cassation held that the waiver of future claims contained in a settlement agreement prevents the victim from claiming further damages even if they were not covered by the settlement.

In this case, the victim suffered various losses then signed a settlement agreement with the insurer of the wrongdoer. Afterwards, the victim sued the wrongdoer and his insurer for further damages that were not covered by the settlement. Under French law, there are two contradictory theories to resolve this issue. First, the ‘theory of the scope of settlements’ states that the settler may claim for some losses that are not pointed out in the settlement. In contrast, the ‘theory of abandonment’ states that the settler waives all his or her rights to claim for damages related to the dispute regardless of the fact that the settlement does not deal with them.¹³ In the matter at hand, the Court decided that the abandonment theory should prevail because the settlement agreement stated that ‘the victim declares himself to be satisfied of all of his rights’. However, this does not mean that the same rule will apply in every case. It mainly depends on the way the settlement agreement is drafted.

In *CRAMA v. Mr X*,¹⁴ it was found that the insurer cannot raise a settlement agreement concluded with the victim of the wrongdoing against the co-perpetrator of the damage.

In this case, the damage was caused by two wrongdoers. The insurer of the first wrongdoer concluded a settlement with the victim and compensated her. Then, the insurer of the first wrongdoer sought to reclaim half of the settlement sum from the second wrongdoer. However, the Court of Cassation found that the second wrongdoer was not bound by the settlement agreement concluded by the first wrongdoer. The fact that the second wrongdoer was aware of the settlement did not mean that it could be enforced against him.

ii Significant cases in substantive terms

Pre-contractual stage

Insurers usually require policyholders to issue a risk of statement before the conclusion of the insurance policy. In practice, it means the policyholder has to fill out an application form before entering the insurance policy. When the policyholder issued a false statement, it is usually raised by the insurer as a defence to deny the insurance claim.¹⁵

However, the insurer can invoke a false statement made by the policyholder in the insurance form only if the questions asked by the insurer were sufficiently precise.¹⁶ The insurer

11 Decision of the Court of Cassation (civ. 3rd), No. 15-25241, 5 January 2017.

12 Decision of the Court of Cassation (crim.), No. 16-83545, 13 June 2017.

13 J Landel, The waiver contained in a settlement prevents the victim from claiming for damages that are not comprised in it, *General Insurance Law Review*, No. 9, p. 489, September 2017.

14 Decision of the Court of Cassation (civ. 2nd), No. 16-20951, 8 February 2018.

15 Articles L.113-2 and L.113-8 of the Insurance Code.

16 For example: *Quatrem v. Raymond X*, Decision of the Court of Cassation (civ. 2nd), No. 16-18975, 29 June 2017.

has to prove it had asked clear questions to raise any defence based on the policyholder's false statement. Consequently, if the question is slightly unclear or stated in overly general terms,¹⁷ the insurer loses any defence based on the imprecise answer given. Accuracy is particularly important as an insurer cannot invoke an omission or a false statement from the policyholder if the questions asked within the application form did not involve the disclosure of the relevant information. In *M Z v. Macif Val de Seine Picardie*, the insurer could not blame the policyholder for not disclosing the lack of a building licence for the property actually covered by the insurance because the insurer had not asked questions about the construction itself.¹⁸

Defences of the insurer against the policyholder

Legal exclusion of intentional breaches

A risk brought about by an intentional breach by the policyholder is not insurable. On this basis, the Court of Cassation recently denied the insurability of a barn destroyed as a result of the owner's failure to repair it. The Court held that the owner could not be unaware of the risk of collapse. Thus, by making the risk certain, the insured had committed a wilful misconduct, thereby excluding the insurer's liability.¹⁹

Moreover, in *Groupe Valophis v. Mutuelles confédérale d'assurances des ruralistes de France* it has been reaffirmed that damage resulting from intentional fault is excluded from the insurance coverage only for its part sought by the policyholder.²⁰ In this case, policyholders had committed arson to benefit from insurance coverage, but the fire spread to the neighbouring building. The Court of Cassation only denied the insurance benefit for the damage to the insured building as the policyholders only intended to burn their own property.

In *Family'Immo v. Lloyd's*,²¹ the Court of Cassation ruled that the serious negligence of the policyholder who knowingly put its clients at risk did not amount to the intentional breach required to exclude the risk's coverage by the insurer.

In this case, an estate agency, Family'Immo, knew that the property bought by its clients had several construction defects but made the sale anyway. Family'Immo was found liable for contractual breach and asked its insurer, Lloyd's, to compensate its client. The Court ruled that even if the negligence of Family'Immo was unacceptable for a professional since it acted in bad faith, it did not amount to an intentional breach within the meaning of the Insurance Code.

Contractual exclusion: recent application

In addition to the legal exclusions, insurers can exclude some risks from the insurance policy. Pursuant to Article L.113-1 of the Insurance Code, those contractual exclusions have to be 'formal and limited'. A significant part of the insurance litigation in France is related to this issue.

In construction insurance, the activity declared to the insurer excludes risks from other undisclosed activities. In the important case *M C v. Mutuelle du Mans IARD* the insured builder had contracted an insurance policy hedging the risk concerning only its structure

17 Article L.112-3 of the Insurance Code.

18 Decision of the Court of Cassation (civ. 2nd), No. 17-28093, 13 December 2018.

19 Decision of the Court of Cassation (civ. 2nd), No. 16-23103, 25 October 2018.

20 Decision of the Court of Cassation (civ. 2nd), No. 17-15143, 8 March 2018.

21 Decision of the Court of Cassation (civ. 2nd), No. 16-10042, 12 January 2017.

work.²² The builder, *Euroconstruction*, entered into a contract for the entire construction of a single-family house. The Court of Cassation ruled that the damage caused on this site was not covered by the insurance as the activity of building a single-family house was not expressly included in the contract.

Upon the occurrence of the damage, the insured must put in a claim accurately and faithfully. The insurer may exclude coverage because of a false statement of claim. To benefit from this exclusion, it was held that it must be provided for in the insurance policy by the insurance company, which must demonstrate the insured's bad faith.²³

Conditions of guarantee: the hard hurdle of policyholders

To limit the coverage, an insurer may also protect itself by setting out conditions precedent in the insurance policy. Usually, the policy imposes certain duties on the policyholder, especially the obligation to take preventive measures. If the policyholder does not comply, the risk is not covered. Contrary to exclusions of guarantee that are easier to defeat, recent insurance litigation has shown that the conditions are very difficult to override, as illustrated in *La Riviera v. Alpha Insurance*.²⁴

In this case, a nightclub owned and operated by La Riviera was ravaged by a fire. It appeared that La Riviera, which had entered into a property and casualty insurance contract with Alpha Insurance, did not comply with precautionary measures listed in the contract. La Riviera raised plenty of defences to override the conditions precedent of the insurance policy. All of them failed.

First, La Riviera argued that the conditions were so numerous that they contradicted each other. According to La Riviera, the guarantee was therefore illusory. This head of claim referred to *Chronopost*,²⁵ in which the Court of Cassation decided that a contractor cannot limit his or her essential obligation to the point that the obligation is no longer effective. Nevertheless, the Court rejected the claim by stating merely that the guarantee was not illusory.

La Riviera also questioned the appropriateness of the conditions. According to La Riviera, the breached preventive measures would not have enabled it to avoid the fire even if they had been taken. The Court rejected the argument, standing by a strict application of the clause.

Finally, La Riviera discussed the nature of the conditions. It argued that the condition precedent in fact amounted to an indirect exclusion of guarantee that was to be treated under the aforesaid Article L.113-1 of the Insurance Code. The claim was rejected on procedural grounds. Meanwhile, the substantive issue of qualification is left unresolved. As observed by some authors, it could be a valuable defence in future cases.²⁶

22 Decision of the Court of Cassation (civ. 3rd), No. 17-23741, 18 October 2018.

23 Decision of the Court of Cassation (civ. 2nd), No. 17-20491, 5 July 2018.

24 Decision of the Court of Cassation (civ. 2nd), No. 16-22869, 18 January 2018.

25 Decision of the Court of Cassation (com.), No. 93-18632, 22 October 1996.

26 J Bigot, J Kullman and L Mayaud, *Traité de droit des assurances*, LGDJ, t.5, No. 394, 2017.

Defences of the insurer against a third party: major change for car insurance

This may be the most discussed topic recently. In *Fidelidade-Companhia de Seguros Ltd*,²⁷ the Court of Justice of the European Union (ECJ) stated that European Directive 72/166/CEE,²⁸ which deals with car insurance, prohibited domestic law from providing that certain defences, such as the invalidity of the car insurance policy, can be raised by the insurer against the victim of a car accident.

The recent Growth and Development Act²⁹ brought French law into conformity with European law. The newly adopted Article L.211-7-1 of the French Insurance Code provides that the invalidity of a car insurance policy cannot be raised against the victims.

Scope of the insurance policy: the PIP case

Another ongoing legal saga, the Poly Implant Protheses (PIP) breast prostheses scandal, has lasted over nine years in France. In 2010, PIP placed breast prostheses on the market that were produced without regard to certain public health regulations. The hazardous prostheses were implanted in thousands of patients, leading to disputes in several countries. In *Electromedics Ltd and others v. Allianz IARD*,³⁰ the Court of Cassation made a ruling in an action brought by the foreign distributors of the defective prostheses against the insurer of PIP.

In the case at hand, distributors from Brazil, Italy and Bulgaria asked for compensation from Allianz IARD on the basis of a liability insurance policy that Allianz had entered into with PIP. The distributors raised multiple losses that were covered under the policy (e.g., losses of turnover, stocks, margins, provisions paid for compensation of the customers). However, the insurance policy defined its territorial scope as limited to the ‘harmful events’ that occurred in France. Thus, the issue was whether the damage had occurred in France. According to the foreign distributors, the harmful event occurred during the manufacturing of the prostheses by PIP (i.e., the harmful event would allegedly have occurred in PIP factories in France). The Court of Cassation rejected the argument and held that the harmful event was the breaking of the prostheses, which occurred outside France. Thus, the losses suffered did not fall within the material coverage of the insurance policy.

Remedies: the situation of the insurer during natural disasters

Natural disasters have become a growing cause for concern in the insurance sector, especially because case law tends to deprive insurance companies of any recourse against third parties that could have contributed to the damage on the grounds of force majeure. This trend was recently illustrated in *Swisslife Insurance v. SNCF and the State*.³¹

In 2003, major abnormal rainfalls occurred in the south east of France. This resulted in floods that particularly hit the town of Arles. Swisslife Insurance compensated a large number of inhabitants who suffered damage to their properties. The final bill amounted to more than €5 million, yet the town was surrounded by flood barriers connected to the railway line used by SNCF, the French national rail operator. These protections having been ineffective,

27 Decision of the Court of Justice of the European Union [C-287/16], 20 July 2017.

28 Council Directive 72/166/EEC of 24 April 1972 on the approximation of the laws of Member States relating to insurance against civil liability in respect of the use of motor vehicles, and to the enforcement of the obligation to insure against such liability.

29 Growth and Development Act No. 2019-486 of 22 May 2019.

30 Decision of the Court of Cassation (civ. 2nd), No. 16-14951, 8 June 2017.

31 Decision of the Council of State (div. 7th), No. 403367, 15 November 2017.

Swisslife Insurance exercised recourse against SNCF and the French state. However, the Council of State, which heard the claim, found no breaches by the defendants. The Court pointed out that the floods were provoked by one of strongest rainfalls on record. The Court concluded that the state and SNCF could not be held liable since their alleged breaches would be excused on the grounds of force majeure.

IV THE INTERNATIONAL ARENA

i International jurisdiction: the measures of inquiry in futurum

In *Ergo Versicherung AG v. EPMD*,³² it was ruled that French courts could order measures of inquiry *in futurum* in France within an insurance dispute even if foreign courts had substantive jurisdiction to handle the case.

French law refers to European standards provided under Regulation Brussels I *bis*³³ to establish international jurisdiction of French courts. Article 35 of Regulation Brussels I *bis* provides that a party may apply for 'protective measures as may be available under the law of that Member State, even if the courts of another Member State have jurisdiction as to the substance of the matter'.

In this case, the policyholder applied for measures of inquiry *in futurum*. Under French law, measures of inquiry *in futurum* can be granted by the president of the court to allow a party to collect evidence before any legal proceedings.³⁴ Therefore, the issue was whether those measures of inquiry *in futurum* are protective measures within the meaning of Regulation Brussels I *bis*. The Court of Cassation found measures of inquiry *in futurum* consisted in protective measures and fell within the scope of Article 35 of Regulation Brussels I *bis*.

ii Applicable law: recent developments within transport insurance

The Court of Cassation recently had to interpret an exclusion clause raised by an insurer against a transporter under an insurance policy that covered the international carriage of goods in *AIG Europe the Netherlands v. Miedzynarowy Transport Drogowy*.³⁵

The dispute was about an exclusion of guarantee provided by a transport insurance policy. In this case, two conflicting sets of rules were potentially applicable: the UN Convention on the Contract for the International Carriage of Goods by Road (CMR)³⁶ and the conflict rules applicable for insurance matters. The Court stated that the CMR is a special convention applicable to transport that could not govern the law applicable to the insurance contract but only determine the insurable risk. Thus, the Court applied the rules of conflict applicable to insurance matters.

32 Decision of the Court of Cassation (civ. 1st), No. 16-19731, 14 March 2018.

33 Regulation (EU) No. 1215/2012 of the European Parliament and of the Council of 12 December 2012 on jurisdiction and the recognition and enforcement of judgments in civil and commercial matters.

34 Article 145 of the Civil Procedure Code.

35 Decision of the Court of Cassation (com.), No. 15-13384, 15-13386, 15-14272, 8 March 2017.

36 Convention on the Contract for the International Carriage of Goods by Road (CMR) Geneva, 19 May 1956.

V TRENDS AND OUTLOOK

i Prospective outcomes of recent legal developments

Class actions

French law has recently developed to allow class actions in limited circumstances. Consumer class action may only be brought by an association of consumers. The action must also be related to sales contracts or provision of services contracts concluded by consumers placed under the same or similar situations.³⁷

The case *National Confederation of Housing v. 3F Real estate company*³⁸ does not concern an insurance dispute but may have an impact on class actions that could be brought against an insurer.

In this case, the Court of Appeal of Paris declared inadmissible the action of an association of consumers seeking remedies for a breach committed by a professional lessor under several similar rent contracts. According to the ruling, the rent contracts were not ‘provision of services’ contracts within the meaning of the Consumer Code. We can imagine that this reasoning could be transposed to class actions against an insurer, which could be declared inadmissible since those actions are found in the Insurance Code and not the Consumer Code.

Insurers may also intervene in class actions as the guarantor of the victims or the wrongdoer. The Healthcare System Modernisation Act³⁹ extended class actions to damages arising from healthcare products, which is a growing concern for insurers.

Information due to the policyholder

The Insurance Distribution Act⁴⁰ has significantly developed the insurer’s duty of information. The text provides some vague standards. For instance, it requires that ‘distributors of insurance products act in an honest, impartial and professional way’. The insurer is also required to provide ‘objective information about the offered insurance product in an understandable form’. Evergrowing litigation may arise from this text, which offers great leverage to policyholders to obtain remedies for breach of pre-contractual information.

ii Evolving sectors of insurance litigation

Car insurance

The ECJ clarified its directive concerning the requirement for Member States to ensure that drivers are insured. In *Fundo de Garantia Automovel v. Alina Antonia Destapado* the ECJ ruled that a vehicle whose owner has stopped driving must still be insured until the vehicle is officially decommissioned.⁴¹ The immobilised car must be insured, albeit kept in a private location without any intention of it being used again. The ECJ has also confirmed that the

37 Article L.623-1 of the Consumer Code.

38 Appeal (Paris), div. 4, ch. 3, 9 November 2017, No. 16/05321. Proceedings are still pending before the French Court of Cassation.

39 Healthcare System Modernisation Act No. 2016-41 of 26 January 2016.

40 Insurance Distribution Act No. 2018-361 of 16 May 2018.

41 Decision of the Court of Justice of the European Union [C-80/17], 4 September 2018.

obligation to provide liability insurance to all running vehicles includes damages arising from any vehicle component,⁴² irrespective of whether the component is used in the movement of the vehicle or not.

Terrorism

In France, damages arising from terrorism are submitted to two different regimes with regard to the nature of the damage. Corporal damages are covered by the Compensation Fund for Terrorist Acts (CFTA),⁴³ which is financed by a contribution on insurance premiums.⁴⁴ Material damages are left to the insurance sector. Certain insurance policies must mandatorily cover material damages arising from terrorism.⁴⁵ Thus, insurance disputes related to terrorism mainly concern material damages. However, indemnification disputes with the CFTA in relation to corporal damages tend to develop in France as recently illustrated by *Mrs Y v. CFTA*,⁴⁶ in which the CFTA successfully challenged the status of victim of the claimant and denied indemnification.

Cyber risk

According to Europol, ransomware is now the predominant threat in relation to cybercriminality. This consists of hacking into an IT system, disabling it and then demanding a ransom to restore the system to its normal state. To tackle this and other cyberattack-related issues, insurers have issued customised insurance policies covering this kind of risk. However, the high complexity of cyberattacks makes it difficult to know what kinds of risk fall under the insurance coverage. This may lead to some highly technical debates about the scope of coverage in the future. Moreover, the insurability of the cyberattack risk is also under discussion. Notably, it remains unclear whether the ransom paid to restore a system is insurable.

Political risk

The same goes for political risk. Mirroring global trends, employees of French multinational companies face an increasing risk of kidnapping around the world.⁴⁷ Specific insurance policies cover all the losses incurred by the company in the event of an attack against its employees on foreign territory: care of the victims, medical care, loss of profits, ransom paid and even the fees of a professional negotiator. The same issues may arise as those discussed above in relation to cyberattack risks regarding the validity of these guarantees: the insurability of the risk and the scope of the coverage.

42 Decision of the Court of Justice of the European Union [C-100/18], 20 June 2019.

43 Articles L.126-1 and L.422-1 of the Insurance Code.

44 Article L.422-1 of the Insurance Code.

45 Article L.126-2 of the Insurance Code.

46 Decision of the Court of Cassation, No. 17-10456, 8 February 2018.

47 Risk management: the kidnapping insurance, *Le Nouvel Economiste*, 15 June 2011.

GERMANY

*Marc Zimmerling and Angélique Pfeiffelmann*¹

I OVERVIEW

The German insurance market contributes substantially to Germany's prosperity and economic growth.² In this context, the effective and cost-efficient settlement of insurance disputes is an important driver for the industry's success. It ensures legal certainty and fosters trust in the sector. The following chapter gives an overview of the legal framework for insurance disputes in Germany and highlights the current jurisprudence of German courts.

II THE LEGAL FRAMEWORK

i Sources of insurance law

The Insurance Contract Act

The main source of insurance law in Germany is the Insurance Contract Act (VVG). It sets out the general rules for insurance contracts as well as the statutory provisions for specific insurance branches. The VVG applies to all types of insurance contracts, except for reinsurance and maritime insurance contracts (Section 209 VVG). It came into force in 1908 and remained largely unchanged until a major reform in 2008.³ The objective of the reform was to modernise German insurance law and improve the position of the insured person.⁴

Important changes included:

- a the introduction of a right to revoke the insurance contract by the policyholder within 14 days of the conclusion of the contract (Section 8 VVG);
- b the introduction of certain advisory, documentation and information duties of the insurer (Section 6 et seq. VVG);

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2 According to a study conducted by the association for economic research and consulting Prognos, www.prognos.com/publikationen/alle-publikationen/688/show/288ea05be5faba014c4511664f33e9a0/.

3 It is therefore important to consider carefully whether decisions and publications on insurance law refer to the current or the old rules of the VVG.

4 Entwurf eines Gesetzes zur Reform des Versicherungsvertragsrechts of 20 December 2006, Bundestagsdrucksache 16/3945, p. 1.

- c the abolition of the ‘all-or-nothing’ principle⁵ in favour of the ‘more-or-less’ principle⁶ (Sections 26(1), 28(2), 81(2) VVG);
- d the abolition of insurance-specific limitation periods, rendering applicable the general limitation period of three years pursuant to Section 195 of the German Civil Code (BGB); and
- e the introduction of a new place of jurisdiction at the place of the policyholder’s residence (Section 215(1) VVG).

The overarching purpose of the reform was to provide greater protection to the insured person by setting out restrictions to the freedom of contract. The restrictions shall, however, not apply to large risks and open policies.⁷ Large risks are risks of: (1) certain transportation and liability insurances (such as insurances for railway vehicles, aircrafts or the transportation of large goods); (2) certain credit and suretyship insurances; and (3) certain property, liability and other indemnity insurances where the policyholder exceeds a balance sheet total of €6.2 million, a net turnover of €12.8 million or an average of 250 employees per fiscal year.⁸ These insurances are typically taken out by big companies that are not in need of protection by the VVG. All other risks are deemed ‘mass risks’, to which the restrictions to the freedom of contract apply without limitation.

German Civil Code

Another source of German insurance law is the German Civil Code (BGB), which is applicable insofar as no specific provisions of the VVG apply. The area of most relevance for insurance contracts is its section on the use of standard business terms. Almost all insurance contracts contain standard business terms of the insurer, especially insurance contracts concluded with a consumer. Section 305 et seq. BGB set out the rules for the incorporation of standard business terms into the contract, the assessment of their effectiveness and the interpretation of their content. These rules apply regardless of whether the other party is a consumer or not. However, stricter requirements apply where a consumer is concerned.

Other provisions applicable to insurance law are the rules on the statute of limitations. As the special limitation periods for insurance claims were abrogated with the VVG reform in 2008, the general rules in Section 195 et seq. BGB apply. The limitation period is three years,⁹ commencing at the end of the year in which the claim arose and the insured party obtained knowledge of the circumstances giving rise to the claim (or would have obtained this knowledge if it had not shown gross negligence).¹⁰ An exception applies if the limitation period is suspended. For insurance contracts, Section 15 VVG provides an insurance-specific suspension rule. Where a claim arising from an insurance contract has been registered

5 Which allowed the insurer to refuse payment for the insured event if it was caused by the insured person, regardless of the degree of misconduct.

6 Which stipulates that the insurer may only refuse payment in full if the insured person caused the insured event intentionally; in cases of gross negligence, the insurer may refuse payment only partly depending on the degree of negligence.

7 Section 210(1) VVG; an open policy is a contract made in such a manner that, at the time when the contract is concluded, only the class of insured interest is designated and it is only specified to the insurer in detail once the contract has been concluded, Section 53 VVG.

8 Section 210 (2) VVG enumerates all large risks conclusively.

9 Section 195 BGB.

10 Section 199(1) BGB.

with the insurer, the limitation period shall be suspended until such time as the applicant has received the insurer's decision in writing. All other rules for suspension are set out in Section 203 et seq. BGB.

German Code of Civil Procedure

A further source of German law that is especially relevant for insurance disputes is the German Code of Civil Procedure (ZPO). It sets out the general rules for litigation proceedings and is also applicable to insurance disputes as far as no specific rules are set out in the VVG.

One of the main principles of German civil procedural law is that each party has to present the facts and prove the case upon which its claim or defence is based. Unlike in common law jurisdictions, there is no pretrial discovery or document production. In general, no party to litigation proceedings is therefore obligated to deliver to the other party the documents or evidence necessary for its case. However, there are exceptions to this principle. One example is Section 142 ZPO, which sets out that the court may direct one of the parties or a third party to produce records or documents, as well as any other material in its possession if one of the parties made reference to it. Another example is Section 422 ZPO, which stipulates the obligation of a party to produce certain documents favourable for its opponent if its opponent is entitled to demand the surrender or production of the relevant documents pursuant to civil law stipulations.

With regard to insurance disputes, the VVG stipulates specific disclosure obligations of the insured person. According to Section 31(1), the insurer may, after the occurrence of an insured event, demand that the policyholder or the beneficiary shall disclose all the information necessary to establish the occurrence of the insured event or the extent of the insurer's liability. In addition, the insurer may demand supporting documents to the extent that the policyholder may be reasonably expected to obtain them. The policyholder is even obligated to disclose facts unfavourable to him or her. The VVG therefore sets out more extensive disclosure obligations of the insured person than it would have under the rules of the ZPO. However, Section 31 VVG does not set out any consequences for cases of non-compliance. Therefore, the insurer will usually incorporate the policyholder's disclosure duties in its general terms and conditions and stipulate contractual consequences for non-compliance.¹¹

Another specific aspect of insurance disputes concerns direct claims of third parties against the insurer. This issue typically arises in relation to liability insurances that cover damage claims made by third parties against the policyholder. In general, a third party cannot make direct claims under the insurance contract against the insurer of the damaging party. Therefore, the third party may only enforce its damage claim against the policyholder ('liability claim') who may then raise a claim against his or her insurer ('coverage claim'). However, there are exceptions to this rule. One is set out in Section 115 VVG, which provides a direct claim of the third party against the insurer if: (1) third-party vehicle insurance is concerned; (2) the policyholder has become insolvent; or (3) the policyholder's whereabouts are unknown. If one of these requirements is fulfilled, the third party may directly claim payment from the insurer and initiate court proceedings against it without having to proceed against the policyholder first.

11 Rixecker in Römer/Langheid, VVG, 6th edition 2019, Section 31 [1].

The ZPO also stipulates the place of jurisdiction for litigation proceedings regarding claims in connection with the insurance contract. Optional places of jurisdiction are the place of the insurer's registered seat,¹² the place of performance of the contract¹³ or the place of the insurer's branch office.¹⁴ In general, all these venues favour the insurer. With the introduction of Section 215 VVG in 2008, the legislator established a new place of jurisdiction that favours the insured person. The policyholder can now also choose to proceed against the insurer at the court in whose district he or she has his or her place of residence. For actions brought against the policyholder, only this court shall have jurisdiction. The parties can only deviate from this place of jurisdiction to the detriment of the policyholder after the dispute has arisen or if the policyholder moves his or her domicile to a different country after signing the contract or if his or her domicile is unknown at the time the action is filed.¹⁵ The purpose of this change was to guarantee the policyholder access to a court near his or her domicile.¹⁶ This was supposed to compensate for the subject-specific and economic advantages of the insurer.

ii Insurance regulation

German Insurance Supervision Act

The main legal source for insurance regulation is the German Insurance Supervision Act (VAG), which implemented in 2015 the European Solvency II Directive.¹⁷ It enables the supervision of insurance companies in their legal and financial operations (Section 294(2) VAG) by the German Federal Financial Supervisory Authority (BaFin) and the supervisory authorities of the federal states. The BaFin is the competent supervisory authority for private insurance companies that operate in Germany and are of material economic significance as well as for public insurance companies that participate in free competition and operate across the borders of any federal state (Section 320 VAG). The supervisory authorities of the federal states are mainly responsible for overseeing public insurers whose activities are limited to the federal state in question and private insurance companies of lesser economic significance.¹⁸

Therefore, all private and public insurance companies, pension funds and reinsurers carrying out private insurance businesses within the scope of the VAG and that have their registered office in Germany are subject to supervision.¹⁹ Social insurance institutions²⁰ are not supervised under the VAG but regulated by other government agencies.

The primary objective of the VAG is the protection of policyholders and beneficiaries (Section 294(1) VAG). To ensure that only regulated companies offer insurance services,

12 Section 17 ZPO.

13 Section 29 ZPO.

14 Section 21(1) ZPO.

15 Section 38(3) ZPO; Section 215(3) VVG.

16 Klimke in Prölls/Martin, VVG, 30th edition 2018, Section 215 [1].

17 Directive 2009/138/EC of 25 November 2009 on the taking-up and pursuit of the business of Insurance and Reinsurance (Solvency II) (recast).

18 www.bafin.de/dok/7859578.

19 www.bafin.de/dok/7859578.

20 i.e., statutory health insurance funds, statutory pension insurance fund, statutory accident insurance institutions and unemployment insurance institutions.

insurance companies must acquire a licence before commencing business operations (Section 8(1) VAG). To be granted authorisation to operate, the insurance company must fulfil a number of requirements. This includes, *inter alia*, that the company:

- a* operates in the legal form of a public limited company;²¹
- b* has its legal seat in Germany;²²
- c* engages only in insurance businesses and directly related businesses and observes the principle of business segregation (e.g., a life insurance company may not at the same time provide health or property insurance);²³
- d* submits a detailed business plan that contains the company's charter and sets out which insurance segments will be operated as well as the risks that are intended to be covered;²⁴
- e* demonstrates that it has a sufficient amount of its own funds²⁵ as well as sufficient resources to develop the business and sales organisation;²⁶ and
- f* has at least two members of the management board that are 'fit and proper' persons.²⁷

In its ongoing supervision, the BaFin monitors, among other things, whether the insurance company complies with all statutory and regulatory requirements, whether it is capable of fulfilling its insurance contracts and whether it observes the principle of good business practice (e.g., keeping proper accounting records and rendering proper accounts).²⁸ In accordance with the Solvency II Directive, it also supervises the company's solvency, in particular the fulfilment of certain capital requirements.

In the event of any undesirable conduct by an insurance company, especially non-compliance with legal requirements, the BaFin may take any appropriate and necessary measures to prevent or eliminate this conduct (Section 298 VVG). For consumers, it is also possible to file a complaint against an insurance company with the BaFin.²⁹ The BaFin will review the complaint and issue a report with its legal opinion. If necessary, it may also take regulatory steps against the insurance company. However, it is not authorised to render a binding decision or give legal advice.

iii Insurable risk

German insurance law differs between two types of insurable risks: socially insured risks and privately insured risks. Socially insured risks are codified in the German Social Code (SGB), which distinguishes between health insurance, unemployment insurance, nursing care insurance, pension insurance and occupational accident insurance. They are statutory insurances that do not come into effect by agreement but are taken out by law when the insured person fulfils certain requirements.

The VVG only applies to privately insured risks. Because of the freedom of contract, the parties to an insurance contract may, in principle, insure any type of risk they chose to. They

21 This includes SEs, mutual societies or public-law institutions, Section 8(2) VAG.

22 Section 8(3) VAG.

23 Section 8(4) VAG; see also www.bafin.de/dok/7859578.

24 Section 9(1)–(3) VAG.

25 Section 9(2) No. 4 VAG.

26 Section 9(2) No. 5 VAG.

27 Section 9(4) No. 1 Lit a) VAG.

28 Section 294 VAG.

29 www.bafin.de/dok/7858102.

are only bound by the limitations applicable to any civil law contract (e.g., the prohibition of contracts that violate public policy or a statutory prohibition).³⁰ The VVG regulates the most common types of private insurance in Germany by stipulating the rules applicable to the different insurance branches. The most relevant branch in Germany is the liability insurance that insures damage claims of a third party against the policyholder.³¹ What is special about this insurance branch is that some liability insurances are on a voluntary basis while others are compulsory insurances. This is the case where the legislator deemed it especially important to insure the risk of damages to a third party caused by the conduct of another party.³² The most prominent example of compulsory liability insurance is the third-party vehicle insurance, from which the other compulsory insurances evolved. Other insurance branches stipulated in the VVG are legal expenses insurance, transport insurance, fire insurance for buildings, life insurance, occupational disability insurance, accident insurance and private health insurance.

iv Fora and dispute resolution mechanisms

In general, arbitration and other alternative dispute resolution mechanisms (ADR) have experienced an expansion in recent years.³³ In Germany, however, the popularity of arbitration and ADR rather depends on the type of insurance contract concerned. A distinction can be drawn between reinsurances, insurances for commercial and industrial risks and insurances for mass risks.

Disputes regarding reinsurances are traditionally solved amicably between the parties.³⁴ The reason for this is a kind of ‘gentlemen’s agreement’ to solve reinsurance disputes by negotiations for amicable settlement. However, arbitration proceedings have become more and more common in the past 30 years and most reinsurance contracts now also contain arbitration clauses. This may be attributed to an increased willingness in the Anglo-American reinsurance market to refer reinsurance disputes to arbitration, which also reflects on the German market. Another reason might be the increase of disputes regarding large risks that involve higher stakes for the parties. A third factor may be that more reinsurance companies withdraw from the reinsurance market, making it less necessary to solve disputes amicably to retain ongoing business relationships.

In insurance disputes concerning commercial and industrial risks there is a rather restrictive use of alternative dispute resolution mechanisms, especially arbitration.³⁵ This is a distinctive aspect of German insurance law in comparison to other jurisdictions. It might be owing to the still widely held perception by German insurers that German court proceedings are, when compared to other jurisdictions, more efficient, less time-consuming and less costly. Furthermore, German courts regularly have specialised chambers that will hear insurance law-related disputes. This ensures a qualified legal judgment that otherwise only specialised arbitral tribunals might be able provide. Benefits of this kind in German court proceedings apparently still outweigh the general advantages of arbitration for many insurance companies. However, there is reason to believe that the use of arbitration clauses in commercial or industrial insurance contracts will increase in the future. For contracts that

30 Looschelders in Langheid/Wandt, *Münchener Kommentar zum VVG*, 2nd edition 2016, Section 1 [144].

31 Lücke in Prölls/Martin, *VVG*, 30th edition 2018, before Section 100 [5].

32 Klimke in Prölls/Martin, *VVG*, 30th edition 2018, introduction to Sections 113–124 [1].

33 Wolf, *NJW* 2015, 1656 (1659).

34 Gal in Langheid/Wandt, *Münchener Kommentar zum VVG*, 2nd edition 2017, chapter 130 [5]–[8].

35 Gal in Langheid/Wandt, *Münchener Kommentar zum VVG*, 2nd edition 2017, chapter 130 [9]–[10].

are related to international law or written in a foreign language, or for contracts that contain unusual clauses or concern risks of a high technical nature, arbitration proceedings may, in principle, be deemed more favourable.³⁶

In German insurance contracts concerning mass risks, arbitration clauses are basically non-existent.³⁷ This is owing to the fact that they are often concluded with ‘consumers’ under German consumer protection law, which significantly raises the bar for a valid arbitration agreement. Section 1031(5) ZPO states that arbitration clauses involving consumers are only valid if they are contained in a separate record or document signed by both parties that shall not contain agreements other than those making reference to the arbitration proceedings. If the arbitration agreement is included in a contract, it is only valid if it has been recorded by a notary. Both requirements are rather difficult to fulfil in practice. In addition, arbitration clauses in insurance contracts are usually part of the insurer’s general terms and conditions and therefore have to fulfil the requirements set out in Section 305 et seq. BGB (see above under Section II(i) BGB). This leads to a high risk that an arbitration clause contained in an insurance contract for mass risks could be deemed invalid by a court.

Because of these difficulties with arbitration proceedings against consumers, the German Insurance Association formed the association *Versicherungsombudsmann eV* (the Insurance Ombudsman Association) in 2001 to establish a mechanism for out-of-court dispute settlement of insurance disputes with consumers before an ‘insurance ombudsman’.³⁸ Under this mechanism, consumers may file a complaint against an insurance company (or an insurance broker) with the ombudsman.³⁹ To be able to refer an insurance dispute to the ombudsman, the insurer needs to be a member of the Insurance Ombudsman Association,⁴⁰ which almost all insurance companies in Germany are.⁴¹ The complaint is only admissible if the insured person has made a complaint with the insurance company first and if at least six weeks have passed since then.⁴² The ombudsman cannot decide on complaints that: (1) have a value of more than €100,000; (2) concern healthcare or nursing care insurance; (3) have already been filed with or decided by a court or another institution; or (4) are obviously unfounded.⁴³ The proceedings shall take no longer than 90 days.⁴⁴ The insured party may refer the dispute to an ordinary court at any time.⁴⁵ If the complaint is admissible and the value in dispute is no more than €10,000, the ombudsman can render a decision that is binding for the insurance company; otherwise, it can make a non-binding recommendation.⁴⁶ Dispute settlement before the insurance ombudsman has proven to be quite successful. In 2017, the Insurance Ombudsman Association received 18,956 complaints, of which it settled 14,329.⁴⁷

36 Gal in Langheid/Wandt, *Münchener Kommentar zum VVG*, 2nd edition 2017, chapter 130 [11].

37 Gal in Langheid/Wandt, *Münchener Kommentar zum VVG*, 2nd edition 2017, chapter 130 [16]–[17].

38 www.versicherungsombudsmann.de/welcome/.

39 Section 2(1) Code of Procedure of the Insurance Ombudsman (VomVO).

40 Section 1 VomVO.

41 www.versicherungsombudsmann.de/der-verein/mitglieder/.

42 Section 2(3) VomVO.

43 Section 2(4) VomVO.

44 Section 7(6) VomVO.

45 Section 11(2) VomVO.

46 Sections 10(3), 11(1) VomVO.

47 Annual report of the Insurance Ombudsman Association, p. 2, www.versicherungsombudsmann.de/wp-content/uploads/Jahresbericht2017.pdf.

III RECENT CASES

i Judgment of 19 December 2018, IV ZR 255/17, regarding the requirements for an adjustment of health insurance premiums

In a recent and highly regarded judgment of 19 December 2018, the Federal Court of Justice (BGH) had to decide on the controversial issue of whether the independence of the trustee who has consented to an adjustment of health insurance premiums is a constitutive prerequisite for the validity of the adjustment and therefore subject to review by the civil law courts.

In the case at hand, the claimant had challenged the adjustment of his private health insurance premium and based this, *inter alia*, on the argument that the trustee, who is required to consent to the premium adjustment according to Section 203(2) VVG, had not been financially independent from the health insurer according to Section 157(1) VAG.

The BGH denied the policyholder's claim for repayment of the adjusted insurance premiums, holding that the independence of the trustee was not a constitutive prerequisite for the substantive validity of his consent.⁴⁸ The BGH justified this with the argument that the civil courts were only able to review the calculation of the premium adjustment and the formal requirements of consent made by a duly appointed trustee.⁴⁹ Whether the appointment of the trustee was lawful and valid was, because of its supervisory nature, solely subject to control by the competent supervisory authority.⁵⁰ Therefore, the financial independence of the trustee was not an independent requirement to be reviewed by the civil courts when assessing the validity of the premium adjustment.⁵¹

With its judgment, the BGH had decided on a highly disputed issue in lower instance case law and legal literature.⁵² The BGH referred the case back to the Regional Court of Potsdam (the LG Potsdam), which now must decide on the substantive validity of the premium adjustment. However, it remains to be seen whether the lower instance courts will follow the BGH's judgment. In view of the rising costs of health insurers, the adjustment of health insurance premiums is currently under review in numerous lawsuits brought by policyholders. In two parallel judgments of 20 March 2019, the LG Potsdam has already openly contradicted the BGH's findings.⁵³ According to the lower instance court, the BGH had exceeded the constitutional limits placed on a judicial development in the law. Other courts have followed this reasoning.⁵⁴ Therefore, the BGH will have to make a judgment on this issue again in the near future.

48 BGH, Judgment of 19 December 2018, IV ZR 255/17 [30].

49 BGH, Judgment of 19 December 2018, IV ZR 255/17 [29].

50 BGH, Judgment of 19 December 2018, IV ZR 255/17 [29].

51 BGH, Judgment of 19 December 2018, IV ZR 255/17 [30].

52 BGH, Judgment of 19 December 2018, IV ZR 255/17 [28]-[29].

53 LG Potsdam, Judgment of 20 March 2019, 6 O 192/17; LG Potsdam, Judgment of 20 March 2019, 6 O 203/17.

54 Roger, *r* +s 2019, 274, 277.

ii Judgment of 12 September 2018, IV ZR 17/17, regarding the deduction of fund losses from the repayment of insurance premiums following a revocation of the insurance contract

In a recent decision of 12 September 2018, the BGH confirmed its position on the calculation of the repayment of insurance premiums for fund-based life insurances after a revocation of the contract.

Referring to an earlier judgment of 21 March 2018,⁵⁵ the BGH held that when insurance premiums had to be repaid following the revocation of a fund-based insurance contract, the losses of the fund had to be deducted from the repayment in accordance with the rules of German unjust enrichment law (Section 818(3) BGB).

In the case at hand, the plaintiff – a consumer – had claimed the repayment of his life insurance premiums from the defendant – a life insurer – after the former had revoked the underlying insurance contract. The effectiveness of the revocation (in accordance with the old law) was not in dispute. The defendant argued, however, that he had lost assets because of the losses from the fund in which the savings components of the premiums were invested. The essential question was therefore whether any of the fund's losses would have to be deducted from the repayment claim under Section 818(3) BGB. This was an issue under much discussion until the BGH affirmed this stance for fund losses that accounted for only a small portion of the savings component with its judgment of 11 November 2015.⁵⁶

In its recent judgment of 21 March 2018, the BGH followed this earlier ruling, but held that a deduction applied equally to fund losses that accounted for more than just a small portion of the savings component or even for a total loss.⁵⁷ According to the BGH, when a consumer enters into a fund-based insurance contract that offers a chance of making a profit, the consumer consciously takes on a risk of total loss. The BGH stated that this complete allocation of the risk to the insured consumer was also compatible with EU consumer protection law. A different view would be contrary to fair risk sharing because it would disadvantage the other policyholders. With its most recent judgment of 12 September 2018, the BGH affirmed this opinion once again.

iii Judgment of OLG Düsseldorf of 20 July 2018, I-4 U 93/16, regarding the coverage of directors and officers insurance for claims under Section 64 GmbHG

In a recent judgment of 20 July 2018, the Higher Regional Court of Düsseldorf (the OLG Düsseldorf) decided on the controversial issue of whether a directors and officers (D&O) insurance policy covers claims made by the insolvency administrator under Section 64 of the Limited Liability Companies Act (GmbHG).⁵⁸

Section 64 GmbHG addresses an obligation on the director of a company to compensate the company for payments made after it has become illiquid or after it has been deemed to be over-indebted. Whether a claim of this kind is covered under a D&O insurance policy is

55 BGH, Judgment of 21 March 2018, IV ZR 353/16.

56 BGH, Judgment of 11 November 2015, IV ZR 513/14.

57 BGH, Judgment of 21 March 2018, IV ZR 353/16 [18].

58 OLG Düsseldorf, Judgment of 20 July 2018, I-4 U 93/16.

currently under discussion in legal literature and case law.⁵⁹ The main point of discussion is whether claims made under Section 64 GmbHG qualify as ‘claims for damages’ or as other compensation claims, since most D&O insurance policies only cover the former.

The OLG Düsseldorf decided against any liability on the part of the D&O insurer for a claim made under Section 64 GmbHG. In this regard, it relied on the established jurisprudence of the BGH, which qualifies the claim under Section 64 GmbHG as a compensation claim *sui generis*.⁶⁰ According to the BGH, the aim of Section 64 GmbHG is to replenish the company’s assets to guarantee equal satisfaction for its creditors.⁶¹ Therefore, a payment in violation of Section 64 GmbHG results in damage to the company’s creditors but not to the company itself.

Following on from this, the OLG Düsseldorf stated that there was a decisive difference between a claim for damages and a claim made under Section 64 GmbHG.⁶² The latter existed regardless of whether the company had suffered a financial loss or not. Therefore, the OLG Düsseldorf held that an informed policyholder could not assume that it was insured against a risk arising out of payments made in violation of Section 64 GmbHG; the D&O insurer could not be expected to be held liable for a claim that existed regardless of whether any damage had occurred or not.⁶³

This judgment has become final. The BGH has not yet decided on this issue.

iv Judgment of the OLG Düsseldorf of 19 October 2018, I-4 U 10/18, regarding the coverage of liability insurance for claims under unwritten liability principles of common law

A further judgment recently made by the OLG Düsseldorf concerned a claim for coverage under liability insurance for an insured event that took place in Scotland.⁶⁴

The insurance policy covered damage claims against the policyholder under statutory private law liability provisions.⁶⁵ Therefore, the court had to decide whether a liability insurance under German law grants coverage for liability claims that follow from unwritten liability principles of common law.

The court affirmed that the insurance policy was not restricted to liability claims under German law and expressly covered insured events occurring outside Germany.⁶⁶ The fact that the legal consequences of the insured event arose regardless of the will of the involved parties was relevant for the qualification as a statutory liability provision. According to the OLG Düsseldorf, a liability claim made under the unwritten legal concept of a ‘breach of contract’ under common law fulfils this requirement.⁶⁷

59 See, e.g., Lange in Veith/Gräfe/Gebert, *Der Versicherungsprozess*, 3rd edition 2016, Part E, Section 21 [93]; Seitz/Finkel/Klinke, *D&OVersicherung*, 2016, Section 1 AVB-AVG [161]; OLG Celle, Judgment of 1 April 2016, 8 W 20/16.

60 BGH, Judgment of 20 September 2010, II ZR 78/09 [14].

61 BGH, Judgment of 8 January 2001, II ZR 88/99.

62 OLG Düsseldorf, Judgment of 20 July 2018, I-4 U 93/16 [73].

63 OLG Düsseldorf, Judgment of 20 July 2018, I-4 U 93/16 [86].

64 OLG Düsseldorf, Judgment of 19 October 2018, I-4 U 10/18.

65 OLG Düsseldorf, Judgment of 19 October 2018, I-4 U 10/18 [20].

66 OLG Düsseldorf, Judgment of 19 October 2018, I-4 U 10/18 [23].

67 OLG Düsseldorf, Judgment of 19 October 2018, I-4 U 10/18 [23].

v **Judgment of OLG Karlsruhe of 20 April 2018, 12 U 156/16, regarding spontaneous disclosure obligations of the policyholder before entering into the insurance contract**

In a judgment of 20 April 2018, the OLG Karlsruhe affirmed the right of a policyholder not to disclose health issues about which the insurer did not ask.⁶⁸

In the case at hand, the insurer had asked the policyholder before entering into the contract to declare that he had not been diagnosed with or treated for cancer, HIV, mental illness or diabetes up to that date. The policyholder confirmed this, despite the fact that he had already been diagnosed with multiple sclerosis. Two years later, he became unable to work because of multiple sclerosis and claimed insurance benefits. The insurer denied its liability and declared the contract void because of fraudulent misrepresentation. The OLG Karlsruhe rejected this and held that the policyholder had not committed fraudulent misrepresentation by not revealing that he suffered from multiple sclerosis.

In making its decision, the OLG Karlsruhe passed judgment on a question that has been disputed since the reform of the VVG in 2008. The reform had introduced a requirement for the insurer to request information in writing it deemed relevant for the conclusion of the contract from the insured person (Section 19(1) VVG). With this change to the previous provision, it became questionable whether the policyholder had a spontaneous disclosure obligation even if the insurer had not asked a specific question.

While the Higher Regional Court of Düsseldorf⁶⁹ and some commentators in legal literature⁷⁰ deny this, the majority of judgments made by higher regional courts, as well as the majority of commentators in legal literature, are of the opinion that the policyholder has a spontaneous disclosure obligation in certain situations. While some assert that a disclosure obligation arises when the materiality of the risk is evident,⁷¹ others say that it has to be a relevant risk according to the policyholder's assessment.⁷² A third view states that there is a disclosure obligation only where a risk is so exceptional that a question regarding it cannot be expected to be asked by the insurer.⁷³

The OLG Karlsruhe decided contrary to its established jurisprudence and denied that there was a spontaneous disclosure obligation on the part of the policyholder in the case at hand. According to the OLG, this was in line with the legal situation before changes were made to Section 19 VVG, namely if the insurer asked the policyholder specific questions before entering into the insurance contract, it had documented the facts it deemed relevant for its decision.⁷⁴ As this was the case here, the insurer could not assert that the policyholder was obliged to disclose further information the insurer did not request, which nevertheless could have been relevant for the contract.

As the controversy around this question continues, it remains to be seen how the BGH will decide on this issue.

68 OLG Karlsruhe, Judgment of 20 April 2018, 12 U 156/16.

69 OLG Düsseldorf, Judgment of 29 June 2009, I-4 W 20/09 [16].

70 Weiberle, VuR 2008, 170.

71 Müller-Frank in Langheid/Wandt, Münchener Kommentar zum VVG, 2nd edition 2017, Section 22 [7].

72 Armbrüster in Prölss/Martin, VVG, 30th edition 2018, Section 22 [5].

73 OLG Celle, Judgment of 9 November 2015, 8 U 101/15 [77]; OLG Hamm, Order of 27 February 2015, 20 U 26/15 [10].

74 OLG Karlsruhe, Judgment of 20 April 2018, 12 U 156/16 [36].

IV THE INTERNATIONAL ARENA

Cross-border insurance contracts have proliferated in recent years, putting insurance disputes increasingly into a more international context. Frequent questions that arise in cross-border insurance disputes regard the correct place of jurisdiction and the applicable law. For German courts, EU Regulation (EC) No. 593/2008 of 17 June 2008 on the law applicable to contractual obligations (Rome I) and EU Regulation (EC) No. 1215/2012 of 12 December 2012 on jurisdiction and the recognition and enforcement of judgments in civil and commercial matters (recast) (the Recast Brussels Regulation)⁷⁵ set out the relevant rules for these questions.

Rome I applies to insurance contracts concluded after 17 December 2009 and provides the rules to identify the applicable law to contractual obligations in civil and commercial matters involving a conflict of laws. Article 7 Rome I sets out specific rules for insurance contracts covering large risks as well as insurance contracts covering mass risks situated inside the territory of the Member States. To all other insurance contracts, especially regarding mass risks situated outside the territory of a Member State as well as reinsurance contracts, the general rules of Article 3–6 Rome I apply.⁷⁶

Regarding the question of jurisdiction, the Recast Brussels Regulation provides the relevant rules for legal proceedings instituted on or after 10 January 2010 against a defendant that has its domicile⁷⁷ in a Member State and concern a dispute that is not located solely in one Member State (e.g., one of the parties has its residence or place of business in one Member State and the other party in another Member State or a third state). It contains specific rules for insurance disputes in Articles 10–16. The rules are similar to those under German law (see Section II.i, ‘German Code of Civil Procedure’). If the defendant has its residence in Switzerland, Norway or Iceland, the Lugano Convention (2007) applies with corresponding rules.

The Recast Brussels Regulation also applies to the enforcement of judgments rendered by a court of a different Member State. In general, such judgments shall be recognised and enforceable in the other Member State without any special procedure or declaration of enforceability being required.⁷⁸ However, the Recast Brussels Regulation does not apply to the enforcement of arbitral awards.⁷⁹ Regarding the recognition and enforcement of foreign awards by a German court, the rules of the Convention of 10 June 1958 on the Recognition and Enforcement of Foreign Arbitral Awards (New York Convention) apply.⁸⁰ Regarding the recognition and enforcement of domestic awards, the rules of the ZPO apply.

75 As well as its predecessor, Council Regulation (EC) No. 44/2001 of 22 December 2000 on jurisdiction and the recognition and enforcement of judgments in civil and commercial matters, which still applies to legal proceedings instituted before 10 January 2015 as well as to judgments given or court settlements concluded before that date (Article 66 of the Recast Brussels Regulation).

76 Rome I, however, does not apply to insurance contracts providing benefits for employed or self-employed persons in the event of death or survival or of discontinuance or curtailment of activity, or of sickness related to work or accidents at work, excluding life assurance according to Article 9 No. 2 of the Solvency II Directive.

77 For a company, this would be the place where it has its statutory seat, central administration or principal place of business, Article 63 of the Recast Brussels Regulation.

78 Articles 36(1), 39 of the Recast Brussels Regulation.

79 Article 1(2)(d) of the Recast Brussels Regulation.

80 Section 1061 ZPO.

V TRENDS AND OUTLOOK

Future developments in insurance disputes could arise from the introduction of the ‘model declaratory action’ in Germany, which came into force on 1 November 2018 and has the aim of facilitating collective redress for consumers in cases of mass damage caused by large companies.

Only qualified institutions (mainly consumer associations) are authorised to initiate and conduct a model declaratory action. It follows the opt-in approach, which means that concerned individuals must apply for registration in a register of action. At least 50 consumers must have registered their claims effectively within two months of the official public notice of the action for the declaratory action to be admissible.

The subject matter of the action has to be a ‘declaratory target’ (i.e. the determination of the presence or absence of factual and legal prerequisites for the existence or non-existence of a claim or (another) legal relationship between a consumer and a company). The qualified institution must show that the claims or legal relationships of at least 10 consumers depend on these declaratory targets. In the event of a positive declaratory judgment, each consumer must enforce its claim individually.

The model declaratory action could also become relevant for insurance-related disputes. Possible situations could encompass legal issues concerning a large number of policyholders; for example, claims in relation to an increase in insurance premiums, unauthorised premature terminations or the invalidity of unfavourable insurance policy terms. However, the extent to which qualified institutions will make use of the model declaratory action for insurance disputes in the future remains to be seen.

INDIA

*Neeraj Tuli and Rajat Taimni*¹

I OVERVIEW

The Indian insurance industry has seen significant growth and development in recent years. The removal of the requirement to seek an approval from the government of India to increase the foreign investment cap from 26 per cent to 49 per cent in insurers and insurance intermediaries is one of the factors that has led to an increase in the quantum of economic investments in existing Indian participants, along with various foreign participants exploring options for setting up insurance joint ventures in India and several overseas reinsurers setting up branch offices in India, including Lloyd's of London, which has set up a branch office in India under the Lloyd's India Regulations. Recently, the government of India indicated that it would examine suggestions to further open up foreign direct investment in the insurance sector (vide the Union Budget 2019–2020, tabled in Parliament on 5 July 2019) and, in particular, was considering a specific proposal to permit 100 per cent foreign direct investment in insurance intermediaries registered in India.

It is also relevant to note that with insurers being permitted to issue products under the 'use-and-file' process for commercial risks, there has been an increase in product development and innovation in India. The recent issue by the Insurance Regulatory and Development Authority of India (IRDAI), on 18 May 2019, of the 'Exposure draft on IRDAI (Regulatory Sandbox) Regulations 2019' proposes to set up a sandbox environment within the insurance sector. The draft regulations indicate that a sandbox framework may be rolled out as a 'testing environment' to increase insurance penetration in the Indian market and benefit policyholders by facilitating further innovations in the insurance sector in India, and to provide the ecosystem necessary for experimentation. At present, it remains to be seen how the regulatory sandbox will ultimately be implemented and what categories of innovation will be eligible in the future.

Over the past few years, there has been an upsurge in the frequency and severity of claims, specifically those made under professional indemnity (PI), directors and officers liability (D&O), employment practice liability (EPL) and cyber policies. We see this trend only going upwards in the years to come as the awareness of risks associated with any business increases and particularly as the legal and regulatory framework tightens.

However, we do see the government taking initiatives to improve the business environment; for instance, the setting up of commercial courts for adjudicating commercial disputes, including insurance and reinsurance disputes, is a development that we hope would have a positive impact on timelines for adjudication of disputes. The average time taken by an

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Indian court of first instance to decide a case is anywhere between five and seven years. With the setting up of the commercial courts, there is the expectation that these timelines will be substantially reduced.

II THE LEGAL FRAMEWORK

i Sources of insurance law and regulation

Insurers, reinsurers and insurance intermediaries in India are governed by the IRDAI. The primary legislation regulating the Indian insurance sector comprises the Insurance Act 1938 (the Insurance Act) and the Insurance Regulatory and Development Authority Act 1999 (the IRDA Act). Pursuant to the powers granted to it under both of these statutes, the IRDAI has issued various regulations governing the licensing and functioning of insurers, reinsurers and insurance intermediaries.

Appeals against orders issued and decisions made by the IRDAI may be referred to the Securities Appellate Tribunal in accordance with the procedural rules notified in this regard.

The year 2018 was significant for the insurance sector as several regulations and guidelines issued by the IRDAI were notified, including the following.

The IRDAI (Insurance Brokers) Regulations 2018 were issued to replace the previous IRDA (Insurance Brokers) Regulations 2013.

The IRDAI (Re-insurance) Regulations 2018 (the Reinsurance Regulations), which are applicable to life, general and health insurers, were issued to replace the IRDAI (General Insurance – Reinsurance) Regulations 2016 and IRDAI (Life Insurance – Reinsurance) Regulations 2013. They also amend to some extent the IRDAI (Registration and Operations of Branch Offices of Foreign Reinsurers Other than Lloyd's) Regulations 2015 and the IRDAI (Lloyd's India) Regulations 2016. The Reinsurance Regulations prescribe significant changes to the erstwhile order of preference Indian insurers were required to follow for placement of reinsurance business and also expressly govern engineering, aviation, crop, trade credit, liability, oil and energy lines of reinsurance business. Non-admitted insurers who are listed with the IRDAI as cross-border reinsurers can reinsure risks in India in accordance with the IRDAI's regulations on the reinsurance of life and general insurance business and subject to compliance with the order of preference for cessions. Further, the Reinsurance Regulations also provide that Indian Insurers may now adopt alternative risk transfer solutions (also called 'financial reinsurance' in life reinsurance business) to fit their specific needs and profile, subject to obtaining the prior approval of the IRDAI.

The IRDAI (Unit Linked Insurance Products) Regulations 2019 and the IRDAI (Non-Linked Insurance Products) Regulations 2019 were issued to replace the erstwhile IRDA (Linked Insurance Products) Regulations 2013 and the IRDA (Non-Linked Insurance Products) Regulations 2013, respectively. The new regulations set out revised norms in relation to the design and issuance of linked and non-linked life insurance policies by life insurers in India.

In addition, and as mentioned above, The IRDAI's recent exposure draft of the IRDAI (Regulatory Sandbox) Regulations 2019 proposes setting up a sandbox environment within the insurance sector to foster further innovation.

ii Insurable risk

As is the case under English law, Indian law also requires a person entering into an insurance contract to have insurable interest in the subject matter of the contract. Insurable interest must be present in all types of insurance, failing which it would be a wagering contract, which is void.

Neither the Insurance Act nor the IRDAI regulations set out precisely what constitutes insurable interest or an exhaustive list of risks that can and cannot be insured. However, there is guidance provided by way of other statutes, court judgments and the IRDAI regulations.

‘Insurable interest’ has been defined under Section 7 of the Marine Insurance Act 1963 as follows:

Insurable interest defined – (1) Subject to the provisions of this Act, every person has an insurable interest who is interested in a marine adventure.

(2) In particular a person is interested in a marine adventure where he stands in any legal or equitable relation to the adventure or to any insurable property at risk therein, in consequence of which he may benefit by the safety or due arrival of insurable property, or may be prejudiced by its loss, or by damage thereto, or by the detention thereof, or may incur liability in respect thereof.

To have an insurable interest in anything, there must be subject matter to insure, the insured should have some legally recognised relationship with the subject matter and the loss of the property should cause pecuniary damage to the insured.² If the insured suffers a loss or derives benefit, he or she has an insurable interest in the subject matter of the insurance contract.³ The courts have held that ‘[i]nsurable interest is not complete ownership. It need not necessarily even strictly be title and interest in the object insured.’⁴

Further, Paragraph 6(b) of the Guidelines⁵ on Product Filing Procedures for General Insurance Products of 18 February 2016 states that ‘[t]he product should be a genuine insurance product covering an insurable risk with a real risk transfer. “Alternate risk transfer” or “financial guarantee” business in any form shall not be accepted including indirect insurance products such as insurance derivatives.’

There are specific requirements as far as trade credit policies are concerned, as for instance they cannot cover (1) factoring, reverse factoring and bill discounting; and (2) any receivable arising from a financial service or consultancy service.

Further, Indian law recognises the principle that the law will not help a criminal to recover any kind of benefit from or for his or her crime.⁶ Accordingly, the results of a criminal act will typically not fall for cover under an insurance policy and no benefits extended to the perpetrator.

Non-admitted insurers are not permitted to directly insure property situated in India or any ship or other vessel or aircraft registered in India. However, a person resident in India is permitted to take or continue to hold a health insurance policy issued by an insurer outside India provided the aggregate remittance does not exceed the limits prescribed by the

2 *New India Assurance Co Ltd v. GN Sainani* (1997) 6 SCC 383.

3 *OIC v. Sham Lal* AIR 2006 J&K 103.

4 *New India Assurance Company Ltd v. TT Finance Ltd and Ors* 2013 ACJ 997.

5 Ref No. IRDAI/NL/GDL/F&U/030/02/2016.

6 Srinivasan M N, *Principles of Insurance Law*, 9th ed.

Reserve Bank of India (RBI). In this regard, a person resident in India may take or continue to hold a life insurance policy issued by an insurer outside India, subject to certain foreign exchange requirements stipulated in the Master Direction – Insurance of 1 January 2016 (as amended) issued by the RBI. Similarly, a person resident in India may take or continue to hold a general insurance policy issued by an insurer outside India, provided that the policy is held subject to the conditions provided under the Foreign Exchange Management (Insurance) Regulations 2015.

In addition to the above, foreign reinsurers are now allowed to access the Indian market and are permitted to set up branch offices in India or operate through service companies set up in India under the IRDAI (Lloyd's India) Regulations 2016. Non-admitted insurers who are listed with the IRDAI as cross-border reinsurers can reinsure risks in India in accordance with the IRDAI's regulations on the reinsurance of life and general insurance business and subject to compliance with the order of preference for cessions. The restrictions on non-admitted insurers mean that cross-border insurance disputes involving insurers and insureds are scarce in this jurisdiction. Further, even in the case of policies obtained by Indian residents from insurers residing abroad, the Insurance Act 1938 gives policyholders a right to override contrary policy terms in favour of Indian law and jurisdiction as long as the insurance business is transacted in India.

iii Fora and dispute resolution mechanisms

There are no exclusive procedures or judicial venues for resolution of insurance disputes. Insurance disputes, in the absence of an arbitration clause, can be litigated before the civil courts or consumer forums. The option to approach the consumer forums, however, lies only with the insured in the event of a dispute. The civil and consumer courts have territorial and pecuniary jurisdiction to adjudicate disputes. The civil courts or consumer forums that decide the matter will vary according to the value of the dispute and the geographical limits of the defendant insurance company within which the cause of action for the dispute arises.

India has a three-tier hierarchy of courts to hear civil disputes. There are approximately 600 district courts at the lowest level, 24 high courts in the middle and the Supreme Court of India at the top of the pyramid. The high courts of Delhi, Mumbai, Chennai and Kolkata have original jurisdiction to hear matters over a certain pecuniary value, so the civil courts and judges under them do not hear matters involving values higher than that limit. In all other cases, district courts and the competent courts of first instance have an unlimited pecuniary jurisdiction to hear any insurance dispute. There is no right to a hearing before a jury and cases are decided by judges.

The Indian legislature enacted in 2015 the Commercial Courts Act 2015 (the Commercial Courts Act) for fast-track resolution of commercial disputes. Special commercial courts were set up under the Commercial Courts Act for exclusive adjudication of commercial disputes. The Commercial Courts Act defines a commercial dispute to include insurance and reinsurance disputes over the value of approximately 300,000 rupees. Recent amendments to the Commercial Courts Act have proposed compulsory mediation for parties before filing a commercial suit. The authority responsible for conducting mediation has not been designated yet.

The insured also has the option to approach the consumer courts, set up under the Consumer Protection Act 1986 (the Consumer Protection Act). The Consumer Protection Act lists insurance as a service and provides for a three-tier hierarchy to hear consumer disputes. There are 626 district consumer disputes redressal commissions, which until recently could

accept claims up to a value of approximately 2 million rupees. There are 36 state consumer disputes redressal commissions, accepting claims of up to approximately 10 million rupees and appeals against the decisions of the district commissions. At the apex is the National Consumer Disputes Redressal Commission (NCDRC), accepting matters with a value of over 10 million rupees and appeals against the decisions of the state commissions.

However, the central government recently introduced the Consumer Protection Act 2019, which has increased the aforementioned pecuniary jurisdiction of the consumer courts as follows: (1) the district consumer disputes redressal commissions can now accept claims up to a value of approximately 10 million rupees; (2) the state consumer disputes redressal commissions can accept claims of up to 100 million rupees; and (3) the NCDRC can now only accept matters valued at over 100 million rupees. However, the new Act is yet to come into force by way of a formal notification.

As a mechanism of alternative dispute redressal, the insured can also approach the Insurance Ombudsman for disputes that do not exceed 2 million rupees in value. The Insurance Ombudsman is not a judicial authority and does not have power to enforce its decisions against the insurer.

III RECENT CASES

Disputes between the insured and the insurer usually arise when the insured's claim, which the insured believes is covered under the policy, is rejected in part or in full by the insurer. There can be disagreement between the insurer and the insured in relation to the scope of the insuring clauses or extensions, the applicability of exclusions or compliance with the policy terms and conditions, and the quantum payable under the policy if liability is admitted.

The manner of computing the limitation period for insurance claims is given under Article 44(b) of the Limitation Act 1963, which states that time is to be calculated from 'the date of the occurrence causing the loss, or where the claim on the policy is denied either partly or wholly, the date of such denial'. The prescribed limitation period for filing a claim in the civil court or an arbitration is three years, whereas the limitation period for filing a claim in the consumer court is two years.

As discussed above, in the absence of an arbitration clause in the policy, an insured can approach a commercial court or (if the dispute qualifies) a consumer court. An insurer can only approach a commercial court. The remedies available are either specific performance of the contract or claims for damages. Indian courts also award interest and costs to the winning party. Interest is usually awarded at a rate of 9 per cent to 12 per cent from the date of the cause of action till the date of recovery. Costs remain at the discretion of the courts.

If the policy contains an arbitration clause, the courts in India will direct the parties to arbitrate. If disputes relating to liability are excluded from an arbitration clause, then such a dispute is not arbitrable. The Supreme Court of India recently ruled that if the arbitration clause covers quantum disputes only, then disputes on liability cannot be arbitrated.⁷ Following the amendments introduced in 2015 to the Arbitration and Conciliation Act 1996, the role of the court is now limited to examining the existence of the arbitration agreement only.⁸ However, recently while considering an arbitral reference made under an

7 *Oriental Insurance Company Limited v. Narbheram Power and Steel Pvt Ltd* (2018) 6 SCC 534.

8 Section 11(6A) of the Arbitration and Conciliation Act 1996 – '[6A] The Supreme Court or, as the case may be, the High Court, while considering any application under sub-section (4) or sub-section (5) or

insurance policy in an application under Section 11 of the Arbitration and Conciliation Act 1996, the Supreme Court held that since the insurer had denied liability, the arbitration clause could not be triggered.⁹ Similarly, in *United India Insurance Co Ltd v. Antique Art Exports Pvt Ltd*,¹⁰ the Supreme Court denied an arbitral reference since a discharge voucher had already been executed.

The presence of the arbitration clause, however, does not exclude the jurisdiction of the consumer courts. This principle was settled by a full bench of the NCDRC and subsequently confirmed by the Supreme Court of India.¹¹ The reasoning adopted is that since the consumer courts are special courts constituted to serve a social purpose, the Arbitration and Conciliation Act 1996 does not bar their jurisdiction.

Sections 19 and 20 of the Marine Insurance Act 1963 set out the requirements of good faith and non-disclosure in the following terms:

§19 Insurance is uberrimae fidei

A contract of marine insurance is a contract based upon the utmost good faith, and if the utmost good faith be not observed by either party, the contract may be avoided by the other party.

§20 Disclosure by assured

(1) Subject to the provisions of this section, the assured must disclose to the insurer, before the contract is concluded, every material circumstance which is known to the assured, and the assured is deemed to know every circumstance which, in the ordinary course of business, ought to be known to him. If the assured fails to make such disclosure, the insurer may avoid the contract

The above principles are applicable to all classes of insurance and, as they show, the remedy for non-disclosure or misrepresentation under Indian law is avoidance of the policy from the beginning. Even though a policy may not expressly say so, all insurance policies are based on this principle. This duty of disclosure and not to misrepresent facts arises when: (1) a new policy is being taken; (2) an existing policy is being renewed; or (3) an existing policy is amended. An insurer can lose the right to avoid by affirmation and waiver.

We have often seen insurers defend or reject claims for non-disclosure and misrepresentation, and some of the reported and notable cases include the following.

Recently in *Reliance Life Insurance v. Rekhaben Nareshbhai Rathod* (decided on 24 April 2019), a division bench of the Supreme Court of India extensively dealt with the insured's disclosure obligation and observed that:

The object of the proposal form is to gather information about a potential client, allowing the insurer to get all information which is material to the insurer to know in order to assess the risk and fix the premium for each potential client. Proposal forms are a significant part of the disclosure procedure and warrant accuracy of statements. Utmost care must be exercised in filling the proposal form. In a proposal form, the applicant declares that she/he warrants truth. The contractual duty so imposed is such that any suppression, untruth or inaccuracy in the statement in the proposal form will be

sub-section (6), shall, notwithstanding any judgment, decree or order of any Court, confine to the examination of the existence of an arbitration agreement.'

9 *United India Insurance Co. Ltd. & Ors v. Hyundai Engineering and Construction Co Ltd & Ors* AIR 2018 SC 3932.

10 2019 5 SCC 362.

11 *Emaar MGF Land Limited & Anr v. Aftab Singh* [Civil Appeal No. 23512 – 23153 of 2017].

considered as a breach of the duty of good faith and will render the policy voidable by the insurer. The system of adequate disclosure helps buyers and sellers of insurance policies to meet at a common point and narrow down the gap of information asymmetries. This allows the parties to serve their interests better and understand the true extent of the contractual agreement. The finding of a material misrepresentation or concealment in insurance has a significant effect upon both the insured and the insurer in the event of a dispute. The fact it would influence the decision of a prudent insurer in deciding as to whether or not to accept a risk is a material fact. As this Court held in Satwant Kaur (supra) 'there is a clear presumption that any information sought for in the proposal form is material for the purpose of entering into a contract of insurance'.

Notification requirements are set in the policy document and vary from one policy to another. While some policies require immediate notice, some stipulate a specific time period and others say that notice should be given as soon as practicable. Depending upon the language used, it needs to be assessed whether timely notification is provided.

While the IRDAI has issued circulars, we believe that the latest position with respect to the consequences of delay is set out in an August 2018 judgment delivered by a three-judge bench of the Supreme Court in *Sonell Clocks and Gifts Ltd v. The New India Assurance Co Ltd*.¹² The Supreme Court upheld repudiation on the basis of delayed notification and observed that the notification requirement 'is not a technical matter but sine qua non for a valid claim to be pursued by the insured, as agreed upon between the parties'.

Indian law recognises the concept of subrogation by which the insurer is entitled to pursue recoveries in respect of losses suffered by the insured that the insurer has indemnified. This right arises pursuant to both statute and case law. As for statute, the Marine Insurance Act 1963, specifically Section 79,¹³ is relevant.

There are numerous case laws dealing with subrogation, of which we consider the *Economic Transport Organization v. Charan Spinning Mills (P) Ltd*¹⁴ decision to be the most prominent. This case was decided in 2010 by the highest court of India, the Supreme Court. The Supreme Court explained that subrogation is inherent, incidental and collateral to a contract of indemnity, which occurs automatically when the insurer settles the claim under the policy, by reimbursing the loss suffered by the insured.

We are not aware of any Indian statute or case law that prescribes or limits the types or rights or claims that can be pursued under a subrogation action. The only limitation being that the insurer cannot claim anything more than the amount indemnified to the insured. The insurer becomes subrogated as an indemnifier to all the rights and remedies that the insured has against any third parties. The insurer can exercise these rights either in the name of the insured or as a subrogee-cum-attorney holder on behalf of the insured. While the

12 MANU/SC/0891/2018.

13 79. *Right of subrogation.* –

(1) *Where the insurer pays for a total loss, either of the whole, or in the case of goods of any apportionable part, of the subject-matter insured, he thereupon becomes entitled to take over the interest of the assured in whatever may remain of the subject-matter so paid for, and he is thereby subrogated to all the rights and remedies of the assured in and in respect of that subject-matter as from the time of the casualty causing the loss.*

(2) *Subject to the foregoing provisions, where the insurer pays for a partial loss, he acquires no title to the subject-matter insured, or such part of it as may remain, but he is thereupon subrogated to all rights and remedies of the assured in and in respect of the subject-matter insured as from the time of the casualty causing the loss, insofar as the assured has been indemnified, according to this Act, by such payment for the loss.*

14 (2010) 4 SCC 114.

right is inherent to an indemnity contract, nevertheless, in certain circumstances parties may execute a subrogation letter or subrogation-cum-assignment deed, which sets out the precise rights and obligations of the parties (e.g., the costs sharing arrangement).

In the event that the insured fails to preserve its recovery rights, waives them or generally acts in breach of the subrogation clause, then the remedies available to insurers were explained in *EID Parry (India) Ltd. v. Far Eastern Marine Transport Co Ltd and Ors*¹⁵ in the following terms:

As is laid down in the policy of insurance, the insurer's liability is only to succeed to and not in any way supersede any claim which the insurer may be entitled to make on any carriers or their agents. It is also laid down therein that it is the duty of the assured and the agents in all cases to take such measures as may be reasonable for the purpose of averting or minimising a loss and to ensure that all the rights against the carriers, bailees or other third parties are properly observed and exercised. In particular, the assured or their agents are required to take these steps and failure to comply with this requirement may prejudice any claim under this policy. Under the law of Insurance, the right of the Insurer on payment of the loss to the assured is to be subrogated to the rights of the assured so as to enable the insurer to proceed against the third party and indemnify itself. It is therefore incumbent upon the assured to keep alive his remedies against the carrier or other third party and any default committed by the assured either by allowing the remedy to get time-barred or by abdicating or abandoning, his rights against the carriers or the third party will deprive the insurer of its remedies against the third party for indemnity. In such cases, it is open to the insurer to repudiate the liability under the policy, the loss is not paid to the assured or to lay a counter-claim against the assured for damages if it has paid the loss to the assured.

We do not believe that there are as such any rules governing the insurer's duty to defend, and whether such a duty exists depends on the policy language. The policy will set out whether the insured or the insurer has the duty, and that will govern the manner in which a claim is to be managed. Insurance carriers that use a duty-to-defend clause in their policies have the obligation to manage the litigation process from the notification of the claim. At the same time, insurers have the right to select the defence counsel who would be appointed. The insured usually has no control over the defence counsel assigned.

The duty-to-defend clause in an insurance policy essentially states that in the event a claim being made against the named insured for an alleged wrongful act, the insurance company providing coverage at the time has the duty to defend the claim, even if it is subsequently found to be groundless, false or fraudulent. Therefore, although the claim lacks merit, the insurer still has an obligation to defend the claim.

IV THE INTERNATIONAL ARENA

Overseas insurers are barred from writing direct insurance business in India; however, cross-border reinsurers can reinsure risks written by Indian insurance companies in compliance with the relevant IRDAI regulations. Therefore, international disputes in the insurance sector are disputes relating to or arising out of reinsurance policies.

Indian courts give prominence to party autonomy when it comes to choice of jurisdiction and the law governing contracts. If the contract is silent on governing law and

15 MANU/TN/0570/1983.

jurisdiction, then conflict-of-rules principles apply, and the Indian courts will examine the law and place where the dispute has its closest nexus to determine these questions. Given the restrictions on overseas insurers in writing business in India, these issues have not been considered by the courts in an insurance context.

The Indian Code of Civil Procedure 1908 lays down the procedure for enforcement of foreign judgments and decrees in India. To enforce a foreign judgment, a suit in terms of the foreign decree has to be filed. Prior to enforcement, the courts will examine whether the judgment or decree was passed on the merits of the case by a competent court, principles of natural justice were followed, no fraud was involved and the judgment is not against the public policy of India. If India has a reciprocal arrangement with a foreign country, then judgments pronounced by the courts of that country can be enforced as a decree passed by the Indian courts.

India is a signatory to the New York and Hague Convention for the enforcement of foreign arbitration awards and a foreign award obtained in a signatory country can be enforced in terms of these conventions. Indian courts have increasingly followed a hands-off approach when it comes to arbitration and will enforce foreign arbitration awards. The courts in India have limited scope to refuse enforcement of a foreign award and the usual grounds available under the New York Convention dealing with incapacity of a party's natural justice, suspension of award, scope of the arbitration clause and public policy apply. Under Indian law, public policy has an expansive definition, but in the context of a foreign arbitration this has been watered down to mean fundamental policy of Indian law, fraud, interests of justice and morality.

V TRENDS AND OUTLOOK

While the focus used to be on more traditional lines of insurance, such as catastrophe, life, health and motor insurance, over the past decade or so the Indian insurance market has evolved and we have seen liability products such as PI, D&O, cyber policies and EPL come to the forefront. There is familiarity and demand for these products and consequently significant claims activity. Among the liability products, in our experience over the past five years, there has been a steady upward trend in claims made under PI policies and it remains the busiest claims area, followed closely by D&O. In fact, PI and D&O claims make up at least half of the total claims that we have seen being made under liability policies.

Not only has there been an upsurge in the frequency of claims, but there has also been a sharp increase in the quantum being claimed by the insured, which means that claims severity is also on the rise. The sort of numbers that are at play can be gauged from the recent settlements entered into by Indian technology and pharmaceuticals companies in the United States that have attracted media attention. Another reason for increased exposure is the high legal fees that have to be spent in the defence of claims, which may run for a number of years because of the delays inherent within the court system.

While PI and D&O claims are likely to continue to hold the largest share, we believe that cyber claims will grow at a fast pace in the coming years. We say this specifically in light of the enactment of the General Data Protection Regulation, the ramifications of which are yet to be seen. Another area of interest is EPL, where previously claims were usually made in outside jurisdictions, but we have recently seen claims being made in India, with high-value settlements demanded.

IRELAND

*Sharon Daly, April McClements and Laura Pelly*¹

I OVERVIEW

Ireland is a common law jurisdiction, and the law governing insurance disputes is derived from statute and case law. There has been a divergence between Irish and UK insurance law in many areas since the implementation of the UK Insurance Act 2015. The Consumer Insurance Contracts Bill 2017 (the 2017 Bill) contains proposals that, if enacted, will re-align Irish and UK insurance legislation in a number of areas including warranties and the pre-contractual duty of good faith, however. At the time of writing, the 2017 Bill is at the third stage of review before the Irish Parliament and there is no clear timeline for its implementation, with a recent report from the Department of Finance noting that while the 2017 Bill's progression is in the interests of consumers, it would benefit from further stakeholder consultation and a cost–benefit analysis prior to its progression.²

Litigation is still the most consistent avenue for pursuing insurance disputes in Ireland, but in recent years there has been an increase in the use of alternative dispute resolution mechanisms such as mediation and arbitration. This is reflected by the introduction of the Mediation Act 2017, which requires solicitors to advise their clients of the availability of mediation and entitles courts to stay proceedings to encourage the parties to mediate.

In recent years there has been an increase in insurance regulation and consumer protection measures as reflected in the introduction of the Consumer Protection Code 2012, the Financial Services and Pensions Ombudsman Act 2018, and the implementation of the Insurance Distribution Directive in October 2018.

There is also an increased use of technology in the insurance industry, as well as by insureds, which presents opportunities and challenges for insurers and insureds. In the next year, we expect to see a continued increase both in Irish companies either taking out cyber cover or increasing the limits of their existing cover, and in related coverage disputes. Cloud computing is gaining prominence within the insurance sector and increasing talent and infrastructure in this area will continue to be a key focus until the end of 2019 and beyond. In the next few years, as reliance on data from connected devices increases in the insurance sector's decision-making processes, we anticipate litigation from insureds challenging the claims decisions made by automated claims-processing systems. Litigation is also expected to increase regarding the interpretation of specific articles of the General Data Protection Regulation, and in particular, those that confer rights on individuals in relation to automated decision-making and claims for non-material loss.

1 Sharon Daly and April McClements are partners, and Laura Pelly is a senior associate at Matheson.

2 Department of Finance – Public Consultation on Consumer Insurance Contracts Bill 2017, April 2019.

The Insurance (Amendment) Act 2018, which came into force in July 2018, amends and extends the law in Ireland relating to insolvent insurers.

As the likelihood of a ‘no-deal’ or ‘hard’ Brexit mounts, it is anticipated that the amount of insurance activity in Ireland will continue to rise. It is of particular note that although the lack of clarity in respect of the UK’s position post-Brexit has in the short term inhibited insurance mergers and acquisitions activity in the first half of 2019, we expect the contemplated transactions that have been put on hold will take place in the final quarter of 2019 and into 2020 as the post-Brexit economic position becomes clearer.

II THE LEGAL FRAMEWORK

i Sources of insurance law and regulation

Common law

Ireland is a common law jurisdiction, and the law in relation to insurance disputes is primarily governed by common law principles, the origins of which can be found in case law.

Statute

The Marine Insurance Act 1906 remains the most recent codification of the general principles of insurance law applicable in Ireland. There is no Irish equivalent of the UK Insurance Act 2015, and since its introduction there has been a divergence between the United Kingdom and Ireland in certain areas. Although, the 2017 Bill seeks to make a number of reforms to the area of consumer insurance law (discussed below), which are in line with the UK Insurance Act 2015, it remains to be seen whether this Bill will be enacted in its current form.

In general terms, insurers retain significant freedom of contract; however, this has been curtailed in recent years by Ireland’s enactment of legislation to comply with EU law. In particular, consumer protection law has undergone a number of changes as a result of the Unfair Terms in Consumer Contracts Directive 1993/13/EC and the Distance Marketing of Financial Services Directive 2002/65/EC.

Insurers must take care to comply with the Central Bank of Ireland Consumer Protection Code 2012 (CPC2012) and the Consumer Protection Act 2007 when dealing with a consumer. The term ‘consumer’ is defined quite broadly under CPC2012, as including individuals and small businesses with a turnover of less than €3 million (provided that these persons are not a member of a group having a combined turnover greater than €3 million). Insurers must also ensure that insurance contracts are compliant with the terms of the Sale of Goods and Supply of Services Act 1980.

A number of forms of insurance are compulsory under statute in Ireland, including third-party motor insurance, professional indemnity cover for insurance and reinsurance intermediaries, and professional indemnity cover for certain other professionals (e.g., lawyers and medical practitioners).

ii Key developments

Apart from the changes to Irish law to transpose EU legislation, there have been very few legislative amendments in insurance law in the past year. The most relevant amendments are set out below.

The EU (Insurance Distribution) Regulations 2018

The EU (Insurance Distribution) Regulations 2018 (the IDD Regulations) became law on 27 June 2018, transposing the EU Insurance Distribution Directive (IDD).³ The implementation of the IDD Regulations was postponed until 1 October 2018 to provide the insurance industry with additional time to put in place the necessary organisational and technical changes required to ensure compliance. Most recently, the EU (Insurance Distribution) (Amendment) Regulations 2018 were introduced, which made minor amendments to the IDD Regulations.

The IDD regulations introduced a number of key changes and concepts in respect of insurance distribution. For example, under the IDD regulations, undertakings and insurance intermediaries (but not ancillary intermediaries) must provide an assessment of suitability when providing advice on certain offerings. They must carry out an appropriateness assessment relating to sales where no advice is given, such as for execution-only sales.

Additionally, the the IDD introduces the requirement to prepare and provide customers with an insurance product information document (IPID). Insurance distributors must, prior to the conclusion of a contract, and irrespective of whether any advice is given and whether the product forms part of a package, provide relevant information about the product in a comprehensive form, aiming to facilitate consumers in making informed decisions about which product is most suitable for them. The European Commission has prescribed detailed requirements relating to the content, design, structure and format of the IPID.

The Central Bank (Amendment) Bill 2019

In June 2019, the Department of Finance received government approval to draft the heads of the Central Bank (Amendment) Bill 2019 (the 2019 Bill) for the proposed Senior Executive Accountability Regime (SEAR). It is proposed that SEAR will be applied to a subset of regulated entities, such as insurance undertakings, where role-related 'prescribed mandatory responsibilities', to be set out by the Central Bank of Ireland (CBI), will be attached to certain executive roles within an organisation. This will be a risk-based approach, effectively making certain key executives responsible for certain risks within the organisation. The purpose of this approach is to make individual executives more accountable for their responsibilities. To achieve the desired effect of the 2019 Bill, each individual carrying out a function whereby they would be responsible for a relevant risk identified by the CBI will be required to complete a 'statement of responsibilities', which clearly sets out the role they are undertaking and their responsibilities within this role. It is expected that the draft heads of the 2019 Bill will be published in the fourth quarter of 2019 and that the Bill will be drafted in close consultation with the Attorney General, before a public consultation process is carried out on the new regime.

The Judicial Council Act 2019

The Judicial Council Act 2019 (the 2019 Act) was signed into law on 23 July 2019, but is yet to commence. The 2019 Act provides for the establishment of the Judicial Council, which will be a body comprised of the entire Irish judiciary, regardless of the court in which they sit. The Council will be responsible for the establishment of the Personal Injuries Guidelines Committee (PIGC), which will carry out certain of the Council's functions. The Council's functions (primarily acting through the PIGC) will be to progress and periodically review

3 Directive (EU) 2016/97 of the European Parliament and of the Council of 20 January 2016 on insurance distribution (recast).

guidelines for assessing general damages for personal injuries, to provide education for the judiciary, to review sentencing guidelines and promote public confidence in the judiciary, as well as other matters. The PIGC may also offer guidance on matters such as the range of damages to be considered for a personal injury. The establishment of the PIGC and its carrying out of its functions aim to address the elevated levels of damages awarded in personal injuries cases before the Irish courts in comparison with those in other jurisdictions, an issue that has received significant media attention, particularly in the context of the impact these damages have on insurance premiums in Ireland.

The proposed directive on representative actions for the protection of collective interests of consumers

On 26 March 2019, the European Parliament approved an amended version of the European Commission's proposal for a directive on representative actions for the protection of collective interests of consumers. This amended version aims to address concerns with the original text identified by the European Parliament, including protecting against frivolous litigation and avoiding overlapping claims. The proposed directive will become law once the Council and the European Parliament reach an agreement on the European Commission's proposal.

Should the Council and the European Parliament reach agreement, the directive will require Member States to implement collective redress mechanisms for violations of specifically designated parts of EU consumer protection law. The draft directive aims to enable qualified representative entities protecting the interests of consumer groups to initiate legal action to obtain a remedy (including monetary compensation) for an infringement of EU consumer protection laws by traders, including insurers.

The draft directive, if enacted, will fundamentally change the landscape of enforcement of European consumer protection law. It is worth noting that several Member States already allow for certain collective redress mechanisms, whereas this is not currently the case in Ireland.

The 2017 Bill

The 2017 Bill seeks to make a number of reforms in the area of consumer insurance law. The 2017 Bill is based on recommendations contained in a report by the Law Reform Commission in its report of Consumer Insurance Contracts 2015. The proposed legislation changes are similar to those enacted in the UK Insurance Act 2015.

The 2017 Bill will apply to consumer insurance contracts only. One of the most significant reforms contained in the 2017 Bill is the recommendation that the existing pre-contractual duty of good faith be abolished and replaced with a statutory duty to answer carefully and honestly specific questions posed by an insurer that identify the material risks and relevant information actually relied on by the insurer.

The 2017 Bill also proposes the abolition of the concept of warranties in insurance contracts and their replacement with suspensive conditions, that is, on breach of the condition, the insurer's liability is suspended for the duration of the breach, but if the breach has been remedied by the time that a loss has occurred, the insurer must (in the absence of any other disclosure) pay any claim made.

Finally, the 2017 Bill introduces proportionate remedies where a consumer's non-disclosure, misrepresentation or other breach of contract is innocent or a result of negligence and will allow the insured to claim damages for late payment of claims by insurers.

As stated above, there is currently no clear timeline for implementation of the Bill.

iii Applicable legal principles

Essential elements of an insurance contract

Irish insurance contracts are governed by common law, contract law and the principle of utmost good faith. There is no statutory definition of an insurance contract in Irish law, and legislation does not specify the essential legal elements of an insurance contract. The courts have considered it on a case-by-case basis, and the common law definition of an insurance contract is of persuasive authority in Ireland (as set out in *Prudential Assurance v. Inland Revenue*).⁴

The leading Irish case of *International Commercial Bank plc v. Insurance Corporation of Ireland plc*⁵ sets out the main characteristics of an insurance contract, which are as follows:

- a the insured must have an insurable interest in the subject matter of the insurance policy;
- b there must be payment of a premium;
- c in the event of the occurrence of the insured risk, the insurer undertakes to pay the insured party;
- d the risk must be clearly specified;
- e the insurer will indemnify the insured against any actual loss; and
- f the principle of subrogation applies, where appropriate.

Insurable interest

One of the most recognisable aspects of insurance law is the concept of insurable interest. The seminal case of *Lucena v. Crauford*⁶ held that an insurable interest was a 'right in the property, or a right derivable out of some contract about the property which in either case may be lost upon some contingency affecting the possession or enjoyment of the property'. While this definition has been widened in recent years,⁷ this remains the basic definition. Under Irish law, there is no fixed definition of insurable interest; however, generally speaking, it is accepted that the 'insured must have a relationship of proximity to the risk and must also have an economic interest'.⁸ This means that if a policyholder has no such insurable interest, then there is no loss for an insurer to indemnify. The Marine Insurance Act only addresses insurable interest in relation to marine insurance. The Life Assurance Act 1774, which was applied to Ireland by the Life Insurance (Ireland) Act 1866, brought the necessity of insurable interest into life assurance policies.

In the United Kingdom there has been much debate surrounding the ever-changing nature of insurable interest, especially between the 'legal interest' test and the wider 'factual expectation' test. In *PJ Carrigan Ltd and Carrigan v. Norwich Union Fire Society Ltd*,⁹ the Irish High Court expressed its preference for the wider 'factual expectation' test. Almost identically to UK law, Irish insurance law has posited that any insurance contract that resembles a wager or gambling is contrary to public policy and should therefore be illegal.

4 [1904] 2 KB 658.

5 [1991] ILRM 726.

6 (1808) 127 E.R. 858

7 *Sharp and Roarer Investments Ltd v. Sphere Drake Insurance (The Moonacre)* [1992] 2 Lloyd's Rep. 501, *National Oilwell (UK) Ltd v. Davy Offshore Ltd* [1993] 2 Lloyd's Rep 582 and *Deepak Fertilisers & Petrochemicals Corp Ltd v. Davy McKee (London) Ltd* [1999] 1 All E.R. (Comm.) 69.

8 Commercial Law Practitioner 1996, 3(4), 98-101.

9 [1987] IR 618.

It is worth noting that Section 5 of the Consumer Insurance Contracts Bill 2017 (which is still draft legislation) provides that an insurer cannot reject an insurance contract with a consumer that would otherwise be valid on the grounds that the insured does not have an insurable interest.

Subrogation

Insurers are entitled to bring subrogated claims on behalf of their insured in cases where the insurer has paid out fully on a claim and seeks to claim these costs back from the true wrongdoer.

Utmost good faith, disclosure and representations

Parties to Irish insurance contracts are subject to a duty of utmost good faith, which imposes a duty on the insured to disclose all material facts before inception or renewal.¹⁰ A material fact is one that would influence the judgment of a prudent underwriter in deciding whether to underwrite the contract, or the terms on which it might do so (e.g., the premium).

The duty goes beyond a duty to answer questions on a proposal form correctly; however, the Irish courts have determined the questions on the proposal form will inform the duty. The remedy for breach is avoidance.

Misrepresentation is closely related, and attracts the same remedy. Misrepresentations can be fraudulent, reckless or innocent. The common law position is that a misrepresentation is fraudulent if it is made with knowledge of its falsity, without belief it was true, or with reckless disregard as to whether it was true or false.

In practice, many Irish insurance policies contain ‘innocent non-disclosure’ clauses that prevent the insurer from avoiding the policy on the basis of innocent non-disclosure or innocent misrepresentation.

The 2017 Bill proposes replacing the duty of disclosure with a duty to answer specific questions honestly and with reasonable care. There would then be no duty to provide additional information on renewal unless specifically requested by the insurer.

The 2017 Bill proposes that for innocent or negligent non-disclosure or misrepresentation, the principal remedy should be to adjust the payment of the claim taking account of the carelessness of the insured and whether the breach in question affected the risk. The Bill retains avoidance as a remedy for fraudulent breaches on public policy grounds.

iv Fora and dispute resolution mechanisms

Jurisdiction

In Ireland, the jurisdiction in which court proceedings are brought will depend on the monetary value of the claim. The District Court deals with claims up to a monetary value of €15,000, the Circuit Court deals with claims with a monetary value up to €75,000 (€60,000 for personal injury cases) and claims in excess of this are heard by the High Court. The High Court has an unlimited monetary jurisdiction.

The High Court also has a specialist division, the Commercial Court, that deals exclusively with commercial disputes. Insurance and reinsurance disputes can be heard in the

¹⁰ The Consumer Insurance Contracts Bill 2017 proposes to abolish the duty of utmost good faith.

Commercial Court if the monetary value of the claim or counterclaim exceeds €1 million and the Court considers that the dispute is inherently commercial in nature. Insurance disputes before the courts in Ireland are heard by a single judge and there is no jury.

Proceedings in the Commercial Court normally move at a much quicker pace as proceedings are case managed. Depending on the time required for the hearing, the length of time from entry to the Commercial Court list to hearing generally takes between one week and six months. Entry to the list is at the discretion of the judge and entry may be refused if there has been any delay. A strong emphasis is placed on alternative dispute resolution and the Commercial Court Rules provide for up to a four-week stay of proceedings to allow the parties to consider mediation.

A new court of appeal was established in 2014 to deal with appeals from the High Court. The court of appeal hears appeals from the High Court except when the Supreme Court believes a case is of such public importance that it should go directly to the highest court in the state.

Alternative dispute resolution

Insurance disputes may also be dealt with by way of alternative dispute resolution (ADR) and it is common for insurance contracts to require disputes to be determined by ADR. Mediation and arbitration are the most common forms of ADR used in Ireland.

Mediation

Since 1 January 2018, the Mediation Act 2017 has required solicitors in Ireland to advise their clients of the merits of mediation as an ADR mechanism before issuing proceedings in court. The Mediation Act also requires the solicitor to swear a statutory declaration confirming that they have advised their clients on the benefits of mediation. This declaration is in turn filed with the originating document in the relevant court office.

Following the introduction of the Mediation Act, any court may adjourn legal proceedings on application by either party or of its own initiative, to allow the parties to engage in mediation. Failure by either party to engage in ADR following such a direction can result in the party being penalised in relation to costs.

Arbitration

In Ireland, the law on arbitration is codified in the Arbitration Act 2010 (the 2010 Act), which incorporates the UNCITRAL Model Law on International Commercial Arbitration. The arbitrator's decision is binding on the parties and there is no means of appeal. Where parties have entered into a valid arbitration agreement the courts are obliged to stay proceedings. Ireland is a party to the New York Convention on the Recognition and Enforcement of Foreign Arbitral Awards 1958, allowing Irish arbitral awards to be enforced in any of the 157 countries party to the Convention.

Any dispute that arises under any insurance or reinsurance contract that contains an arbitration clause must be referred for arbitration. However, there is an exception for consumers, who are not bound by an arbitration clause in an insurance policy where the claim is less than €5,000 and the relevant policy has not been individually negotiated.

The High Court has powers to grant interim measures of protection and assistance in the taking of evidence, though most interim measures may now also be granted by the arbitral tribunal under the 2010 Act. Once an arbitrator is appointed and the parties agree to refer their dispute for the arbitrator's decision, then the jurisdiction for the dispute effectively passes from the court to the arbitrator.

While an arbitral award can be set aside by the court under Article 34 of the 2010 Act, the grounds on which this can be done are extremely limited, and the party will need to furnish proof that:

- a* a party to the arbitration agreement was under some incapacity or the agreement itself was invalid;
- b* the party making the application was not given proper notice of the appointment of the arbitrator or the arbitral proceedings or was otherwise unable to present his or her case;
- c* the award deals with a dispute not falling within the ambit of the arbitration agreement;
- d* the arbitral tribunal was not properly constituted; or
- e* the award is in conflict with the public policy of the state.

While arbitration will incur additional costs, such as the arbitrator's fees and venue hire, it has the benefit of confidentiality, which may be attractive to the parties to the dispute.

The Financial Services and Pensions Ombudsman

The Financial Services and Pensions Ombudsman (FSPO) is the amalgamation of the Financial Services Ombudsman and the Pensions Ombudsman, pursuant to the Financial Services and Ombudsman Act 2017. The FSPO is an independent body established for the purposes of resolving disputes between consumers and financial services or pensions providers (including insurers and brokers) either informally through mediation or by way of formal investigation. The FSPO's decisions are legally binding, with a right of appeal to the High Court. If a complaint is upheld, the FSPO can direct the provider to pay compensation of up to €500,000 to the consumer or may direct the provider to rectify or correct the issue. Decisions are published on the FSPO's website on an anonymous basis. The FSPO's 'Overview of Complaints 2018' highlights that some 1,843 complaints received by the FSPO in 2018 related to the insurance sector, the second highest number by sector. Exercising its powers under the Financial Services and Ombudsman Act 2017, the FSPO published 228 binding decisions it had issued during 2018. In respect of the insurance sector, these decisions related to a wide variety of matters and products, including administration of a whole life policy, processing of a motor insurance claim, mobile phone insurance claims and claims relating to automatic renewal of travel insurance.

III RECENT CASES

i Insured's obligation to provide material information on standard forms

In *Kirby v. Friends First Life Assurance Company Limited*,¹¹ a case concerning non-disclosure of material facts in the context of an income protection policy, the High Court rejected the argument that the shortness of the application form relieved the insured of the obligation to provide material information and found that the defendant insurance company was entitled to repudiate the policy because the plaintiff had failed to furnish information concerning his medical history.

The High Court considered that from a practical viewpoint, an applicant could provide an additional sheet containing the relevant details or indicate that there are additional details that could be provided upon request. In assessing whether there was, from an

11 [2018] IEHC 786.

objective viewpoint, a non-disclosure of material information, the Court confirmed that the appropriate test was whether the information would have reasonably affected the mind of a prudent insurer in determining whether it would accept the insurance risk and if so, on what conditions. The Court ruled that there was a material non-disclosure that did not fall within any of the exceptional situations referred to in relevant authorities and therefore found in favour of the defendant.

ii The cost of coming off record where cover is declined

*Levingstone v. O'Leary & Ors*¹² involved an application by a firm of solicitors seeking liberty to come off record for a defendant where its insurers had repudiated cover and the solicitors were instructed by the insurers. Cover was declined in 2018 on the basis of breach of a claims cooperation condition that was a condition precedent to cover and for which the solicitors had repeatedly sought unsuccessfully to engage with the insured on the defence since 2012.

The High Court noted the generally accepted view of the courts that they should not place a solicitor and client into a 'forced form of liaison'. While the Court allowed the firm of solicitors to come off record, the Court found that it should not have taken close to six years for the insurance company to deny coverage, and that this amounted to an excessive delay on the part of the insurer. Consequently the Court directed the insurer to pay the costs of the application and also the costs incurred by the plaintiff after a certain date (linked to the delay the Court determined as excessive) in processing the firm of solicitors' claim against Mr O'Leary.

IV THE INTERNATIONAL ARENA

i Jurisdiction

Choice of forum, venue and applicable law clauses in an insurance contract are generally recognised and enforced. However, where the insured resides in an EU Member State, the Brussels I Regulation, Recast Brussels Regulation and Rome I Regulation may limit the application of these clauses.

ii Recognition and enforcement procedures

For judgments that fall under the Brussels I Regulation and the Lugano Convention, it is relatively straightforward to secure recognition and enforcement of foreign judgments, provided that the judgment is not within the recognised grounds for refusal.

For judgments to be enforced at common law (i.e., not one subject to the Brussels Regime or the Lugano Convention), the courts have discretion whether to recognise such a foreign judgment. However, as a general principle, and on the basis of respect and comity between international courts, the approach of the Irish courts to proceedings seeking recognition and enforcement is generally positive, provided the judgment is for a definite sum, is final and conclusive, and has been given by a court of competent jurisdiction (albeit there are other criteria, by reference to which recognition and enforcement may be challenged).

12 [2019] IEHC 550

V TRENDS AND OUTLOOK

i Brexit

It is not possible to comment on trends and the outlook for 2020 without mentioning Brexit. The triggering of Article 50 by the UK government confirmed that the United Kingdom will leave the European Union. It was intended that this exit would take place in March 2019; however, following an extension to the original time frame, it is now due to take place in October 2019. Because of the continued uncertainty surrounding the United Kingdom's trading conditions with the EU post-Brexit, a number of financial services companies are establishing subsidiaries or even headquarters in one of the remaining 27 EU Member States. Loss of access to the single market or EU passporting rights would be highly undesirable for these companies. Ireland, with its well-known prudential regulation, highly educated English-speaking workforce, common law jurisdiction (with a fast-track Commercial Court) and its proximity to the United Kingdom is regarded as somewhat of a hub for the insurance industry. As the likelihood of a 'no-deal' or 'hard' Brexit mounts, it is anticipated that the amount of insurance work passing through this jurisdiction will continue to rise.

It is of significant relevance for UK firms and branches of UK entities considering re-establishing themselves in Ireland in anticipation of Brexit that authorisation and ongoing supervision of such entities (and certain of their key executives) will be carried out by the CBI. Where such entities are seeking to establish themselves in Ireland, they must comply with, inter alia, the Corporate Governance Requirements for Insurance Undertakings 2015, the Corporate Governance Requirements for Captive Insurance and Reinsurance Undertakings 2015, the Consumer Protection Code 2012 and the Minimum Competency Code 2012.

ii Cyber, General Data Protection Regulation and related data issues

The introduction of the General Data Protection Regulation (GDPR), which came into force on 25 May 2018, has raised data protection to a board-level issue, as companies now face potentially vast fines in the event of an infringement of the GDPR. This level of focus has also led to an increase in the take-up of cyber insurance policies and it is anticipated that this market will continue to grow. Data protection and processing in Ireland is governed primarily by the Data Protection Acts 1988 to 2018, the GDPR (which has enhanced data subject rights and transparency, provided for greater penalties for breach of relevant obligations, and extraterritorial effect in certain circumstances) and by guidance issued by the Irish Data Protection Commission (DPC).

The administrative penalties regime provided for by the GDPR allows for the imposition of very significant fines and, given the large global turnover of entities falling within the DPC's remit, it is only a matter of time before large fines are imposed by the DPC. Certain insurance policies exclude fines and penalties from cover, but other policies cover fines and penalties imposed 'to the extent insurable by law'. The 2018 Act is silent on this point and the question of whether GDPR fines are insurable in Ireland remains uncertain. The GDPR provides that fines must be effective and proportionate, as well as dissuasive (i.e., designed to 'dissuade' companies from infringing their data protection obligations). The doctrine of *ex turpi causa* prevents a claimant from pursuing legal remedies to recover or benefit from their own illegal acts. Public policy would be undermined if one could simply take out insurance against the imposition of all fines intended to be dissuasive and to act as a deterrent against breaching one's legal obligations. Recent English case law on this doctrine suggests that some level of

moral turpitude is required and consequently there could be a sliding scale of insurability, with criminal or quasi-criminal fines likely to be uninsurable. The issue of insurability will be an important one to be considered by the Irish courts in the future.

Article 82(1) of the GDPR also provides a new remedy for a person who has suffered material or non-material damage as a result of an infringement of the GDPR, including a right to compensation, and it can be expected there will be an increase in claims for non-material damage in the future.

iii Warranty and indemnity insurance

Warranty and indemnity insurance protects against losses incurred as a result of a breach of warranties or indemnities and is becoming increasingly popular as a risk transfer mechanism in merger and acquisition transactions. These bespoke policies can be designed to indemnify either the seller or buyer, depending on who seeks to benefit from the policy, but buy-side policies tend to be more common, providing protection for the buyer and facilitating a seller's desire for a clean exit. We anticipate continued growth in this area in 2020.

ITALY

*Andrea Atteritano*¹

I OVERVIEW

The field of insurance contracts is extensively regulated in Italy, especially as a result of provisions enacted at the EU level. The same complexity is reflected in litigation, with a high number of cases brought before Italian courts each year. Disputes cover not only traditional topics related to civil liability and damage compensation, but also claims for nullity of finance-related insurance products (such as unit- and index-linked policies) because of their alleged lack of compliance with the Italian Consolidated Financial Act, and claims for mis-selling and incorrect management of underlying assets and personal funds.

Contrary to other specific areas of dispute resolution – such as private enforcement, intellectual property and corporate litigation, which are subject to the jurisdiction of specialised courts or divisions – insurance disputes can be brought to the attention of any Italian court, provided that the general criteria on jurisdiction are fulfilled. Usually the place where the insured is domiciled will determine the local court's jurisdiction, so virtually every court in Italy decides on insurance disputes. For this reason, and also taking into account that the *stare decisis* rule does not apply in Italy, court decisions over insurance claims may vary significantly, offering quite a diversified picture in Italian case law, especially in the absence of clear leading cases rendered by the Supreme Court.

II THE LEGAL FRAMEWORK

i Sources of insurance law and regulation

The most significant sets of provisions governing insurance contracts in Italy are:

- a* the Italian Civil Code (ICC),² which establishes under Article 1882 ff. the general rules on contracts and obligations, as well as the specific rules governing insurance contracts;
- b* the Insurance Code,³ which provides the general legal framework concerning insurance companies, intermediaries and brokers; and

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2 Royal Decree No. 262 of 16 March 1942.

3 Legislative Decree No. 209 of 7 September 2005, published in the Official Journal (OJ) on 13 October 2005.

- c* the Consolidated Financial Act (TUF)⁴ and the regulations of the Italian securities market regulatory authority, CONSOB, which govern the pre-contractual requirements to be met by the intermediaries' distribution network when selling insurance-investment products (such as unit- and index-linked life insurance policies).

Additional relevant provisions derive from the regulations issued by the Italian Insurance Market Regulatory Authority (IVASS), which establishes (1) specific rules regarding each type of insurance contract or some of their specific aspects; (2) transparency and disclosure requirements to be met in the pre-contractual phase of the conclusion of the insurance contract; and (3) post-sale requirements.

The Consumer Code⁵ is also part of the relevant legal framework if the policyholder qualifies as a consumer, and particularly in relation to contracts concluded at a distance or on unfair terms.

Finally, the national legal framework is integrated by various EU provisions related to insurance undertakings.

As to recent developments in the national legislative framework, the following items are worth mentioning:

- a* Legislative Decree No. 68/2018,⁶ IVASS Regulations Nos. 39, 40 and 41⁷ of 2018 and CONSOB Regulation No. 20307/2018,⁸ which implemented the EU Insurance Distribution Directive (IDD),⁹ also amending the Insurance Code and the Consumer Code. These provisions establish additional rules for intermediaries with particular reference to pre-contractual disclosure requirements and conduct rules, aimed at safeguarding the interests of policyholders.
- b* Law No. 124/2017,¹⁰ which provides, inter alia, for new rules concerning competition in the insurance market and uniform criteria for determining the value of non-economic damages. In addition, it establishes that insurance companies will be compelled to offer discounts to customers in the field of motor insurance under certain conditions (vehicles third-party insurance is compulsory in Italy).
- c* Law No. 24/2017 (the Gelli-Bianco Law),¹¹ which introduces the obligation upon healthcare facilities to conclude a third-party civil liability policy and establishes specific procedures related to damage claims (see Section V).

ii Insurable risk

As a general rule, under Italian law, insurance contracts cannot cover risks connected to illicit events. For example, insurance contracts do not cover:

- a* events caused by fraud or gross negligence of the insured;
- b* the risk connected to the payment of a ransom in cases of kidnapping;

4 Legislative Decree No. 58 of 24 February 1998, published in the OJ on 26 March 1998.

5 Legislative Decree No. 206 of 6 September 2005, published in the OJ on 8 October 2005.

6 Legislative Decree No. 68 of 21 May 2018, published in the OJ on 16 June 2018.

7 Published by IVASS on 2 August 2018.

8 Published by CONSOB on 15 February 2018.

9 Directive (EU) 2016/97 of the European Parliament and of the Council of 20 January 2016 on insurance distribution, published on EU OJ on 2 February 2016 (L 26/19) (IDD).

10 Law No. 124 of 4 August 2017, published in the OJ on 14 August 2017.

11 Law No. 24 of 8 March 2017, published in the OJ on 17 March 2017.

- c* administrative fines;
- d* the risk of temporary driving disqualification or suspension of a driving licence; and
- e* damage caused to the public administration by public officials.

All other risks are, in general terms, insurable, provided that there is an interest upon the contracting party to insure the specific asset or event.

In particular, with reference to the concept of ‘insurable interest’, Article 1904 ICC establishes that a non-life insurance agreement is invalid if the policyholder does not have an interest in the compensation of the damage. Moreover, if the interest never existed or if it ceased to exist before the conclusion of the contract, the latter is null and void. When the interest ceases to exist after the conclusion of the contract, then the policy is considered terminated. This provision is grounded on the fact that the existence of an interest is considered a fundamental element of the agreement under Italian contract law.

As a consequence, it is generally not possible to insure the assets of another subject against damages. However, interest is not necessarily connected to an ownership right, it being sufficient that a relevant relationship is in place between the insured person and the insured object (e.g., the Italian Supreme Court considers a house ‘fire-insurable’ by tenants, who bear the responsibility if the damaging event occurs).

Policyholders are free to insure their risks also with foreign companies, which must nevertheless comply with certain requirements. EU insurance companies can carry out their activities without having their registered office in Italy, under the approval of their home-country regulatory authority. Additional fulfilments might be required, depending on the type of insurance contract.

The nationality of the insurance company might impact the law applicable to some aspects concerning the merit of the dispute, as well as the enforcement of a possible negative judgment. With regard to finance-related products, for instance, the principle of home country control could lead to the application of the law of the country of the insurer for issues regarding the composition of the fund underlying the policy; moreover, if the insurer has no assets in Italy, the enforcement shall be started abroad, in accordance with the relevant rules of the selected forum.

The involvement of a foreign insurance company in an Italian litigation also implies some minor changes in terms of procedural rules, particularly aimed at granting a full right of defence to the party involved. The translation of the policyholders’ writ of summons in a language known to the insurer might be requested under certain conditions, as well as the Italian translation of documents filed by the insurer in another language. In addition, foreign entities are granted with a longer minimum term of appearance.

iii Fora and dispute resolution mechanisms

In Italy there is no specific court dealing with insurance disputes, and these tend to be decided predominantly by civil courts. When a policy is entered into with a consumer, the competent court is the one of the place of residence or domicile of the insured (although alternative criteria for jurisdiction may apply at the plaintiff’s discretion).

As regards international disputes, the jurisdiction of the Italian courts is established pursuant to the Brussels Regulation¹² and thus Italian ordinary courts may have jurisdiction depending on the cross-border elements contained in the insurance contract (e.g., if the policyholder resides in Italy).

As to the procedural rules generally applicable to all insurance-related disputes (i.e., also for foreign insurance companies), the plaintiff shall start compulsory mediation proceedings before initiating full legal proceedings in court; this constitutes a prerequisite for action. A court claim could therefore be lodged only if the mediation proceedings proved to be unsuccessful, as may be the case if the defendant does not attend mediation or the parties do not reach an agreement.

Italian law also provides for some alternative dispute resolution mechanisms, which are summarised below.

For disputes regarding compliance by the insurer or its financial intermediaries (e.g., banks, investment companies and other financial intermediaries) with the provisions of the Consolidated Financial Act (and relevant implementing regulations on distribution of insurance investment policies), claimants may refer the matter to the Arbitrator for Financial Disputes (ACF), established by CONSOB.

Arbitration clauses, on the other hand, are not common in insurance contracts with consumers and must be specifically negotiated and approved in writing if proposed by the insurer. Furthermore, for certain types of coverage (e.g., accidents and health insurance), IVASS provides specific requirements as to the seat of the arbitration.

Arbitration clauses are commonly used when insurance contracts are entered into with being decided by an arbitrator (or a panel of arbitrators) once it has already arisen.

This scenario is subject to further developments in the future, as a Ministry Decree is soon expected to set up a further alternative dispute resolution mechanism (as established under the recently introduced Article 187 *ter* of the Insurance Code), which is likely to follow the ACF model of specialised arbitral tribunals.

This would represent a voluntary venue for dispute resolution and would therefore be more accessible, even for individuals and small companies.

III RECENT CASES

Like insurance contracts in general, insurance disputes can be classified into litigation focused on life insurance policies and third-party policies. Recent insurance law hot topics for Italian courts are indicated below based on the same classification.

i Life insurance

With regard to life insurance policies, one of the main issues concerns the nature and validity of unit- and index-linked policies.

Despite the clear approach of the European Court of Justice (ECJ) – which has repeatedly stressed the insurance nature of these kinds of products – the debate in Italy is still open, in part because of the case-by-case approach preferred by the Italian Supreme Court, whereby unit- and index-linked policies may be classified as insurance products only

12 Regulation (EU) No. 1215/2012 of the European Parliament and of the Council of 12 December 2012 on jurisdiction, and the recognition and enforcement of judgments in civil and commercial matters (the Brussels Regulation).

if the demographic risk undertaken by the insurer prevails over the financial risk borne by the policyholder. On this basis, and in very general terms, Italian judges tend to requalify unit- and index-linked policies as financial products, especially when policyholders' invested premiums are not granted.

The issue of the qualification of these products is particularly relevant, as it results in the application of rules (those of the TUF) that are different from those the insurance companies and intermediaries had in mind when distributing the policies (i.e., the provisions of the Insurance Code), thus exposing them to the risk of a negative outcome in the event of disputes. A law was passed with the aim of solving this problem, including unit- and index-linked products in the TUF,¹³ but the results were not satisfactory. The application of TUF provisions to those products was only partial, and therefore the requalification led to the application of also some other TUF provisions that were not provided for in the law.

The legal framework therefore became confused, and this uncertainty (which the legislature intends to eliminate with the implementation of the IDD) clearly impacted the different approaches of the Italian courts. Investors who lost (or partially lost) invested premiums generally raised several different claims to be reimbursed for their losses.

A first common claim is the request to terminate the policies (or to award the insured damages) for breach of informative duties, related to both the conclusion of the policies and the contractual relationship.

On this point, the Court of Appeal of Milan found that when all the risk related to the investment is borne by the insured, the policy has a financial nature.¹⁴ Accordingly, the information duties provided by the TUF and relevant regulatory provisions should apply, under penalty of damage compensation, rather than repayment of the invested premium and nullity of the policy. On this basis, the Court of Milan ordered the insurance company, which sold the products directly to the insured, to pay damage compensation. The decision is in line with the case law precedents of the Joint Divisions of the Supreme Court, which established that the breach of information duties does not result in the nullity of policy, but rather in the obligation to pay damages.¹⁵

The grounds on which the claim is brought are particularly significant since, in the event of repayment of the invested premium as a result of nullity of the policy, the obligation to repay would in principle lie with the insurer. In contrast, liability for damages would in principle lie with the subject dealing with the distribution of the products, which might be either the insurer or a third party (intermediaries or brokers). Furthermore, claims for repayment are subject to a 10-year limitation period, while a five-year limitation period applies to claims addressing pre-contractual liability (according to prevailing case law).

Another common request is to declare unit-linked policies null and void for being in breach of mandatory rules or without a written form (as required by Article 23 TUF).

In this context, in a decision of 20 October 2017,¹⁶ the Court of Treviso considered the lack of a framework agreement to lead to the nullity of the policy, for having been concluded

13 Law 28 December 2005 No. 262, which introduced Article 25 *bis* TUF with the purpose to extend the application of Articles 21 and 23 TUF to insurance financial products. The provision entered into force only on 1 July 2007 after CONSOB's implementing regulation was issued.

14 Court of Appeal of Milan, 11 May 2016.

15 Supreme Court, Joint Divisions, 19 December 2007, No. 26724; Supreme Court, Joint Divisions, 19 December 2007, No. 26725.

16 Court of Treviso, 20 October 2017.

in breach of Article 23 TUF. This Article provides that financial products have to be concluded together with a framework agreement, namely a written contract between the intermediary and the investor reporting all information on the future investments (this provision should no longer apply to unit-linked policies after the implementation of the IDD). In this case, the Court also ordered the insurance company to reimburse the paid premium. However, the topic is subject to debate as other courts have ruled (more reasonably in our view) that the framework agreement is not required if the policy contains all the relevant information stipulated in Article 23 TUF.¹⁷ Some others have taken the view that, even if the framework agreement is required, the lack of it would trigger a repayment obligation for the intermediary rather than for the insurer¹⁸ (unless, of course, the product has been directly distributed by the insurance company).

Other claims were grounded on the request to terminate the policies for breach of contractual provisions or annul them because they were issued without a proper consent (or resulting from misleading information provided at the moment of the conclusion of the policies).

With respect to the former claim, on 30 April 2018 the Supreme Court confirmed a decision of the Court of Appeal of Milan and declared the termination of the policy because of the inconsistency between the risk profile (and preferred investments) indicated in the proposal form by the policyholder and the assets linked to the policy eventually chosen by the insurance company.¹⁹ In particular, the Supreme Court applied the relevant provisions of the TUF and relevant secondary legislation, which stipulate precise informative duties to be carried out at the moment of the distribution of financial products, confirming a previous decision of 2012.²⁰ In its decision, the Supreme Court pointed out that in the case of unit-linked policies, the judge shall assess on a case-by-case basis whether they shall be considered insurance or financial products. In the latter case, the Court shall apply the relevant TUF provisions regarding the intermediary's information and conduct obligations.

On 5 March 2019, the Italian Supreme Court²¹ issued an important new judgment on unit-linked policies, setting out detailed and precise guidelines on assessing their nature. More specifically, the Supreme Court declared that unit-linked policies have mixed legal purposes (financial and life insurance) and that they may be considered as insurance contracts only if an effective transfer of the risk from the insured to the insurer is provided. The reference is to the 'demographic risk' in relation to which the judge shall assess the extent of the insurance coverage. This evaluation should be made taking into consideration (1) the premium paid by the policyholder, (2) the duration of the policy and (3) the type of investment. The policy at issue provided death cover equal to 0.1 per cent of the counter value of the units of the fund linked to the policy and the Supreme Court objected that this amount, compared to the premium amount paid by the policyholder, was not enough for the balance of the obligations of the parties under the contract. Moreover, the Supreme Court also declared that even if

17 Court of Parma, 13 February 2017, No. 233; Court of Mantova, 6 May 2016, No. 533; Court of Verona, 28 September 2016; Court of Rimini, 12 August 2016, No. 6,532.

18 Court of Salerno, 24 May 2016; Court of Bari, 3 March 2011, No. 801.

19 Supreme Court, 30 April 2018, No. 10,333.

20 Supreme Court, 18 April 2012, No. 6,061.

21 Supreme Court, 5 March 2019, No. 6319.

the financial purpose prevails, the life insurance purpose must in any event be compliant with the general principles set out by the Italian Civil Code, by the Insurance Code and by IVASS regulations.

It is also worth mentioning the recent judgment of the Court of Verona,²² clarifying that even where the unit-linked policy has a financial nature, the payments due to the insured from the insurer may not be subject to enforcement proceedings.

The issue of unit-linked policies was also discussed at the European Union level. On 31 May 2018, in line with its previous decision of March 2012,²³ the ECJ stated that unit-linked policies can be considered to fall within the concept of 'insurance contracts'.²⁴ Further, to be qualified as an insurance contract, it is sufficient that the agreement establishes the payment of a premium by the insured party in exchange for the supply of a service by the insurer in the event of the death of the insured party, or the occurrence of a different event specified in that contract. Accordingly, the ECJ found that EU Directive 2002/92 applied, which governs insurance mediation²⁵ rather than EU Directive 2004/39 on financial intermediation.²⁶

ii Third-party insurance

With regard to claims related to third-party insurance, one of the most debated issues recently concerned claims-made clauses, which was finally settled by a very recent decision of the Supreme Court.

These clauses are contained in third-party insurance policies and generally establish that the policy will cover only those damages for which the third party raises a claim during the period of validity of the policy. However, these clauses can be formulated in different ways and, for example, may also provide that the policy will cover only those cases in which both the damage and the claim occur within the period of validity of the policy.

The validity of insurance contracts containing claims-made clauses was subject to extensive scrutiny by Italian courts, which in some cases declared them null and void as vexatious under Article 1341 ICC. The courts considered that those clauses limited the liability of insurance companies, with a consequent need for the explicit written consent of the insured for the contracts to be valid.

In some other cases, the validity of the whole contract was challenged, as it would have allegedly constituted an agreement that was outside the scope of lawful atypical insurance contracts, thus being unenforceable under Italian law.

The Joint Divisions of the Supreme Court were therefore requested to issue a decision on the topic. The judgment was rendered in September 2018 and, while it rejected the alleged grounds of invalidity reported above, it substantially declared that the validity of claims-made clauses shall be assessed on a case-by-case basis.²⁷

22 Court of Verona, 17 April 2019. See also Supreme Court, Joint Divisions, 31 March 2008, No. 8271.

23 European Court of Justice, 1 March 2012, C-166/11.

24 European Court of Justice, 31 May 2018, C-542/16.

25 Directive 2002/92/EC of the European Parliament and of the Council of 9 December 2002 on insurance mediation, currently repealed by the IDD.

26 Directive 2004/39/EC of the European Parliament and of the Council of 21 April 2004 on markets in financial instruments, currently repealed by Directive 2014/65/EU of the European Parliament and of the Council of 15 May 2014 on markets in financial instruments.

27 Supreme Court, Joint Divisions, 24 September 2018, No. 22,437. 22437. In this context, see also more recently Court of Brescia, 2 May 2019.

In particular, the Court confirmed that insurance contracts containing claims-made clauses are not atypical, especially taking into consideration that recent laws expressly govern them. Moreover, such clauses cannot be considered vexatious, as they merely define the object of the contract and do not limit the liability of the insurance company. Accordingly, the potential invalidity of such clauses cannot generally be upheld and must be assessed depending on additional and specific elements, including the way they are formulated.

Finally, another topic worth mentioning is that of legal costs. In particular, insurance companies are usually joined in the proceedings to indemnify the insured, and the issue of the awarding and attribution of legal costs is usually debated. The Supreme Court, in a decision of 4 May 2018,²⁸ held that the indemnification should cover not only the legal costs that the losing party pays to the counterparty, but also the costs related to the legal assistance provided to the losing party, even if these exceed the agreed cap (within the limit of one-quarter of it, as provided under Article 1917 ICC).

IV THE INTERNATIONAL ARENA

i Jurisdiction

In the context of litigation involving international parties, the issue of jurisdiction is often raised. A recent case focused on this topic in the context of civil liability litigation, and in particular on the possibility of a damaged party suing in his or her own country the foreign insurance company of the counterparty. The Italian court applied EU Regulation No. 44/2001,²⁹ which establishes different alternative criteria for identifying the court that has jurisdiction to decide the case. In its reasoning, the judgment found that, as a general rule, an insurance company may be sued before a court of the state in which the company has its registered office, in which the event occurred or, alternatively, in the place in which the litigation has been commenced by the subject who suffered the damage, provided that the insured and the insurer can be summoned in the same proceedings. In addition to those general criteria, the court clarified that under Article 9 of Regulation No. 44/2001, the insurer may also be sued before the court of the state in which the claimant is domiciled if litigation is commenced by the insured, the beneficiary of the policy or the person who concluded the insurance contract. Following a case law precedent of the ECJ, the court concluded that pursuant to Article 11 of Regulation No. 44/2001 all the above-mentioned criteria apply also to litigation commenced by the person who suffered the damage, who can therefore directly bring an action against the insurance company of the counterparty if that is possible under the domestic law of the person who suffered the damage (which it is in Italy).

ii Representatives of foreign insurance companies

With reference to third-party insurance, and specifically on the point of standing, a topic recently addressed by both EU and Italian courts concerned the possibility of suing directly the claims representative of a foreign company. Pursuant to Article 1 of Directive 2000/26/CE,³⁰ every insurance company that issues its policies in foreign states has to appoint a claims

28 Supreme Court, 4 May 2018, No. 10,595.

29 Council Regulation (EC) No. 44/2001 of 22 December 2000 on jurisdiction and the recognition and enforcement of judgments in civil and commercial matters, currently repealed by the Brussels Regulation.

30 Directive 2000/26/EC of the European Parliament and of the Council of 16 May 2000 on the approximation of the laws of the Member States relating to insurance against civil liability in respect of the

representative in each Member State other than the one in which it has its registered office. The claims representative shall be responsible for handling and settling claims arising from the events referred to in Article 1. However, the Directive does not specify whether it is possible for the insured to sue the claims representative directly. On this point, the ECJ ruled that the representative is entitled to receive judicial notices on behalf of the company, but cannot stand trial on behalf of the company, as established by Article 18 of the Rome II Regulation (which considers the insurer as the only subject that can be sued directly).³¹ On the other hand, the Italian Supreme Court later issued a decision that, according to some scholars, would be at odds with that of the ECJ as it held that the plaintiff would be entitled to bring an action before the damaged person's national court also against the representative of the company.³²

iii Home country control

The topic of unit-linked policies is also often connected to the activity of international insurance companies in Italy. With particular reference to EU companies, one of the principles most often debated is that of 'home country control'.

In decisions rendered in 2016 and 2015, the Courts of Turin and Milan rejected policyholders' requests for the declaration of nullity of unit-linked policies, as these were linked to hedge funds not allowed under Italian law.³³ The decisions were grounded on the principle of home country control, according to which the investments linked to the policy are governed by the rules of the law of the country in which the insurance company has its registered office. This holds true even if the policies are governed by Italian law. In this context, it is also worth noting that this principle has been applied recently by the Supreme Court.³⁴

iv Punitive damages

Another recent and much-debated issue among private insurance associations is the decision of the Supreme Court rendered in July 2017 concerning punitive damages.³⁵ The decision was rendered in the context of the enforcement of a US judgment in Italy and substantively introduced the possibility of recognising the award of punitive damages against an Italian company in a foreign judgment. However, this matter did not touch upon the insurance field and is unlikely to have an impact on existing Italian insurance contracts, as punitive damages are still not insurable under Italian law. Furthermore, the decision will not result in the possibility of Italian judges awarding punitive damages, as a specific law would be required for that purpose.

use of motor vehicles, currently repealed by Directive 2009/103/EC of the European Parliament and of the Council of 16 September 2009 relating to insurance against civil liability in respect of the use of motor vehicles, and the enforcement of the obligation to insure against such liability.

31 European Court of Justice, 10 October 2013, C-306/12.

32 Supreme Court, 18 May 2015, No. 10,124.

33 Court of Turin, 17 March 2016; Court of Milan, 11 February 2015, No. 1,884.

34 Supreme Court, 5 March 2019, No. 6319.

35 Supreme Court, 5 July 2017, No. 16,601.

V TRENDS AND OUTLOOK

i Healthcare disputes

The recently introduced Gelli-Bianco Law regarding hospitals and other healthcare facilities' liability is likely to have a significant impact on insurance litigation, with preliminary data registering an increase in disputes in the medical field since the entry into force of the Law on 1 April 2017.

On the one hand, the Law establishes that healthcare facilities are responsible for any damage they (or the operators working therein) may cause to third parties. On the other hand, healthcare facilities are now obliged to conclude a policy that covers the risk related to damages claims that may stem from this liability. Subjects who have allegedly suffered damage can bring an action against the insurance company directly. Under certain conditions and within certain limits, the healthcare facilities have the option to reverse the liability for the potential damages arising, on to the healthcare operator responsible for the illicit event.

Before bringing an action into court grounded on the aforementioned liability, any interested party must initiate a compulsory preliminary attempt at settlement with the other parties involved (including the insurance company), with the assistance of an expert appointed by the court for the calculation of the amount of the alleged damage (the proceedings are governed by Article 696 *bis* of the Italian Code of Civil Procedure). Alternatively, it is possible to seek the assistance of a civil mediator.

This item is therefore likely to increase in importance in the future because of the complexity of the matters, the number of subjects potentially involved and the multiple steps that govern relevant claims.

ii Unit-linked policies

As reported above, disputes related to unit-linked policies are widespread in Italy, with several pending proceedings throughout the country. These policies are nonetheless still one of the highest-selling products in the life insurance market, accounting for 34 per cent of the total premiums in 2017. Preliminary data for 2019 seems to confirm the positive trend.

iii Tampering policies

Another topic currently under the spotlight of Italian insurance-related press is that of tampering policies, which were introduced to the insurance market to protect companies from the risk of accidental or intentional contamination of food-related products, which may occur if the systems of production, conservation and distribution of the products are not hygienically appropriate or because of fraudulent acts of third parties. The withdrawal of the contaminated product from the market may have disruptive consequences: it may damage the company's reputation and usually results in high unexpected costs. Tampering policies prevent these consequences by providing reimbursement for the consultancy costs in the various phases of the crisis, the costs directly incurred for the withdrawal of defective products, the information to be provided to consumers and the re-distribution of new products. The area of product liability disputes is currently very active in Italy and tampering policies introduce a new relevant element to the scenario, whose developments shall be closely monitored in the future.

iv Insurtech

Insurtech (i.e., the application of new technologies to the insurance sector) is a growing field in Italy, even though its figures are low compared with the Anglo-Saxon market. Some insurance companies are also carrying out research aimed at verifying the applicability of blockchain technology to prevent disputes and, ultimately, litigation, especially in the medical and transport fields. Attention is also focused on aspects related to the internet of things and artificial intelligence. All in all, this sector is still in its infancy but it is likely to increase. Specialist areas of competence will therefore be required to deal with potential disputes in the future.

KOREA

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I OVERVIEW

In the Republic of Korea, the insurance industry has been ‘soft’ over the course of the past year. Economic growth from the end of 2018 to the end of 2019 has been forecast at around 2.1 per cent, with this rate varying according to different publications; and while the economy remains stable, with a relatively high insurance penetration rate of approximately 13 per cent, insurers continue to experience unexpected losses, market saturation, under-performance and regulatory compliance issues. It is expected therefore that gross written premiums and overall income will decrease for the Korean life and non-life insurance market this year. However, Korea still remains active as the seventh-largest insurance market in the world, with a highly regulated financial services industry. The industry sector comprises insurers conducting (1) life insurance business, (2) non-life insurance business and (3) accident and health insurance, with certain other similar coverage areas that are known as the ‘third area of insurance business’ in Korea. Currently, there are 24 life insurers and 30 non-life insurers that are admitted to conduct the business of insurance in Korea; the licences for three of these – Allianz Global Corporate & Specialty, Asia Capital Re and Pacific Life Re – were issued by the Korean regulatory authorities in 2016. Foreign insurers as non-admitted insurers also engage in insuring local risks in Korea through the non-admitted market and through ‘fronting arrangements’.

Over the course of the past year, insurance market participants and consumers have continued to engage in contentious matters in Korea, including insurance coverage and claims disputes, claims regarding mis-selling of insurance products, reinsurance recovery actions and compliance issues with the Korean regulators involving data protection and privacy law arising from data breaches. There was one case that the Korean Supreme Court heard in the current year involving the strict application of an insurer’s duty to explain key important terms of an insurance policy, and two other cases related to the method of calculating insurance proceeds. There was also a notable decision by the Seoul Central District Court dealing with coverage under a cyber insurance policy (see Section III).

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II THE LEGAL FRAMEWORK

i Sources of insurance law and regulation

In Korea, the insurance industry is regulated by two main pieces of legislation: (1) the Insurance Business Act (IBA), which sets out the statutory framework for the regulation of the insurance business in Korea; and (2) the Korean Commercial Code (KCC), which sets out the general corporate formalities and governance to be observed by all companies, including the legal requirements for insurance contracts issued in Korea.

The regulation of the insurance industry in Korea is supervised in a two-tier system for all insurance and insurance services companies, including insurers, reinsurers, producers, brokers and agents, by the Financial Services Commission (FSC) and the Financial Supervisory Service (FSS). The missions of the FSC and the FSS are to promote and ensure (1) maintenance of the stability of the financial services markets, (2) mechanisms for the financial strength and solvency of insurers, and (3) protection of consumers.

The FSC, at the executive level, prepares financial policies and systems and has quasi-legislative authority to legislate finance-related laws and regulations, and amends the development plans and regulations of insurance business; monitors, inspects and sanctions financial institutions, including insurance companies; and approves the establishment of financial institutions, including insurance companies, by granting licences. The FSC regulates the Korean insurance business in accordance with the IBA and its subordinate regulations, decrees, guidelines, etc.

The FSS, as the 'executive arm' of the FSC, records the current status of insurance contracts and the financial condition of insurers, monitors business operations of insurers and sanctions insurers for non-compliance or violations of relevant laws or regulations. It also supervises insurers and the insurance industry on a day-to-day basis, secures consumer protection, oversees other matters and enforces activities delegated by the FSC. The FSS also directly inspects, audits and supervises insurers and their employees, and also the solicitation activities of insurance producers, agents and brokers.

As mentioned above, the IBA regulates the insurance business in Korea to address the requirements for obtaining an insurance business licence; insurance product filings; regulation of solicitation and marketing practices, including bank assurance and other alternative distribution channels; claims and claims handling procedures; asset management and permitted investments; prudential regulation, including capital adequacy and solvency requirements; accounting rules; examinations and prescribed fines, penalties and sanctions; permissibility of concurrent and ancillary businesses of insurers; and the closure, liquidation and policy transfers.

There are some minor changes to the IBA noted in this chapter following amendments to the Enforcement Decree of the IBA in August 2018, which took effect in December 2018. In particular, the amendments extended the applicable scope of an insurer's duty to confirm whether a customer has previously purchased insurance coverage that may be redundant or duplicative to be effective during concurrent or successive terms of insurance covering the same or similar risks previously purchased. This confirmation process previously existed when insurers solicited automobile insurance or fire insurance but has now been amended to cover all types of non-life insurance contracts. The amendment in effect seeks to improve the insurance system so that consumers do not inadvertently enter into insurance contracts that are redundant or duplicative, resulting in multiple payments of insurance premiums for the same risks unknown to the customer or policyholder.

The chapter of the KCC relevant to insurance is composed of three major sections: (1) general rules applicable to insurance contracts; (2) life insurance contracts; and (3) non-life insurance contracts. Provisions of the KCC relate to the conclusion or execution of insurance contracts and the validity of insurance contracts, including renewals, amendments, cancellation and termination.

ii Insurable risk

Risks that can and cannot be insured

The concept of insurance may be found in Article 2(1) of the IBA, which provides that an insurance product is a contract that is concluded for the purpose of covering a risk pursuant to an accidental occurrence, which promises payment of insurance proceeds in the form of money or other benefits set out in the contract, in exchange for consideration paid by the policyholder. 'Covering a risk' involves the concept of an 'insurable interest' and the element of an 'accidental occurrence' relates to the basic premise of insurance relating to fortuitous events. The requirement for the policyholder to provide 'consideration' means that there must be an obligation on the part of the policyholder to pay insurance premiums for there to be a binding insurance contract. Risks covered under an insurance contract that satisfy the foregoing three elements of an insurance product are viewed as insurable.

In addition to the above, the KCC prescribes certain circumstances that may render insurance contracts null and void, as explained below.

First, Article 644 of the KCC stipulates that an insurance contract will be null and void if, at the time of concluding the insurance contract, a risk has already occurred or cannot occur, resulting in there being no risk to insure under the insurance contract. However, this rule shall not apply if both parties to the insurance contract, including any insured, are unaware of these facts.

Second, pursuant to Article 669(4) of the KCC, if the insured amount substantially exceeds the value of the risk insured (i.e., excessive insurance coverage) owing to fraud by the insurer or its agents, the insurance contract will be deemed to be null and void. The provisions of Article 669(4) apply equally to cases involving redundant or duplicative insurance in accordance with Article 672(3) of the KCC.

In addition to the exceptions above, an insurance contract may also be rendered null and void because of violations of Article 103 of the Civil Act. A Korean court previously issued a ruling that a policyholder entering into multiple insurance contracts with the purpose to fraudulently receive multiple payments of insurance proceeds for a single loss would create a situation where fraudulent policyholders could take advantage of insurance to the detriment of insurers and other policyholders, using insurance as a bona fide manner to protect against unforeseen losses. As a result, such fraudulently concluded insurance contracts are to be declared null and void for violating the protection of the insurance system, and social order, as prescribed by Article 103 of the Civil Act.

Insurance to be taken out with local insurer

Pursuant to Article 3 of the IBA, no person may conclude an insurance contract with another person who is not an insurer, and a person who is not an insurer may not act as an intermediary or on behalf of an insurer to solicit insurance. A person who is qualified to obtain a licence to conduct the business of insurance shall be limited to a stock company, a mutual company or a foreign insure, or as a branch office in Korea of a foreign insurer that is duly licensed to conduct the business of insurance pursuant to Article 4(6) of the IBA. It is to be noted that

a foreign insurer may establish a local subsidiary or a local branch in Korea. The minimum capital to establish a subsidiary or a branch of a foreign insurer is 30 billion Korean won and 3 billion won, respectively. Also, in the case of a local Korea branch, it will be limited to the lines of business that its home office is authorised in the foreign jurisdiction. Other than the foregoing, there is no other material difference between the requirements for setting up a local branch and a local subsidiary as an insurer in Korea.

Notwithstanding the general rule that insurance must be taken out by local admitted insurers, Article 3 of the IBA and Article 7 of the Enforcement Decree of the IBA provide exceptions as to when a person may enter into an insurance contract with a non-admitted insurer. Specifically, a person may conclude an insurance contract with a non-admitted insurer for the following lines of business:

- a* life insurance, export cargo, import cargo, aviation, hull, travel insurance, long-term accident and health, or reinsurance with a foreign non-admitted insurer or reinsurer;
- b* an insurance contract with a non-admitted foreign insurer, if the person has been rejected by three or more insurers with respect to insurance being sold in Korea;
- c* a contract with a non-admitted foreign insurer with respect to the types of insurance not sold in Korea; and
- d* an insurance contract concluded in a foreign country but the policyholder subsequently has it maintained in Korea before the policy period expires. Although non-admitted foreign insurers may conclude the foreign insurance under the exceptions, solicitation and marketing may not be conducted onshore in Korea and are limited to email, telephone, facsimile and other electronic communications on a cross-border basis.

The IBA does not regulate insurance contracts entered into with non-admitted foreign insurers and generally no case law exists explicitly addressing cross-border non-admitted insurance in Korea. However, if a person conducts the business of insurance without a licence issued by the FSC, that person may be subject to criminal punishment.

iii Fora and dispute resolution mechanisms

In Korea, insurance disputes are resolved by (1) civil litigation before a court of law (including mediation by the court), (2) arbitration, and (3) decision of the FSS Financial Disputes Mediation Committee (FDMC) under the Financial Consumer Protection Bureau.

Korean courts do not exclusively resolve insurance disputes, nor is there is a designated arbitral institution or procedures that exclusively deal with insurance disputes. Thus, insurance disputes must be resolved in the civil courts or through arbitration proceedings in the same way as other general cases.

Civil litigation and mediation

A Korean court will have jurisdiction over a dispute involving a foreign party when a substantial nexus exists with Korea. More specifically under Korean law, a Korean court shall have jurisdiction to hear the case when a policyholder's residence or the insurer's principal place of business is located at the place where the Korean court has jurisdiction; however, the parties may separately agree in writing to designate jurisdiction over disputes to another court, including those outside Korea, along with the governing law.

The Korean judiciary is composed of three levels: (1) the district courts, (2) the high courts, and (3) the Supreme Court. A district court is the court of first instance involving a trial of the facts and the law. A high court is empowered to hear appeals by parties from the

district courts; the high courts may review, on a *de novo* basis, both the facts and law applied at the district court. The Supreme Court is the highest court in Korea and hears appeals from the high courts. The Supreme Court will only review the legal merits of a case to determine if the facts were properly analysed and applied in the courts below at the first and second instances, and the decision of the Supreme Court in a dispute is final.

Generally, disputes in district courts are resolved within eight to 12 months, but proceedings may be shorter or longer depending on the complexity of each case. Appellate proceedings may take anywhere from eight to 10 months until a decision is rendered by a high court. An appeal to the Supreme Court may run its course for two to three years until a decision is rendered.

As mentioned earlier, a Korean court may order the parties to proceed with mediation as requested, on application by the parties, or at the court's discretion and as conducted by the court. Alternatively, a case may be referred to the mediation committee. Mediation decisions have the same legal effect as court judgments. In cases where parties are unable to arrive at an agreement, they can return to and continue with court proceedings.

Arbitration

There are both domestic and international arbitration cases that are instituted under various arbitration institutional rules with seats either in Korea or in other arbitration hubs such as Singapore, Hong Kong, London and the United States. It is common that parties assign the rules of institutions to govern arbitration proceedings such as the International Chamber of Commerce, the Singapore International Arbitration Centre, the Hong Kong International Arbitration Centre, as well as the Korean Commercial Arbitration Board, which has gained recognition as another option for arbitration by contracting parties.

Arbitration is invoked in lieu of other dispute resolution methods (e.g., litigation) when the parties have expressly or impliedly agreed to an arbitration clause. In certain situations, the arbitration may require resolution under local arbitration laws pursuant to the governing law of a contract. In Korea, if the parties have agreed to or in the absence of any applicable governing law, then cases may be subject to the Korean Arbitration Act or the Korean Act on Private International Law.

Korea is a party to the UN Convention on the Recognition and Enforcement of Foreign Arbitral Awards 1958 (the New York Convention). Thus, an arbitral award duly delivered by the KCAB shall be recognised and enforced in other countries that are party to the New York Convention and foreign arbitral awards rendered in other countries that are parties to the New York Convention will be recognised and enforceable in Korea. Korean courts may also recognise arbitral awards rendered in foreign countries that are not party to the New York Convention by applying standards similar to those used to determine the enforceability of foreign judgments in Korea.

Mediation by the FSS

The FSS mediation for disputes is available to consumers who seek remedies and damages against financial institutions (e.g., insurers, banks, securities firms and asset management companies) that are subject to supervision by the FSC and the FSS.

Procedurally, consumers may request a mediation order from the FDMC on their challenges to the validity and effect of certain financial products. The FDMC will then usually request an insurer to submit a report on the position of the insurer relating to the dispute, with relevant documents, and secure statements and testimony from the parties

and material witnesses. After reviewing the case, the FDMC may issue a mediation order and request that the parties accept the recommendations under the order. The parties may accept the mediation order that would have the same effect as a judgment of a court of law. However, if either party rejects the mediation order, the dispute may proceed to court if a party seeks to resolve the dispute through a more legal and formal venue. If at any point, either party submits a complaint to the court with respect to the subject dispute, the FDMC mediation procedure will be terminated.

The number of insurance-related disputes in mediation at the FSS exceeded 20,000 in 2015, and by 2017 the total number of mediations neared 23,000.

Subrogation

In Korea, the insured's rights are automatically assigned to the insurer upon payment of the insurance proceeds following a valid claim for damages or losses as provided for under an insurance contract. In other words, subrogation occurs by operation of law and does not require a contractual provision or separate contract in favour of the insurer of the subrogation rights. Thus, the insurer is assigned only those rights that the insured had against a third party and can only pursue actions against parties in its own name that could have been brought by the insured in the first place. Further, before any subrogation is pursued by the insurer, the rights arising under the operation of law do not require the insurer to first prove the liability of the third party; rather, liability will be disputed under the subrogation claim. This means that the insurer, at its discretion, will first pay the insured for any damage or losses incurred and then make a subrogation claim against the third party, and that claim will then proceed with a determination of the coverage and the quantum of damages.

The prima facie elements that give rise to a subrogation claim in favour of an insurer under an insurance contract arise when: (1) a third party exists; (2) the third party caused the insured accident, or loss or damage to an insured; (3) the insurer is contractually obligated to pay the insurance proceeds under an insurance contract; and (4) the insured has a valid claim against the third party.

III RECENT CASES

Several significant claims dispute cases were decided by the Supreme Court over the past year and half arising out of mis-selling by an insurer through breaching its duty to explain the key important provisions of the insurance contract, and the method of calculating insurance proceeds in different situations.

i Duty of an insurer to explain the key provisions of an insurance policy

The Supreme Court, in Case 2016Da277200, gave rise to a new precedent in the area of directors and officers liability insurance (D&O insurance), for which there is a dearth of case law or guidance in Korea, especially as D&O insurance is not widely purchased.

In this case, the claim by a commercial insured against its directors or officers arose under a D&O insurance policy in respect of loss sustained during the period of their wrongful act. The insurance policy defined the insured's loss as including any legal costs incurred by the insured when bringing the claim against its directors and officers. A criminal claim was filed against the directors and officers of the insured for breaching Article 176 of the Financial Services and Capital Markets Act (FSCMA) for unfair trading activities. The insured brought

a claim against its insurer to recover the attorneys' fees incurred in bringing the claim against the directors and officers. The insurer denied payment of the insurance proceeds on the basis of a criminal-acts exclusion because of the alleged violation of the FSCMA.

The Supreme Court ruled that even if a criminal-acts exclusion exists, it shall not be incorporated as part of the insurance policy and have no legal effect if the insurer failed to explain it to the insured. Under Korean law, an insurer has an affirmative duty to explain the key important provisions of an insurance contract to a prospective policyholder or insured. Important provisions not explained by an insurer to a policyholder or insured shall not be incorporated as part of an insurance policy and will not be effective. In this case, the insured failed to explain the key important provisions to the prospective insured under the insurance policy, including the criminal-acts exclusion. Despite the fact that the insured is a large financial institution and had subscribed to the D&O insurance policy for a long time, the Supreme Court in this case strictly applied the Korean law and ordered the insurer to pay the insurance proceeds. This case demonstrates the Supreme Court's position of strictly applying the duty to explain key important provisions of the insurance policy to strengthen customer protection, even in a commercial setting between sophisticated counterparties.

ii Calculating insurance proceeds for a victim's death or bodily injury

In Case 2018Da248909, the defendant owned a car repair shop and the claimant was a customer. The claimant was injured while waiting for his car to be repaired at the defendant's shop. In the process of repairs, the defendant removed a nut from an air hose and the claimant observing the repair process was struck by the nut, which was projected by the highly compressed air from the hose. The district court held that the defendant had a duty to ensure customers' safety when carrying out repair work on his premises, and his failure to do so resulted in liability to compensate the claimant for personal injuries and related losses.

Under Korean law, insurance proceeds are determined by multiplying the claimant's wages at the time of the accident and the number of days up until the maximum age at which the claimant is expected to be capable of working. The district court ruled that an ordinary worker in an urban area is deemed to be capable of working until the age of 60. However, following an appeal through the Supreme Court, it was ruled instead that an ordinary worker in an urban area is deemed to be capable of working until the age of 65.

This decision of the Supreme Court will increase the amount of insurance proceeds Korean insurers will have to pay in respect of death and bodily injury claims, which may also in turn increase insurance premiums. It is expected that the decision will also impact policy wording, underwriting, claims, loss ratios, etc.

iii Determining the amount of insurer's liability in third party direct action claims

Supreme Court Case 2018Da300708 involved a direct action filed by a claimant against the automobile insurer of a reckless driver. The claimant brought the direct action claim for property damage against the driver's liability insurer for the total loss of the claimant's car. The driver's insurer denied the claim on the basis that the subject wording in the insurance policy limited the insurer's liability for compensation to merely the diminished value of the subject property 'when the cost of repairing the car after the accident exceeds 20 per cent of the car's purchase value prior to the accident'. In this case, the claimant's repair costs did not exceed 20 per cent of the car's value at the time of the accident. In the subject automobile

insurance policy, various criteria and methodologies were included to provide for the calculation of insurance proceeds in addition to the foregoing limitation for compensation in liability claims.

In its ruling, the Supreme Court held that a direct action claim by a third-party claimant against a liability insurer is permitted pursuant to the KCC, and any calculation of the insurance proceeds for the direct action claim would be subject to the general laws of Korea and to the KCC. More clearly, the Supreme Court held that while criteria and methodologies for the calculation of insurance proceeds existed in the automobile insurance policy, the third-party direct action claim should be adjudicated without regard to these from the quantum perspective; however, the claim may still be subject to certain defences contained in the policy.

The Supreme Court ruled that the quantum of damages was to be calculated pursuant to general Korean laws and the KCC, and remanded the case back to the lower courts for a review of the damages to be paid by the insurer to the third-party claimant in the direct action. The importance of this case highlights the necessity of ensuring equitable and speedy claims handling and settlement for parties suffering property damage or personal injuries while adjudicating third-party claims in direct actions outside the insurance contract for the purposes of the calculation of damages and insurance proceeds.

iv Scope of coverage related to cyber insurance

Case 2018GaHap528105 in the Seoul Central District Court involved the scope of insurer liability under a cyber insurance policy. In this case, the claimant, a prominent cryptocurrency exchange in Korea, fell prey to a major cyberattack in December 2017, resulting in the theft of cryptocurrencies from its exchange wallets. The claimant was insured under a cyber insurance policy issued by a Korean insurer, which was reinsured by Korea's largest reinsurer and a leading German reinsurer. The claimant filed a complaint against the insurer seeking payment of the insurance proceeds in the district court. The insurer denied the claim on the grounds that the insurance contract was validly terminated on 1 February 2018, when it delivered a termination notice to the claimant because of misrepresentations by the claimant during the underwriting of the cyber insurance policy. Specifically, the claimant misrepresented that it had proper security measures in place to protect against data breaches, security threats and hacking, which was a material condition precedent to the insurance contract to be issued by the insurer. Based on the evidentiary documents submitted by the insurer, the district court held that the insurance contract was validly cancelled ab initio on 1 February 2018 because of a breach of the condition precedent, and the insurer did not have any liability to pay the insurance proceeds.

This case was the first to provide the insurance industry with guidance on insurance coverage under cyber insurance policies by touching on such fundamentals as the legal character of cryptocurrencies as insurable property and the method of quantifying damages arising from cryptocurrency theft. It is expected to serve as a leading case for cyber insurance claims and in particular those involving cryptocurrency-related risks.

IV TRENDS AND OUTLOOK

i Industry-wide dispute on immediate annuity products

The leading life insurers in Korea now face ongoing media pressure, litigation and potential regulatory actions regarding disputes pertaining to the solicitation and sale of immediate annuity products as the FSS and the insurers' respective policyholders allege that policyholders were not paid the expected annuity payments under the contract terms. The FSS regulatory review, which began in late 2017, resulted in a non-binding order against Samsung Life Insurance Co, Ltd declaring it liable to pay additional amounts to the annuity holders of its immediate annuity product.

The dispute was one of the main headlining legal cases for the life insurance industry in Korea last year and it is likely that the litigation and regulatory action will continue for the next few years. The potential claims facing the largest life insurer in Korea add up to approximately US\$430 million; other life insurers are also facing potential claims of significant amounts for similar immediate annuity products that they sold to Korean customers.

In 2018, Samsung Life submitted a request for resolution to the Seoul Central District Court, seeking confirmation that it did not have the liabilities demanded of it by its annuity holders and argued by the FSS. First, the initial dispute involved the policy wording – as to whether deductions were provided for in the annuities. Second, disputes followed on whether terms such as the duty to explain were present, and whether this duty had been fulfilled by the life insurers. The first hearing was held at the Seoul Central District Court on 12 April 2019 with the main dispute concerning whether deductions were provided for in the policy. The life insurers continue to defend these cases in the courts, and this is expected to have a significant impact on their business in the event of adverse rulings.

ii Disputes over multiple-occurrence issues

Lithium batteries manufactured by LG Chem Ltd and installed in electronic cigarettes exploded while being used by customers in several locations in the United States. In total, more than 200 claims were filed against LG Chem and its liability insurer. There are disputes among insurers in Korea as to whether multiple claims such as these can be regarded as a single occurrence rather than as distinct separate and multiple occurrences for which there will be an equivalent number of payments made to the numerous claimants. To date, there are no precedents in Korea regarding numbers of background occurrences or whether multiple claims might be regarded as arising from the same event. The issue has not been presented to a court in Korea, but the issue of the number of occurrences for claims purposes is likely to be litigated with references to case law in other jurisdictions, such as the Larry Silverstein claims against the insurers for losses at the twin towers at the World Trade Center on 11 September 2001, and the decisions of the New York courts.

iii Global exposure for lithium battery explosion claims

In recent years, the utilisation of battery energy storage systems (BESSs) installed in factories as a means to save electricity costs have grown considerably. BESSs have largely been sold and maintained by Korean companies, including SK D&D, as business operators at project sites. Large lithium batteries from manufacturers such as Samsung SDI and LG Chem are purchased with loans secured by credit insurers, who install the BESSs without charge in factories in need of alternative energy sources. Property insurance is procured to cover the risks associated with the BESSs. A number of BESS explosions have been reported and it is

expected that the business operators will lodge claims against the insurers. As with all product liability claims, coverage is dependent on identification of the source of any malfunction and any factors related to defects, irregularities, etc. leading to the explosions, as well as identifying who would be liable for these. It is expected that the insurance industry and the relevant insurers will face challenges in handling product liability claims involving BESSs. Moreover, the industry will have to be vigilant in monitoring and underwriting emerging technologies to be better prepared to address similar issues.

PORTUGAL

Pedro Ferreira Malaquias and Helder Frias¹

I OVERVIEW

In Portugal, the state is the uncontested leader in dispute resolution. In fact, the majority of conflicts are resolved through the legal system, supported by a large network of courts with specific and complex procedural rules; however, with the lack of efficiency of the public system, the importance of arbitration and other alternative dispute resolution methods is increasing significantly.

There are three levels of jurisdiction in Portugal: first and second instance courts, and the Supreme Court. Within the first instance there are specialised courts for specific matters, such as civil, criminal, commercial, labour, family, competition and intellectual property rights courts.

Bearing in mind that the main problem of dispute resolution in Portugal is still the length of time proceedings usually take, in recent years the state has actively amended the legal system – not only implementing procedural rules but also improving infrastructure (new courts, new technologies) and modifying the judicial structure to respond to the increase in litigation and improve the effectiveness and the degree of specialisation of the courts and judges. No major judicial reform was carried out in 2018. As was the case in 2017, it was a year of stabilisation for legislation that has been in force since 2013 and 2014. This legislation has still not proved to be as effective in reducing the length of proceedings as expected, with the exception of procedures in the appeal courts.

II THE LEGAL FRAMEWORK

i Sources of insurance law and regulation

The Portuguese Insurance and Pension Funds Supervisory Authority (ASF) is the competent authority for the regulation and the prudential and behavioural supervision of insurance, reinsurance, pension fund (and corresponding managing entities) and insurance and reinsurance intermediation activities.

The main goal of the ASF is to ensure the sound functioning of the Portuguese insurance and pension funds markets by contributing to the protection of the interests of the policyholders, insured persons and beneficiaries. This goal is pursued by promoting the financial stability and soundness of all institutions under its supervision, as well as ensuring the maintenance by all market operators of high standards of conduct.

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The taking up and pursuit of the insurance and reinsurance business is a regulated activity reserved for duly authorised insurance undertakings by the ASF.

Statutory law is the main source of law in the Portuguese legal system. Custom is also deemed as a source of law in the Portuguese legal system to the extent that the custom is not contrary to the general good faith principle. However, there are very few situations in which it is accepted that an implemented solution had custom as its source. There is, therefore, a stark contrast between the importance given to custom and the practical relevance it actually assumes.

Case law and doctrine play a secondary role (although an important one), even where principles are concerned, as sources of law in the Portuguese legal system. They are used exclusively as a means of disclosing (or identifying or clarifying) pre-existing legal standards or solutions, generally from a legal source. Case law precedents are not binding and the very same issue could receive different treatment from one court to the next.

The main Portuguese insurance and reinsurance statutes and regulations are:

- a* Law No. 147/2015, of 9 September (Law No. 147/2015), as amended, implementing into Portuguese law the Solvency II Directive, which sets out the main rules on, inter alia:
 - authorisation of undertakings;
 - solvency and other financial guarantees;
 - suitability and appropriateness of directors;
 - acquisition of qualifying holdings;
 - systems and controls for the conduct of the insurance and reinsurance business;
 - protection of policyholders, insured persons and beneficiaries (e.g., resolution of complaints); and
 - the inspection and sanction of infractions;
- b* the Portuguese Insurance Contract Law, enacted by Decree-Law No. 72/2008, of 16 April (ICL);
- c* Law No. 147/2015;
- d* the Portuguese Commercial Code (in respect of marine insurance);
- e* the Portuguese Civil Code;
- f* Law No. 35/2018 of 20 July,² which implemented into Portuguese law EU Directive 2014/65/EU on markets in financial instruments and, notably, brings Portuguese legislation in line with the EU PRIIPs Regulation³ on packaged retail and insurance-based investment products;
- g* the regulations issued by the ASF;
- h* the special legislation dealing with compulsory insurance;
- i* the special legislation dealing with consumer protection (including the Portuguese unfair contract terms act); and
- j* the special legislation dealing with distance and off-premises contracts.

In turn, pension funds and their managing entities are governed by Decree-Law No. 12/2006 of 20 January, as amended. Directive (EU) 2016/2341 on the activities and supervision of

2 Among other things, Law No. 35/2018 establishes that the ASF is the supervisory authority for unit-linked life insurance contracts and operations.

3 Regulation (EU) No. 1286/2014 of the European Parliament and of the Council on key information documents for packaged retail and insurance-based investment products (PRIIPs).

institutions for occupation retirement provision (the IORP Directive)⁴ has not yet entered into force. The draft law implementing the IORP Directive into Portuguese law, has already been approved by the Council of Ministers and will be submitted for the National Assembly's appraisal.

The pursuit, on a professional basis, of insurance intermediation activity in the Portuguese territory is deemed a regulated activity reserved exclusively to duly authorised insurance intermediaries. Foreign intermediaries may only pursue insurance intermediation activity within the Portuguese territory if the corresponding procedure for the pursuit of the insurance intermediation business under the freedom to provide services or right of establishment rules (as the case may be) is duly met (in accordance with the single-licence principle).

Insurance and reinsurance distribution activities are governed by Law No. 7/2019. The ASF is currently working on the revision of several regulations regarding insurance and reinsurance distribution activities following the entry into force of Law No. 7/2019.

ii Insurable risk

Under Portuguese law, the risk can be defined as the future and uncertain event whose materialisation is represented by the claim.

Although usually identified as a detrimental event resulting in damages, the risk may correspond to the occurrence of a predetermined event from which damages may not necessarily arise (e.g., the survival of the insured person in a life assurance contract).

The existence of risk is essential for the insurance contract: the insurance contract is null and void if, at the time the contract was concluded, the insurer was aware of the termination of the risk or if the insured person or the policyholder was aware of the existence of the claim.

In essence, there is no insurance without risk.

However, the risk, given that it is essential to the validity of the insurance, is also subject to negative constraints.

First of all, insurable risks shall fall within the classes expressly provided for in the legislation; therefore the risks classified in each class shall not be covered by insurance policies classified in another class.

Aside from this generic limitation, the conclusion of insurance contracts with respect to the following risks is prohibited by law:

- a* criminal, administrative or disciplinary liability (this prohibition does not extend to any civil liability arising therefrom);
- b* kidnapping, illegal restraint and other crimes against personal liberty;
- c* possession or transportation of narcotics or drugs not allowed for consumption; and
- d* the death of children under 14 years of age or the death of those who, because of cognitive impairment or other causes, are unable to govern their person. It should be noted that insurance against the risk of death resulting from an accident of children under 14 years of age is not prohibited, provided it is concluded by educational, sporting or similar institutions that do not benefit from it.

The prohibition referred to in points (b) and (d) above do not cover the payment of strictly compensatory benefits.

⁴ Directive (EU) 2016/2341 of the European Parliament and of the Council of 14 December 2016 on the activities and supervision of institutions for occupation retirement provision (IORPs).

Only limited liability companies by shares, mutual or public institutions may obtain an insurance authorisation from the ASF. Companies that take the form of a European company may also pursue insurance and reinsurance activities.

Insurance undertakings based in the EU, which are duly authorised for the pursuit of their insurance activity within their country of incorporation, may pursue the insurance activity in Portugal under the EU freedom of establishment regime (as a branch) or on a freedom to provide services basis (without a permanent establishment in Portugal) without the need to obtain a specific authorisation from the ASF. The only requirement would be that the ASF is duly notified of the establishment of the branch or the commencement of activity on a freedom to provide services basis by the competent supervisory authority of the relevant home Member State, in line with the EU passport regime.

In turn, if an insurance undertaking incorporated outside the EU wishes to establish a branch in Portugal, it is required to obtain prior authorisation from the ASF.

The fact that an insurance undertaking is operating on a cross-border basis has no material impact on dispute resolution besides the fact that, as a general rule, the insured person may elect to bring a claim against the insurer in its home country.

iii Fora and dispute resolution mechanisms

Portuguese insurance undertakings must receive and resolve any claims or complaints that are filed against them within the deadlines imposed by law. To this effect, insurance undertakings are required to put in place a written internal regulation on the management and settlement of complaints.

If the insurance undertaking fails to reply within these deadlines, or denies the claim or complaint, the interested party may file an appeal with the customer ombudsman (who must be appointed by the insurance undertaking or a group of insurance undertakings), who must handle and resolve the claims and complaints submitted to him or her within the deadlines imposed by law. Insurance undertakings must appoint a preferred interlocutor between the ASF and the customer ombudsman, and the identity of the customer ombudsman must be disclosed to the policyholders, insured persons, beneficiaries or any other interested party. After this period has elapsed, if the insured's claim or complaint is not answered or is dismissed, the claimant can submit a grievance to the complaints service of the ASF. The policy must indicate the insured's right to proceed in this way.

Also, any insurance undertaking with any customer service desk in Portugal must have in each service desk a complaints book available for any customer.

The competent court for any dispute arising out of or in connection with an insurance contract shall be the court of the defendant's domicile. Alternatively, for any dispute filed by the policyholder, the insured or the beneficiary against the insurer, the competent court shall be that of the plaintiff's address.

Insurance-related disputes are subject to the general Portuguese civil procedure, which may be characterised as an adversarial procedure with a preference for oral expression, and with certain fundamental principles, such as the right of access to justice, the right to reasonable duration of proceedings and the right to a fair trial (principle of equity).

Both civil and criminal proceedings include different stages. Generally, proceedings are initiated by the parties submitting pleadings, followed by a stage in which evidence is provided. Subsequently, the trial takes place and the court issues its decision. Finally, the parties can appeal the judgment, provided that certain conditions are met.

Despite the above, the new Civil Procedure Code establishes that all witnesses must be offered with the submission of the pleadings.

There are two kinds of civil proceedings: declarative and enforcement. Through the former, the court's decision has *res judicata* effect and the court decides on the merit of the litigation between the parties. Enforcement proceedings may serve three purposes: the payment of an amount; the delivery of a certain object; or forcing the counterparty to carry out a certain action.

Ordinary declaratory proceedings in Portugal may take from one to three years until a final court decision is issued, while enforcement proceedings may take from one to two years.

Subject to the exceptions provided for in the law, each party bears the burden of proving those facts supporting his or her claim in the proceedings.

The courts have wide discretion when assessing evidence, subject to reasoning founded on the applicable law and the relevant facts.

Court costs are to be advanced by both parties. The winning party may claim from the losing party the judicial fees that were paid during the proceedings. The winning party may have to pay additional amounts at the end of the proceedings and claim the corresponding reimbursement from the losing party.

Arbitration continues to flourish in Portugal. Parties have progressively added arbitral agreements to contracts and there is a general sense that Portugal may become a privileged forum for arbitrations between companies based in Portuguese-speaking countries such as Brazil, Angola and Mozambique. On 15 March 2012, a new Arbitration Law entered into force, replacing the former Portuguese Arbitration Act.

The 2012 Arbitration Law was rather innovative, drawing inspiration from the 2006 version of the UNCITRAL Model Law, and it introduced provisions intended to grant more flexibility with regard to the formal validity of an arbitration agreement, making it simpler to comply with the written form requirement.

After almost eight years since the entry into force of the Arbitration Law, it is reasonable to state that it has increased flexibility in Portuguese arbitration and facilitated the increasing number of arbitral agreements included in contracts.

The leading arbitral centre is the Arbitration Centre of the Portuguese Commercial Association. With regard to foreign arbitration, Portugal is party to the 1958 New York Convention on the Recognition and Enforcement of Foreign Arbitral Awards.

Although alternative dispute resolution, especially mediation, is starting to develop in Portugal (tax arbitration in particular), it is rarely used in insurance matters.

III RECENT CASES

Our experience tells us that the majority of dispute resolution in the insurance field is a result of insufficient or erroneous information made available by policyholders or insured persons at the time of conclusion of the insurance agreement.

The Portuguese higher courts have taken a significant number of decisions regarding the initial risk disclosure obligation. This disclosure obligation means that the policyholder or the insured person must accurately disclose all known circumstances that may be significant for the risk valuation, even if it is not requested in the questionnaire provided by the insurer – the existence of the questionnaire does not minimise the disclosure obligation. Thus, the insured person or the policyholder shall not omit or respond with imprecision, or be inconsistent or contradict themselves.

In one court decision, it was ruled that when concluding an insurance contract, the insured person, knowing about a disease, even if its severity was not yet diagnosed, should have informed the insurer about it and about the subsequent diagnostic process. Therefore, the court decided that at the time a contract is concluded, all the circumstances that may make the claim more likely or its consequences wider shall be declared. Consequently, the intentional and conscious omission of a fact that is essential to the risk evaluation is fraudulent. Hence, pursuant to Article 25 ICL, the insurer has the legitimate right to invoke the nullity of the insurance contract so it can refuse the payment of the insured sum.

In another case, the court found that the insurance contract nullity, in accordance with Article 429 of the Portuguese Commercial Code, does not necessarily require a causal link between the content of the insured person's inaccurate declaration and the insured claim. The causal link to be established shall instead be between the omitted fact and the conclusion of the insurance agreement in its precise terms. The question to be asked is: if the insurer knew about the omitted fact, would it still have entered into the same insurance agreement?

Nevertheless, the fact that a death is caused by an intentionally omitted disease does not preclude the nullity effect. In fact, in that case, a causal link should be established between the omitted disease that caused the death and the terms in which the contract was concluded, in such a way that it can be declared that the contract would have been concluded, or not, should the insurer have known about the disease.

This burden of proof lies on the insurer. The insurer has to claim and prove that the omitted statements were effectively made, that the circumstances were already affecting the insured and that the insurer would not have entered into the insurance agreement in the same terms, not covering, therefore, the risks.

Conversely, insurers are subject to a general duty of information and notification. As the superior courts have stated, the obligation to notify corresponds to the obligation of the insurer to disclose, in due course, the full content of the contractual terms to the insured person, in terms that they are completely and effectively known by the latter; on the other hand, the information duty is essentially the explanation of the contents of the insurance agreement, when no real understanding is expected by the applicant or insured person – its main purpose is the understanding of the content. Communicated terms of the insurance agreement in a way that restricts the information duty, resulting in the effective understanding not being expected, shall be excluded and cannot be enforceable against the insured person, pursuant to the Portuguese Unfair Contract Terms Regime.

However, there is no breach of the information and communication duties if the contractual provisions are drafted in a clear manner and in a way that the insurer does not have to provide for any additional clarification to the insured.

Another commonly debated subject in the superior courts is the automatic termination of the contract resulting from the lack of payment of the insurance premium. According to the superior courts, in the event of non-payment, on one hand, risks are no longer covered; on the other hand, the debt ceases to exist and, as a consequence, payment can no longer be demanded by the insurer. Therefore, this lack of payment leads to the automatic termination of the contract on the payment due date, and no further amounts are due.

In turn, a Portuguese superior court has ruled that to assess the scope of the coverage provided by the insurance agreement it is necessary to review the agreement and the policy's covered risks. The policy shall expressly provide for the risks that are covered and, conversely, the ones that are excluded – all the remaining risks not expressly excluded will be considered covered.

Finally, another superior court has made it clear that the main goal of the insurance agreement shall be construed according to the view of an 'average' policyholder put in the actual policyholder's position. In the event of doubt, any given provision shall be construed in a manner favourable to the policyholder's interests. In the particular case at hand, the risk exclusion clause, according to which a claim would be excluded if it were caused by a person not legally qualified to drive, should be disregarded if the relevant non-qualified driver acted against the will of the car owner. In such cases, the insurer shall be required to pay the claim.

IV THE INTERNATIONAL ARENA

As a general rule, the parties are entitled to agree on the jurisdiction to settle legal or contractual disputes, provided that the relevant dispute is connected to more than one legal jurisdiction. However, this freedom of choice does not allow choosing a competent jurisdiction that involves a material disadvantage to one of the parties in favour of the other, without this other party claiming a legitimate interest in that choice.

The international jurisdiction of Portuguese courts shall be subject to the verification of the following circumstances:

- a* the defendant is, or some of the defendants are, domiciled in Portugal, except in the case of actions relating to rights *in rem* or personal rights to make use of immovable property located in a foreign country. A legal person whose registered office or effective centre is located in Portugal, or that has a branch, agency, subsidiary in Portugal, is considered domiciled in Portugal;
- b* the action should be proposed in Portugal, in accordance with the rules of territorial jurisdiction established under the Portuguese law;
- c* the fact that acts as a cause of action, or some of the facts that are part of it, have been practised in Portugal; and
- d* the right invoked cannot be enforced except by means of an action proposed in Portugal or, in the situation that it cannot be required for the author to propose it abroad, provided that the subject matter of the dispute and the national legal order have some important personal or real connecting factor (in accordance with Article 62 of the Portuguese Code of Civil Procedure).

The international jurisdiction is governed at the Community level by the 1968 Brussels Convention on jurisdiction and the enforcement of judgments in civil and commercial matters (the Brussels Convention).

The Brussels Convention is applicable in the following situations:

- a* in a civil or commercial matter;
- b* in a dispute that has an international element;
- c* when the defendant is domiciled in a contracting state, otherwise the jurisdiction shall be regulated by the contracting state's law;
- d* when it is not a specific convention-regulated matter; or
- e* when it is not a bankruptcy or arbitration matter.

Articles 7 to 12-A are devoted to the jurisdiction in matters relating to insurance and they are drafted with a purpose of protecting the policyholders, as shown below:

- a* the insurer domiciled in a contracting state may be sued in the courts of the mentioned state, the courts where the insurer is domiciled or, in the case of a co-insurer, the courts of the contracting state where the action is going to be taken;
- b* in the case of indemnity or real estate-related insurance, the insurer may be sued in the courts of the state where the harmful event occurred;
- c* in the case of indemnity insurance, the insurer may also be sued in the courts where the action was proposed, provided that the law of the court permits it; and
- d* the insurer can only bring proceedings against the defendant (policyholder, insured or a beneficiary) in the courts of the contracting state in which the defendant is domiciled.

It is not clear whether the jurisdiction in matters relating to the insurance section of the Brussels Convention applies only to direct insurance or whether it extends to reinsurance.

In terms of the restriction applying only to direct insurance, it has to be noted that the section related to insurance is specifically dedicated to the policyholder's protection; on the other hand, it should be noted that there is no substantial difference between the parties' interests in cases of reinsurance that warrant that restriction, which could merely be inferred from the Convention.

Within the EU, Council Regulation No. 1215/2012 of 12 December 2012, as amended, sets out the conditions under which a judgment (concerning civil and commercial matters) issued in one Member State can be enforceable in another.

Therefore, pursuant to this Regulation, a judgment issued in a Member State and enforceable in that Member State may be enforceable in Portugal when, upon application by the interested party, it has been declared enforceable. The application of enforceability is filed in the competent superior court.

Without prejudice to international conventions and treaties in force (for instance, the Lugano Convention), under Portuguese law, it is generally possible to enforce foreign court civil judgments provided that these are subject to a prior confirmation procedure before a Portuguese court. Said confirmation will be granted whenever:

- a* there are no well-grounded doubts concerning either the authenticity of the submitted documents or the judiciousness of the decision;
- b* the decision is final according to the law of the country where the judgment was rendered;
- c* the object of the decision does not fall within the exclusive international jurisdiction of Portuguese courts and the jurisdiction of the foreign court has not been determined fraudulently;
- d* there are no other proceedings between the same parties, based on the same facts and having the same purpose, and no ruling on the same case has been issued by a Portuguese court;
- e* the defendant was duly notified of all the proceedings according to the law of the country where the judgment was rendered;
- f* the foreign court proceedings complied with the procedural law requirements and each party received an adequate opportunity to present its case fairly; and
- g* the acknowledgement of the decision is not patently incompatible with the public policy of the Portuguese state.

V TRENDS AND OUTLOOK

The greatest criticism of the Portuguese legal system is the length of time proceedings take. Furthermore, during the past decade, the annual number of actions filed before court has increased dramatically. In light of the above, both the civil society and the government have been encouraging the promotion of alternative dispute resolution (ADR) mechanisms; namely arbitration, mediation, conciliation and resolution by justices of the peace. In 2001, the government created the Cabinet for Alternative Dispute Resolution, a department of the Ministry of Justice exclusively dedicated to ADR.

Besides arbitration, mediation and conciliation, the most popular form of ADR is conducted by a justice of the peace, who is governed by Law No. 78/2001 of 13 July 2001 (as recently amended by Law No. 54/2013 of 31 July, which widened the scope and jurisdiction of justices of the peace), and numerous centres have been created under the supervision of a special commission. Justices of the peace are only available to settle disputes among individuals and have jurisdiction on civil matters purporting to small claims (up to €15,000). Under the legal framework on justices of the peace, legal persons may now resort to mediation (excluding for class actions) and preliminary injunctions are now available.

In Portugal, the Information, Mediation, Ombudsman and Arbitration Insurance Centre functions as a private non-profit association with the purpose of making available alternative dispute resolution mechanisms for insurance-related matters. To this effect, this Centre created two independent and autonomous procedures: an Insurance Mediation and Arbitration Service and an Insurance Customer's Ombudsman Service.

Since the entry into force of Law No. 7/2019, all insurance distributors (i.e., any insurance intermediary, ancillary insurance intermediary or insurance undertaking) must be registered with an ADR service, as defined under Law No. 144/2015 of 8 September, which implemented into Portuguese law Directive 2013/11/EU on alternative dispute resolution for consumer disputes.

At present, the Centre promotes the settlement of disputes arising from insurance agreements in the following classes:

- a* motor insurance;
- b* civil liability insurance (family, exploration, hunting, use and possession of firearms);
- c* multi-risk home insurance (commercial and housing);
- d* health insurance;
- e* personal accident insurance; and
- f* fire insurance.

Additional insurance classes are expected to be included in the Centre's sphere of competence in the future.

Apart from the above matters, the current year, much like the previous one, has not seen many legislative reforms to the judicial system.

By way of example, a law was passed towards the end of 2017 reinstating over 20 first instance courtrooms with a view of reducing the number and duration of civil actions in civil courtrooms.

However, and notwithstanding the slight improvement observed in recent times, this is still an unresolved issue that insurance undertakings have to deal with in the Portuguese market.

SPAIN

Julio Iglesias Rodríguez and Francisco Caamaño Rodríguez¹

I OVERVIEW

In recent years, Spanish insurance law has undergone a progressive process of renovation and adaptation to European Union law. Following the transposition of the Solvency II Directive,² Spain has still to enact a law regulating the activity of insurance intermediaries and distributors in accordance with the EU Insurance Distribution Directive (IDD).³

In terms of litigation, insurer–insured disputes continue unabated. This has led to the consolidation of important judicial interpretations and doctrine on significant issues that had arisen in the market, such as the scope of a directors and officers (D&O) policy or the question of which party is liable for material damage in a traffic accident when it is impossible to determine the person responsible for the collision.

II THE LEGAL FRAMEWORK

i Sources of insurance law and regulation

In the Spanish legal system, insurance matters are regulated in a variety of laws and regulations, a detailed analysis of which would far exceed the scope of this chapter. For this reason, only the main pieces of legislation are addressed here.

Rules governing access to the market and insurance activities

The conditions for access to the insurance market and the performance of insurance companies' activities are mostly regulated by Law 20/2015 of 14 July on the management, supervision and solvency of insurers and reinsurers, and Royal Decree 1060/2015 of 20 November on the management, supervision and solvency of insurers and reinsurers, which develops Law 20/2015. These regulations are the result of the transposition by the Spanish legislator of the provisions set out in the Solvency II Directive.

Rules governing the mediation and distribution of insurance

The Spanish regulation of insurance mediation and distribution activities can be found in Law 26/2006 of 17 July on private insurance and reinsurance mediation. At the time of

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2 Directive 2009/138/EC of the European Parliament and of the Council of 25 November 2009 on the taking-up and pursuit of the business of Insurance and Reinsurance (Solvency II).

3 Directive (EU) 2016/97 of the European Parliament and of the Council of 20 January 2016 on the distribution of insurance.

writing, a new law replacing Law 26/2006 and incorporating the provisions laid down in the IDD is still pending. The enactment of this new law began last year. However, because of the change of government in Spain and the subsequent dissolution of Parliament, the legislative process has been interrupted.

Furthermore, Commission Delegated Regulation (EU) 2017/2359 of 21 September 2017 supplementing Directive (EU) 2016/97 of the European Parliament and of the Council with regard to information requirements and the conduct rules applicable to the distribution of insurance-based investment products is directly enforceable in Spain, as it is in all other European Union Member States.

Finally, we would highlight the recent entry into force of Law 5/2019 of 15 March, which regulates real estate credit contracts. Law 5/2019 generally prohibits 'loan-linked' insurance sales practices (i.e., those practices in which an insurance product is offered with a loan as an inseparable pack). However, it continues to allow 'combined' or 'grouped' sales practices (i.e., those in which loan and insurance products are offered together but can be contracted separately) but establishes the information and transparency requirements that distributors must comply with in these cases.

Rules governing insurance contracts, in their various forms

In this field, the predominant role of Law 50/1980, of 8 October, on insurance contracts (LCS) should be highlighted. The LCS contains both the general principles that apply to all insurance contracts and the specific provisions governing the main types of insurance contract that exist in Spain (e.g., damage, civil liability, fire, life and sickness). Most insurance litigation in Spain is based on the provisions of the LCS.

In Spain there are also other laws and regulations that apply to specific types of insurance contract. This is the case, for example, for civil liability insurance in respect of the use of motor vehicles (motor insurance), which is regulated in Royal Legislative Decree 8/2004 of 29 October approving the restated text of the Law on Civil Liability and Insurance for the Circulation of Motor Vehicles (LCLICMV), and Royal Decree 1507/2008 of 12 September, which approves the Regulation on mandatory civil liability insurance regarding the circulation of motor vehicles. There are also specific provisions in other regulations for ship or aircraft insurance contracts, civil liability insurance for nuclear damage, civil liability insurance for oil pollution, and export credit insurance.

ii Insurable risk

Although Spanish law does not offer an express definition of insurable risk, as a general rule, a risk is insurable as long as it:

- a* has an element of chance or uncertainty;
- b* refers to a future event, meaning that at the time of entering into the contract the damage or loss has not yet occurred or that the risk still exists. Under Spanish law, according to the general rule on civil liability for damage, the loss occurs at the moment that the action or incident that causes the damage takes place (even though the claim and, therefore, the evidence of it can take place much later in time). Thus, the contract is only valid if it refers to losses arising from actions subsequent to its signing. However,

Article 73 LCS allows for contracts with 'claims-made' clauses that have retrospective effects. In these cases, the claim, as opposed to the actual damaging act that causes the claim, constitutes the 'incident';⁴

c is lawful;

d is possible, meaning that the covered risk may potentially materialise;

e is fortuitous, meaning it is independent of the will of the parties or beneficiaries of the insurance contract. Two clarifications must be made in relation to this criterion:

- Spanish law does consider the insured party's suicide as an insurable incident, even though it is clearly the consequence of a conscious and voluntary action of the insured party. The only restriction imposed in the LCS to avoid fraudulent conduct is a time limit. Article 93 of the LCS holds that 'unless otherwise agreed, the risk of the insured person's suicide will be covered as of one year from the moment of the conclusion of the contract'; and
- even though civil liability derived from wilful misconduct of the insured party cannot be insured under Spanish law, the insurer must provide compensation for the damage caused by such misconduct to bona fide third parties (i.e., those who are not involved in a fraudulent scheme with the insured party). In fact, pursuant to Article 76 LCS, these third parties may bring their claims for compensation directly against the insurer (direct claim); and

f is tangible, has an economic value and can be appraised based on actuarial and experience criteria. Only in this case can the insurance premium, which constitutes an essential element of the insurance contract, be calculated.

Spanish law establishes that a person can enter into an insurance contract on his or her own behalf and interest or on behalf of and for the benefit of third parties (Article 7 LCS), but, as stated in Article 25 LCS (damage insurance) and Article 83 LCS (life insurance), the validity of the insurance contract is subject to the insured party having a legitimate interest in the insurance.

iii Fora and dispute resolution mechanisms

Spanish insurance law is characterised by the protection of the rights of insured persons. For this reason, it has special provisions that, in some cases, oblige the parties to initiate out-of-court proceedings before bringing a claim to court.

For example, where the disagreement between the insurer and the insured is limited to the extent of the damage to be compensated (but there is no dispute as to the coverage of the incident or risk), Article 38 LCS provides that the insurer and the insured must resolve their dispute by means of a compulsory out-of-court procedure⁵ in which each of the parties appoints an expert and the appointed experts try to reach common ground.

If the experts reach an agreement, the procedure concludes with them issuing a report on, among other things, the amount of compensation due. If no agreement is reached, a third

4 In relation to claims-made clauses, Supreme Court judgment 252/2018 of 26 April clarified that Article 73 LCS regulates two different 'rights-restriction' clauses (one for future coverage and another for retrospective coverage) and that retrospective coverage is not required for the validity of future coverage, and vice versa. This doctrine was upheld by the Spanish Supreme Court in its more recent judgment 170/2019 of 20 March.

5 Supreme Court Judgment No. 747/2009 of 11 November.

expert is appointed by the parties (or, if they fail to agree, by the court) so that within 30 days (or the term agreed upon) the three experts issue a final report (unanimously or by a majority vote) that is binding on the parties unless challenged in court.

If any of the parties disagree with this report, it can be challenged in court within the corresponding time limit.⁶

Another example of these special provisions can be found in the area of civil liability regarding the circulation of motor vehicles. Specifically, Article 7 of Royal Decree 8/2004 states that the injured party must file a claim with the insurer requesting compensation and providing information about the incident. The insurer must respond within three months with an offer of reasonable compensation or a response explaining why it believes that compensation is not warranted.

Apart from these special provisions, Spanish law grants freedom to the parties to use the conflict resolution mechanism they deem most appropriate. Although empirical evidence shows that insurance disputes are usually brought before the courts, parties are free, once the extrajudicial proceedings described been completed, to resolve the disagreement using alternative conflict resolution mechanisms (e.g., conciliation, mediation or arbitration). In any case, it should be noted that for a dispute to be validly resolved by arbitration under Spanish law, both parties must consent.⁷

III RECENT CASES

Some of the most important and recurring issues in judicial practice relating to insurance rights litigation are analysed in this section, with a particular focus on decisions rendered in the past 12 months.

i Judicial developments in motor insurance

Because of the volume of contracts taken out, motor insurance continues to represent a large part of the judicial proceedings concerning insurance matters. In recent months, several decisions of interest have been issued.

First, the Spanish Supreme Court has created consolidated case law on who should compensate, and to what extent, non-personal damage arising from a traffic accident in which the party responsible for the incident is not known.⁸

Article 1 LCLICMV establishes that the driver of a motor vehicle is liable, by virtue of the risk posed by driving the vehicle, for damage caused to persons or goods in connection

6 The limits are 30 days for the insurer and 180 days for the insured, with both terms running from the date of notification of the third expert's report (Article 38 LCS). If the third expert is appointed by the court, the terms run from the date the court notifies the parties (Spanish Supreme Court judgment 73/2019 of 22 January).

7 Vide Spanish Constitutional Court judgment 1/2018 of 11 January, which declared Article 76(e) LCS unconstitutional (and therefore null and void) since it allowed the insured to impose on the insurer the submission to arbitration of any dispute that might arise between them in relation to legal expenses insurance.

8 In relation to personal damages, the Spanish Supreme Court had already held repeatedly that (1) if the degree of responsibility of each vehicle is known, compensation must be proportional to this percentage or degree of participation; and (2) if this cannot be determined, both parties are liable for the total personal injury caused to the occupants of the other vehicle (vide Spanish Supreme Court judgments 536/2012 of 10 September, 40/2013 of 4 February, 627/2014 of 29 October and 312/2017 of 18 May).

with the vehicle's role in traffic. With respect to damage to goods, it establishes that the driver is liable to third parties when he or she is civilly liable as established in Article 1902 and following of the Civil Code, Article 109 and following of the Criminal Code, and the provisions of the LCLICMV itself.

After analysis of all these provisions and rules, Supreme Court judgment 249/2019 of 27 May established as a jurisprudential criterion that, in cases where the vehicle responsible for the collision is not known, each of the drivers must compensate 50 per cent of the damage caused to the other vehicle.

Second, the Court of Justice of the European Union (CJEU) issued a preliminary ruling in response to questions raised by the Spanish Supreme Court as to whether compulsory civil liability insurance coverage includes damage resulting from a spontaneous fire in a vehicle that had been parked in a private garage and unused for more than 24 hours. The Supreme Court considered that this type of fire, which had no link to the circulation of the vehicle, which was parked, would fall outside the scope of Article 1 LCLICMV (which refers to traffic events). However, the Court doubted whether these facts could fall within the concept of 'civil liability in respect of the use of vehicles' contained in Article 3 of Directive 2009/103/EC of 16 September 2009 relating to insurance against civil liability in respect of the use of motor vehicles.

In its judgment of 20 June 2019, and similarly to how it ruled on questions raised by courts of other Member States,⁹ the CJEU interpreted the concept of 'use of vehicles' broadly to conclude (1) that a vehicle is used in accordance with its function as a means of transport when it is in motion, but also when parked between two journeys; (2) that the duration of this parking is irrelevant for the purposes of the previous conclusion; and (3) that Article 3 of Directive 2009/103/EC should therefore be interpreted as including in the concept of 'use of vehicles' damage resulting from this type of accident.

Finally, in its judgment 33/2019 of 17 January, the Supreme Court held that the right of recourse of the Spanish Insurance Consortium¹⁰ is restricted solely and exclusively to the insurance company (and does not extend to the insured) if, after payment of the compensation, it is concluded that there actually was an insurance policy in force.

ii 'Risk-restriction' and 'rights-restriction' clauses: D&O insurance

Under Spanish law, risk-restriction clauses are those that specify the risk insured in the policy (i.e., they configure and describe the object of the insurance contract), as opposed to rights-restriction clauses, which restrict or modify the rights of the insured party to seek compensation once the accident has occurred.

9 Vide, for example, the judgment of 15 November 2018 (C-648/2017) in which, in response to a Latvian court, the CJEU considered the damage caused by a vehicle to another vehicle when opening a door in a car park to be damage arising from the circulation of vehicles.

10 The Spanish Insurance Consortium is a public body that, pursuant to Article 11 LCLICMV, is obliged to compensate damage to persons and property when, within the framework of compulsory vehicle insurance, a dispute arises over the validity of the policy.

Article 3 LCS establishes that rights-restriction clauses must be highlighted and specifically agreed to in written form. On the basis of this legal requirement, the Spanish courts have developed a consolidated doctrine that establishes the following as requirements for the validity of rights-restriction clauses:

- a* they are included among the specific conditions of the insurance contract, and not in the general conditions;
- b* their wording meets the criteria of transparency, simplicity and clarity, and, additionally, they must be highlighted within the text of the contract; and
- c* the policyholder expressly accepts them in writing.¹¹

The distinction between risk-restriction and rights-restriction clauses, apparently easy in theory, has generated several disputes. Generally speaking, insurance companies claim that a particular clause contained in the general conditions of the contract (which they use to deny cover) is a risk-restriction clause and therefore binding. In response to this, policyholders claim these clauses are rights-restriction clauses, as they restrict the natural scope of the insurance contract in question and therefore their validity is subject to compliance with the requirements of Article 3 LCS.

These were the arguments put forward in the case resolved by Supreme Court judgment 58/2019 of 29 January in relation to D&O insurance. The policy established that the insured risk was the 'losses' derived from the declaration of responsibility of the managers and directors of a company for their acts in the performance of their post. The special conditions did not specify any limitation or exception to this coverage. However, the general conditions indicated that taxes, social security contributions, fines and penalties imposed under the law, among other things, were not included in this concept of losses.

The beneficiaries of the insurance were held liable for certain tax debts of the company. The insurance company denied coverage on the grounds that tax debts were excluded from the concept of losses and, therefore, from the insured risk. The insured claimed before the courts that, as the natural scope of D&O liability insurance was to safeguard their assets against personal claims arising from improper acts in their corporate management, to exclude liability for tax debts would affect that natural scope, limiting the rights of the insured party (in other words, this was a rights-restriction clause that did not comply with the requirements of Article 3 LCS).

Supreme Court judgment 58/2019 of 29 January held that the natural scope of this type of insurance contract is not limited to civil liability that can be judicially declared on the basis of the Spanish Company Law, but extends to any other liability provided for in the administrative regulations and that has its origin in the directors' performance. This would be the case for the subsidiary liability for tax debts established in the Spanish General Tax Law. For this reason, the exclusion of coverage for this type of claim is a restriction of those rights of the insured party that are required for compliance with Article 3 LCS. Therefore, if the clause restricting those rights does not comply with the requirements set out in Article 3 LCS, it shall be deemed null and void.

11 Vide Supreme Court judgment 234/2018 of 23 April.

iii The direct claim of the injured party and the insurer's defences: limits when the amount of the compensation has already been established in a previous administrative procedure

Article 76 LCS provides that, in the field of civil liability insurance (1) the injured party (or his or her heirs) has a direct claim against the insurer to demand compliance with the obligation to compensate; and (2) the insurer may not deny payment by citing the exceptions that may apply against the insured party. Thus, it is a settled jurisprudential doctrine¹² that, in the event of a direct claim made by the injured third party, the insurer:

- a* may refuse to pay on the grounds that the damage claimed results from a risk that is objectively excluded from the contract (i.e., the risk does not fall within the scope of the contract as specified in the risk-restriction clauses); but
- b* cannot refuse to pay on the basis of exclusion-of-cover clauses that are based on the seriousness of the insured party's harmful conduct (driving under the influence of alcohol or drugs, existence of wilful misconduct, etc.). These are defences linked to the insured that cannot be raised against the injured party.

However, the Spanish courts have also clearly established that the rules of Article 76 LCS cannot serve as a means for the insured party to obtain unjust enrichment.¹³

In its recent judgment 321/2019 of 5 June, the Spanish Supreme Court addressed the scope of the injured party's direct claim against the insurer in cases where a previous administrative procedure established the existence of liability and, additionally, the amount of compensation owed by the liable party.

Such a previous administrative procedure may exist in cases where the insured party is a public body (e.g., when a public hospital is liable for the negligence of one of its doctors). Unlike what would happen in the case of a claim between individuals, under Spanish law, the contentious-administrative courts are the only jurisdiction competent to declare a public body liable.

In judgment 321/2019, the Supreme Court acknowledges that a claim under Article 76 LCS is separate from the claim against the responsible party. Therefore, the injured party does not have to seek the prior declaration, through administrative channels, of the public body's responsibility before claiming against the insurer pursuant to Article 76 LCS. The Article 76 LCS claim is heard by the civil courts, which assess, with a merely pre-judicial scope, whether or not the public body was responsible.

However, where there is a prior administrative procedure, it does affect the filing of a possible direct claim against the insurer. To the extent that (1) the insurer cannot be bound beyond the obligation of the insured; and (2) only the contentious-administrative courts can declare a public body liable to pay, the Supreme Court establishes as a judicial doctrine that the compensation awarded in the administrative sphere constitutes the maximum amount for which the insurer may be liable in any direct claim pursuant to Article 76 LCS. Thus,

¹² Vide Supreme Court judgment 200/2015 of 17 April.

¹³ Vide, for example, Supreme Court judgment 87/2015 of 4 March, which states that the insurance company can also raise any defence that results from the direct relationship between the insured and the injured parties (prior payment by the insured, waiver by the injured party in relation to the latter, etc.); also see Supreme Court judgment 52/2018 of 1 February, which warns that Article 76 LCS does not cover claims in which the damage has been caused by the conduct of the injured party who is seeking to be compensated.

Article 76 LCS cannot be used to try to obtain in civil proceedings (against the insurer) greater compensation than that awarded in administrative proceedings (against the party responsible for the damage).

iv Limitation period for claims against the insurance company for amounts paid in advance to purchase a dwelling under Law 57/1968 of 27 July

Article 1 of Law 57/1968 of 27 July on the receipt of advance payments for the construction and sale of dwellings establishes that those who build dwellings (other than social housing) intended to be used as a permanent or seasonal family residence and who receive part payment of the purchase price before or during construction must guarantee the repayment of the sums received, plus a percentage, by means of (1) an insurance contract with a registered and authorised insurer; or (2) a joint and several guarantee provided by an authorised financial institution.

As a result of the global financial crisis, numerous real estate developments were paralysed and buyers were forced to claim back the sums they had paid in advance. This situation has generated a large volume of litigation in recent years.

In judgment 320/2019 of 5 June, the Supreme Court analysed the statute of limitations of these purchasers' actions against insurance companies provided for in (1) Article 23 LCS (two years) versus (2) the general term provided for personal claims in Article 1964 of the Civil Code (five years).

The Supreme Court has established as doctrine that the applicable limitation period is the one provided for in Article 1964 of the Civil Code because Article 1 of Law 57/1968 established insurance or bank guarantees as alternative guarantees.

IV THE INTERNATIONAL ARENA

The jurisdiction of the Spanish courts to hear cases in which a dispute has arisen between parties from different Member States of the European Union is determined in accordance with the rules set out in Articles 10 and following of Regulation (EU) No. 1215/2012 of the European Parliament and of the Council of 12 December 2012 on jurisdiction and the recognition and enforcement of judgments in civil and commercial matters.

In those cases in which the defendant is not domiciled either in Spain or in another EU country, and there is no bilateral treaty between the defendant's state of residence and Spain, Article 22 *quinquies* of Organic Law 6/1985 of 1 July on the judiciary establishes that the Spanish courts will have jurisdiction to hear disputes arising from insurance issues if:

- a* the insured party, the policyholder or the beneficiary of the insurance contract is domiciled in Spain;
- b* the damage was caused in Spain;
- c* the insured party or the policyholder who is the claimant and all the other parties in conflict agree to submit the dispute to the Spanish courts after the dispute has arisen;
- d* both contracting parties submitted to the Spanish courts' jurisdiction before the dispute arose, and both parties were domiciled in Spain at the time the contract was signed; or
- e* both contracting parties submitted to the Spanish courts' jurisdiction before the dispute arose, and the claimant was the insured party or the policyholder.

Once the jurisdiction of the Spanish courts to rule on an ‘international’ matter has been established, the applicable law to resolve the dispute is determined, generally, by either (1) Article 7 of the Rome I Regulation,¹⁴ or (2) the private international law provisions contained in Articles 107 to 109 LCS.

Consequently, in general terms, the LCS is applicable to those casualty insurance contracts in which the risk is located in Spain and the policyholder (in the case of individuals) has his or her habitual residence or (in the case of legal persons) its registered office or administrative management headquarters there. The LCS is also applicable when the contract has been entered into to fulfil an insurance requirement imposed by a Spanish law.

With regard to life insurance, the LCS is applicable (1) when the policyholder has his or her address or habitual residence in Spain, or is effectively managed from Spain; (2) when so agreed with the insurer despite the policyholder being a Spanish citizen resident abroad; or (3) when the life insurance policy is collective and has been entered into to fulfil a requirement or as a consequence of a job subject to Spanish law.

Finally, in large-risk insurance contracts,¹⁵ the parties are free to choose the applicable law.

V TRENDS AND OUTLOOK

In the near future, litigation in the ‘traditional’ insurance sectors and branches (i.e., motor vehicles, health, civil liability, etc.) will continue to dominate. These proceedings will continue to deal with matters such as whether a given claim is covered, or the effects of a delay in the payment of compensation by the insurer.

However, both the entry into force of Law 5/2019 of 15 March regulating real estate credit contracts (which has a clear impact on the bancassurance sector) and the possible requirements that may be established by the law transposing EU rules on insurance mediation and distribution activities (currently pending enactment) could generate new disputes that do not relate to the coverage of the claim, but to verification of compliance with the obligations imposed on the insurer (and its intermediaries) in relation to the sale of the insurance.

In addition, society develops new needs every day that the insurance market must cover. In particular, the damage caused by the use of drones, the insurtech sector, cyber risks or the new means of transport being used in cities (e.g., electric scooters) are bound to be a source of new disputes.

14 Regulation (EC) No. 593/2008 of the European Parliament and of the Council of 17 June 2008 on the law applicable to contractual obligations.

15 Defined by Article 11 of Law 20/2015 of 14 July, on the organisation, supervision and solvency of insurance and reinsurance companies.

SWEDEN

*Johan Gregow*¹

I OVERVIEW

In Sweden, insurance litigation is often related to issues regarding insurance coverage. Moreover, there are cases related to indemnity insurance. The insurance company instructs counsel to defend the insured in line with the terms under the policy. There are plenty of subrogation cases, namely when the insurer has indemnified the insured and exercises subrogated rights in a claim against a third party. These cases are often settled by arbitration. Recent cases before the Supreme Court have covered issues regarding interpretation of provisions in the policy, third-party claims and the application of time limitation provisions.

In this chapter, we will provide an overview of general principles of Swedish insurance law and illustrate the recent case law.

II THE LEGAL FRAMEWORK

i Sources of insurance law and regulation, supervisory authority

The Insurance Contracts Act (ICA) covers the relationship between the insurer and the insured. This is the core piece of legislation related to insurance under Swedish law. The ICA covers both commercial insurance and consumer-related insurance. It covers, inter alia, requirements on the information to be provided by the insurer to the insured, the insurance policy, limitations of insurers' liability, the premium, insurance coverage, adjustment of claims under the policy and third-party rights under the policy.

The ICA contains no provisions covering the interpretation of insurance policies. In fact, there is no legislation covering interpretation of contracts in general in Sweden. In the absence of legislation concerning the interpretation of insurance policies, the principles of interpretation have instead evolved through legal doctrine and case law. The Supreme Court has created precedents on interpreting regarding, inter alia, exemption of liability clauses in insurance policies.

The Swedish Act on Insurance Distribution (AID) entered into force on 1 October 2018 implementing the EU Insurance Distribution Directive (IDD) into national law. The primary purpose of the IDD is to harmonise the rules for insurance and reinsurance distribution within the EU. The IDD also aims to achieve, when possible, equal competitive conditions and equal customer protection in respect of investments made directly in financial instruments compared to investments in life insurance (i.e., where the insurance premium is invested in financial instruments). The AID covers mediation of all types of insurance. The

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Swedish legislation goes beyond certain EU minimum rules in certain aspects. These include requirements for third-party remuneration and in relation to impartiality, as well as stricter rules on marketing.

The Insurance Business Act establishes the regulatory regime for insurance operations. The Swedish Financial Supervisory Authority (FI) is responsible for supervision, authorisation, sanction assessment, issuance of regulations, and reporting matters for the insurance industry. FI has developed regulations based on Swedish legislation. The regulations relate to, inter alia, issues regarding applications for underwriting permits, knowledge and competence requirements, employee compensation systems, and requirements related to the adjustment-of-loss process and impartiality. There are also special provisions on distribution of insurance-based investment products and certain kinds of pension insurance.

ii Insurable risk

According to Chapter 6 Section 1 and Chapter 8 Section 18 ICA, compensation may be made for any legal interest covered by the insurance.

According to mandatory law, illegal interests will not constitute a basis for entitlement to insurance compensation. Thus, the insurance must not cover loss of income that has arisen illegally. Moreover, the insurance policy cannot cover any payment obligation or loss arising from public sanctions decisions such as fines, environmental sanctions or confiscation of property. However, the insurance policy may provide for, inter alia, coverage of certain kinds of loss suffered by an employer caused by illegal actions by an employee against the employer.

Certain kinds of administrative fees, such as GDPR penalties, should probably be considered non-insurable interests, with insurance against these being unavailable. However, according to certain legal doctrine it has been suggested that such administrative fees can be covered by insurance. The issue is not covered by any Swedish case law. Thus, the legal position under Swedish law is not entirely clear in this respect.

Since there are several different and mutually exclusive kinds of Swedish financial sanctions, arguments could be made that the assessment as to whether the costs for a certain financial sanction are insurable or not should be made on a case-by-case basis, taking into account, inter alia, the reasons behind the sanction concerned and the actions of the insured.

The parties are free to agree to insure any interest other than that related to pure economic loss, actual damage or personal injury (e.g., insurance against moral damage). Moreover, there is no prohibition against the enrichment of the insured. However, another issue concerns whether the insurance policy should be interpreted as providing coverage that may give rise to such enrichment.

iii Fora and dispute resolution mechanisms

The ICA contains no provisions 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.

The losing party can appeal Swedish court judgments in insurance litigation in the same way as in other civil proceedings. A judgment rendered by the district court (i.e., the court of first instance) may be appealed to the court of appeal within three weeks of the judgment being rendered. Leave to appeal is a requirement if the case is to be tried on its merits in the court of appeal. Leave to appeal shall be granted if, inter alia, there is reason

to believe that the court of appeal would arrive at a different conclusion from the judgment rendered by the district court. There are certain applicable limitations preventing the parties from invoking new facts or evidence in proceedings before the court of appeal.

A judgment rendered by the court of appeal may be appealed to the Supreme Court. Leave to appeal should only be granted if a Supreme Court judgment could provide guidance for similar cases (i.e., if there is a need for a precedent). Thus, the requirements for leave to appeal to the Supreme Court are high and, in practice, the court of appeal is the highest instance in the majority of cases.

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. In Sweden, merger and acquisition (M&A) insurance and reinsurance policies are primarily referred to arbitration. Subrogation disputes (i.e., when the insurer has indemnified the insured and exercises subrogated rights against a third party) are sometimes settled through arbitration. This is often the case in, *inter alia*, disputes between the insurer and the insured's contractor in the field of construction. As a main principle, an arbitration clause between the insured and a contractor is also applicable to the insurer in a matter of subrogation.

III RECENT CASES

i Insurance mediation; the Supreme Court cases T 2761-15 and T 25-16

In 2019, the Supreme Court rendered judgments regarding the definition and scope of insurance mediation.

In one of the cases, the question was whether financial advice regarding investment of capital provided in connection with entering into an insurance contract constituted insurance mediation.

The investor had invested in financial instruments within the framework of a capital insurance policy, following advice from a registered insurance mediation company. The investment certificate became worthless and the insured lost the entire amount invested. Initially, the insured made claims against the insurance mediation company; however, this company entered into bankruptcy. The insurance mediation company was insured as stipulated under Swedish law. The investor filed claims against the insurance company. The insurance company alleged that the insurance mediation company's advice did not cover the capital insurance policy. Instead, the insurer argued that the advice related to the investments in the financial instruments, which were placed in the capital insurance product. Therefore, according to the insurance company, it had not been a matter of insurance mediation but of advice on investing in financial instruments.

In the second case, an insurance company had issued a liability insurance policy to an insurance mediation company. A number of individuals had handed over money to the insurance mediation company to invest these amounts in corporate bond products, which would be placed in a capital insurance product. However, it later emerged that the managing director of the insurance mediation company had embezzled the amounts. The insurance mediation company entered into bankruptcy. The insurance company rejected the claims to compensate the individuals, alleging that the corporate bond products were fictitious and thus the managing director's actions did not constitute insurance mediation.

The Supreme Court sought a preliminary ruling from European Court of Justice, which found in its judgment² the following:

- a* Financial advice covering placement of capital in the context of insurance mediation relating to the conclusion of a capital life insurance contract falls within the scope of the Insurance Mediation Directive and should not be considered investment advice under the Markets in Financial Instruments Directive, also known as MiFID II.³
- b* The concept of ‘insurance mediation’ includes work preparatory to the conclusion of an insurance contract, even in the absence of any intention on the part of the insurance intermediary concerned to mediate any actual insurance contract.

On the basis of the preliminary ruling of the European Court of Justice, the Supreme Court found – in both cases – that the actions concerned constituted insurance mediation.

Moreover, in the fraud case, the insurance company also alleged that the exception clause in the policy for damage caused by the insured intermediary intentionally or by gross negligence should apply to the individual suffering the loss.

However, the Supreme Court considered that the insurance mediation company was to be covered by liability insurance by statute. Therefore, there was reason to interpret the insurance policy to the benefit of the insurance mediation company’s clients. In an overall assessment, the Supreme Court found that the exemption clause regarding damage caused intentionally or through gross negligence by the mediator did not apply to loss caused to the insurance mediation company’s clients.

Thus, in both cases the insurance mediation company’s clients were entitled to compensation under liability insurance issued to the insurance mediation company.

ii Interpretation of terms in a liability insurance; Supreme Court case NJA 2018 s. 834

A designer company was commissioned by a contractor to produce design drawings for a school building. The design company’s delivery was defective, which delayed the contractor’s performance for the buyer. Therefore, the buyer was entitled to liquidated damages from the contractor. The contractor, in turn, claimed damages from the designer corresponding to the costs for those liquidated damages. The design company claimed reimbursement under its liability insurance. However, the insurance company alleged that the design company’s claim was not covered by the policy. The insurance company referred to an exception in the terms stating that the policy did not cover liquidated damages, penalties and punitive damages.

The Supreme Court interpreted the policy primarily on the basis of its wording. The Supreme Court found that the exemption clause should be interpreted as it only covered liquidated damages paid out by the insured. When the insured is under an obligation to compensate its contractual party for costs related to liquidated damages paid by a contractor to a third party, this is considered a claim for damages against the insured. The Supreme Court did not accept the insurance company’s argument that the purpose of the exemption clause was to cover any liquidated damages irrespective of which party paid out the liquidated damages. The main reason for the Supreme Court’s interpretation was that the stated purpose

2 Länsförsäkringar Sak Försäkringsaktiebolag and Others, C-542/16, EU:C:2018:369.

3 Directive 2014/65/EU of the European Parliament and of the Council of 15 May 2014 on markets in financial instruments and amending Directive 2002/92/EC and Directive 2011/61/EU.

did not follow from the wording of the policy. Nor was there any firm industry practice that could give guidance for the interpretation. In summary, the insured was entitled to insurance coverage under the policy.

iii Third-party claims under the policy in relation to the insured's bankruptcy; Supreme Court case NJA 2017 s. 601

A customer commissioned a service provider to carry out residential planning. The customer claimed compensation for design errors. The service provider, which entered into bankruptcy, was insured under a liability insurance policy.

According to Chapter 9 Section 7 ICA, a third party that has suffered damage may take direct action against the insurance company in the event of the insured's bankruptcy.

The insurance policy contained a provision stipulating that claims for compensation under the policy had to be reported to the insurance company within six months of the claim being made against the insured, otherwise the insurance company was not liable under the policy.

The service provider never filed a claim for compensation under the policy within the six-month period. Therefore, the insurance company rejected the customer's claims as a third-party claim under the policy. The customer alleged that his claim under the policy was not time-barred by the insured's failure to report the claim within the time limit.

The Supreme Court found that the six-month provision also applied to third-party claims under the policy. Thus, the Supreme Court concluded that, because of the service provider's failure to report the claim within the time limit, the customer was not entitled to compensation according to Chapter 9 Section 7 ICA.

iv The occurrence of damage under liability insurance; Supreme Court case NJA 2017 s. 237

During the period from 1 January 2002 to 31 December 2009, a municipality was covered by a liability insurance policy. Two claims for damages were made against the municipality. These claims are hereafter referred to as the 'building permit case' and the 'school case'. The municipality reported the two claims for damages under the insurance policy.

In the building permit case, the facts were the following. In September 2008, the municipality had granted building permits for the construction of a building. During construction consultations in October 2008, it was noted that construction would start as soon as possible. At an inspection in October 2009, it was found that the building was almost completed. In December 2009, the county administrative board revoked the building permit. The county administrative board's decision gained legal effect in September 2012. The property owner made a claim against the municipality for damages corresponding to the costs for the construction and demolition of the building.

In the school case, the municipality had in the autumn of 2002 decided to place a student in a certain school. The student's education started in 2005. In 2010, it was found that the education placement was not justified. The student, who completed the education programme in 2012, made claims against the municipality for damages for, inter alia, the amount of student loans or, alternatively, loss of income due to delayed entry into the labour market.

In both cases, the municipality's insurer disputed insurance coverage, alleging that the damage had occurred after the end of the insurance period. In the building permit case, the insurance company argued that the damage occurred when the decision to cancel the

building permit gained legal effect, namely in 2012, and further argued that it was at this point that it first became clear that the building had to be demolished, with the resultant economic loss.

In the school case, the insurance company alleged that the damage first occurred in 2012; that is, when the student was granted student loans to supplement his studies or, alternatively, when the student's work income was unrelated to his supplementary studies.

The relevant issue in the Supreme Court was the question of when the damage had occurred, namely whether the damage had occurred during the term of the policy or not. Initially, the Supreme Court stated that damage – with respect to liability insurance – is related to the basis for the claim against the insured. Thus, the occurrence of the alleged damage suffered by the party claiming compensation from the insured should be decisive.

For the Supreme Court, it was clear that an expression such as 'when the damage occurs' may have different meanings in different contexts. Thus, the term had to be subject to interpretation. The Supreme Court made an overall assessment based on the wording of the term, industry practice and the purpose of the term. Moreover, the Supreme Court anticipated that the parties' intention was to achieve fair and reasonable provisions in the policy. Thus, the terms of the policy should be interpreted in a way that implements fair and reasonable provisions.

In summary, the Supreme Court concluded that the damage was covered by the policy. Thus, according to the Supreme Court, it was irrelevant that the damage was only discovered and first confirmed after the end of the insurance period.

IV THE INTERNATIONAL ARENA

Sweden is a party to the 1980 Rome Convention on the Law Applicable to Contractual Obligations (Rome I). With only some exceptions, Rome I governs all the applicable national law for insurance contracts. According to Rome I, the basic principle is that the law chosen by the parties shall govern a contract. However, Rome I contains some restrictive choice-of-law rules regarding insurance contracts.

Furthermore, Swedish courts normally respect the choice of jurisdiction in an insurance contract. As agreements on applicable law are subject to the provisions in Rome I, agreements on jurisdiction are subject to the provisions in Regulation (EU) 1215/2012 on jurisdiction and the recognition and enforcement of judgments in civil and commercial matters.

Arbitration clauses in insurance policies between insurance companies and consumers are invalid. However, arbitration clauses are legally enforceable in corporate insurance contracts and certain types of group insurance for consumers.

For a foreign judgment to be enforced in Sweden, a treaty on enforcement between Sweden and the foreign state is required. Such treaties exist between, among others, EU and EFTA member states. Sweden is a party to the Brussels Regulation, Brussels Convention and Lugano Conventions.

The main rule according to the Swedish Arbitration Act is that a foreign arbitral award based on an arbitration agreement must be recognised and enforced in Sweden. The Swedish Arbitration Act specifies certain exceptional cases in which enforcement would not be approved. The provisions of the Swedish Arbitration Act conform to the United Nations Convention on the Recognition and Enforcement of Foreign Arbitral Awards 1958, to which Sweden is a party.

Moreover, the Swedish courts have the right to refuse the application of foreign law in recognising or enforcing a foreign judgment if it would lead to a result that is manifestly incompatible with public policy in Sweden.

V TRENDS AND OUTLOOK

M&A insurance has increased significantly over the past few years. Any disputes under M&A insurance are always settled by arbitration in Sweden.

Moreover, the importance of directors and officers insurance has also increased. There has been a substantial amount of litigation against former board members and auditors in Sweden in connection to, inter alia, withdrawal of banking licences and damage caused by alleged fraud.

The number of professional liability cases seems also to have increased, and against law firms, among others. In the past, most cases were related to tax advice. Today, one can see an increased number of cases related to M&A advice in particular. This development may continue.

Furthermore, the concept of litigation funding is coming to Sweden and may increase further in the future, which may add to the number of insurance-related disputes.

UNITED ARAB EMIRATES

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I OVERVIEW

This chapter aims to provide an overview of the sources of the UAE insurance law and regulations, including the latest developments in the insurance sector. It examines the recent case laws of the onshore UAE courts on insurance-related cause of actions. It also discusses the latest trends and areas likely to evolve further in insurance disputes in the UAE.

II THE LEGAL FRAMEWORK

i Sources of insurance law and regulation

The UAE Civil Transactions Code, Federal Law No. 5 of 1985 (as amended by Federal Law No. 1 of 1987) (the Civil Code) governs civil transactions relating to different types of contracts in onshore UAE. Parties to any contract, including insurance contracts, are subject to the provisions of the Civil Code. Part III of the Civil Code, commencing from Article 1026 to Article 1055, specifically applies to insurance contracts.

The insurance sector in the UAE is governed by Federal Law No. 6 of 2007 (as amended by Federal Law No. 3 of 2018) on Establishment of the Insurance Authority and Organisation of Its Operations (the Insurance Law). This chapter will focus on onshore insurance, re-insurance entities and the prevailing case laws issued by the UAE courts (excluding the offshore).

The Insurance Law applies to all onshore insurance companies, including foreign companies registered and licensed to operate in the UAE, companies engaged in the operations of cooperative insurance, takaful insurance, reinsurance companies and insurance professionals.

The Insurance Authority established by virtue of the Insurance Law oversees the onshore UAE insurance sector and issues rules and regulations to support the process of regulating and developing the insurance sector.

The main duties of the Insurance Authority as set out under the Insurance Law include protecting the rights of the insured and its beneficiaries, improving performance and efficiency of insurance companies, receiving applications to establish insurance and reinsurance companies, issuing necessary licences, determining unified tariffs for certain types of insurance and proposing programmes to develop the insurance sector. Apart from the Insurance Authority, there are health insurance regulators in Dubai (the Dubai Health

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Authority) and Abu Dhabi (the Department of Health – Abu Dhabi). The Insurance Authority supervises the health sector in coordination with the Dubai Health Authority and the Department of Health – Abu Dhabi.

The provisions of the Insurance Law are not applicable to the insurance companies registered to operate within the free zones in the UAE. Unless there is a specific provision governing insurance in the free zones, the Insurance Law refers to the application of the laws and regulations governing insurance in the onshore UAE. The financial free zones have their own legal and regulatory framework. The Dubai Financial Services Authority and the Dubai International Financial Centre (DIFC) Authorities regulate the framework of insurance companies registered to operate within the DIFC. The Financial Services Regulatory Authority of Abu Dhabi Global Market (ADGM) oversees the insurance companies operating within the ADGM.

Insurance and reinsurance companies operating onshore in the UAE must also follow the regulations issued by the chairman of the board of directors of the Insurance Authority in Board Resolution No. 2 of 2009 Issuing the Implementing Regulations of Law No. 6 of 2007 Concerning the Establishment of the Insurance Authority and the Regulation of Insurance Business (Resolution No. 2), and Board Resolution No. 3 of 2010 on Instructions Concerning the Code of Conduct and Ethics to be Observed by Insurance Companies Operating in the UAE. Circular No. 19 of 2014 (Circular No. 19) prohibits insurance brokerage companies operating onshore in the UAE from dealing with insurance companies that are unlicensed or not registered with the Insurance Authority; insurance contracts concluded with unlicensed or unregistered companies shall be considered null and void.

In 2019, the Insurance Authority issued Board Resolution No. 33 of 2019 Concerning the Regulation of the Committees for the Settlement and Resolution of Insurance Disputes (Resolution No. 33). The committees established for resolving insurance disputes are authorised to settle and resolve all types of insurance disputes arising from the complaints of the insured, beneficiaries or the relevant affected parties against insurance companies incorporated in the UAE and foreign insurance companies licensed to carry out insurance activities in the UAE, including takaful insurance companies. The committees shall consist of a chairman and two or more members appointed by the chairman of the Insurance Authority. The committees are not competent to hear summary and interim cases or precautionary attachments or insurance disputes that include an arbitration clause. Resolution No. 33 was published in the Official Gazette (659 of 2019) dated 31 July 2019 and will come into effect three months after its publication.

The key regulations issued by the Insurance Authority over the past 12 months with respect to the insurance and reinsurance markets are listed below:

- a* Board of Directors Decision No. 23 of 2019 Concerning Instructions Organising Reinsurance Operations, which provides new regulations for the practice of reinsurance operations and the necessary licensing and registration requirements;
- b* Board of Directors Decision No. 15 of 2019 on the Instructions Concerning the Rules of Ownership Ratios in the Capital of Insurance Companies;
- c* Cabinet Resolution No. 7 of 2019 Concerning the Administrative Fines Imposed by the Insurance Authority, which sets out a schedule providing for administrative fines for any person, company or insurance-related profession committing any of the violations contained in the schedule;

- d* Board of Directors Decision No. 12 of 2018 Concerning the Regulation of Licensing and Registration of Insurance Consultants and Organisation of their Operations, which sets out new regulations for the practice, licensing and registration requirements for insurance consultants;
- e* Board of Directors Decision No. 42 of 2017 on the amendment of some provisions of Insurance Authority Board of Directors Decision No. 25 of 2016 Pertinent to Regulation of the Unified Motor Vehicle Insurance Policies; and
- f* Board of Directors Decision No. 14 of 2018, Pertinent to the Application of Financial Solvency Requirements Stipulated in Chapter Two of the Financial Regulations for Insurance Companies and the Financial Regulations for Takaful Insurance Companies on the Branches of Foreign Insurance Companies Operating in the State.

ii Insurable risk

Resolution No. 2 provides for three categories of insurance; namely, life insurance and capital insurance; property insurance; and liability insurance.

The life insurance and capital insurance category includes insurance operations with the objective of paying out certain amounts as a result of death, disability or attaining a specific age. Further, it includes health insurance, personal accident insurance and capital insurance.

In addition, property and liability insurance refers to the following categories of insurance:

- a* insurance against fire risks, risks of land, sea and air transport;
- b* insurance of ships and aircraft, including machinery and cargo;
- c* insurance of satellites and spacecraft and their machines and materials;
- d* insurance of trailers, railway locomotives and land vehicles;
- e* engineering and oil insurance;
- f* health insurance of all types, including insurance against various accidents and liabilities, such as personal accidents insurance, security and breach of trust insurance, insurance of currency, deeds, bonds, shares, either during transport or during safekeeping;
- g* insurance against theft and burglary;
- h* professional liability insurance, inclusive of the liability in the health, engineering, financial, accounting and legal professions and other professions;
- i* workers' compensation insurance and liability insurance by the employer;
- j* crop insurance and livestock and other animal insurance; and
- k* other insurance, usually falling within accident insurance for various risks.

Mandatory insurance is applicable to both medical and motor insurance. This is a compulsory requirement applicable for all seven emirates in the UAE. Every owner of a motor vehicle has a compulsory duty to take out an insurance contract covering his or her civil liability arising out of death or injury from accidents involving the vehicle.

Professional liability insurance is mandatory with respect to certain categories of professionals in the field of accounting and in the financial and legal professions. Federal Law No. 12 of 2014 Concerning Auditing Profession Law regulates the profession of auditors and provides for compulsory insurance for auditors against liability for professional mistakes.

Federal Decree Law No. 4 of 2016 on Medical Liability prohibits practising medical professions without obtaining civil liability insurance against medical errors. Health facility providers are required to insure their medical practitioners against civil liability for medical errors.

There is no specific legislation in the UAE that restricts the insurable risks of a policyholder. However, any contract of insurance against the elements of public policy of the UAE and the principles of shariah law, such as risks against speculative gains similar to gambling, are considered uninsurable risks.

iii Fora and dispute resolution mechanisms

The UAE local courts have jurisdiction to determine insurance disputes in onshore UAE. The UAE court system is a combination of federal and local systems. The emirates of Ajman, Fujairah, Sharjah and Um Al Quwain are part of the federal court system and the emirates of Abu Dhabi, Dubai and Ras Al Khaimah have local court systems.

The federal court system consists of the court of first instance, which has jurisdiction to hear any civil disputes within the emirate, a court of appeal and a court of cassation, which is the highest court. The UAE Union Supreme Court is the highest court in the federal court system.

The financial free zones have their own independent courts. The DIFC courts, based in the DIFC, and the Abu Dhabi Global Markets Courts, located in the ADGM, have jurisdiction to hear all civil and commercial matters within their respective financial zones.

Insurance disputes are also capable of settlement through arbitration. It is noteworthy that under Article 1028(1)(d) of the Civil Code, an arbitration clause may not be included in an insurance policy, unless the arbitration clause is contained in a special agreement separate from the general printed conditions of the insurance policy.

III RECENT CASES

The majority of the insurance litigation cases filed with onshore UAE courts are in connection with claims related to vehicle insurance, insurance covering accidents in the event of a fire and insurance claims with regard to errors or omissions and professional liability.

The UAE courts have established in numerous cases (referring to Article 1026 of the Civil Code) and held that a contract of insurance is a contract of risk in which the insurer is bound to pay compensation to the assured, if the insured risk materialises. It is noteworthy that, similarly to any other contract, an insurance contract must be implemented under its own terms and conditions and in accordance with the requirements of good faith.

The parties to the contract have complete freedom in agreeing on the conditions and applicable scope of the insurance cover and in determining the identity of the beneficiaries who will have the advantage of the insurance, subject to the exceptions and conditions prohibited by Article 1,028(1) of the Civil Code.

Under Article 1,035 of the Civil Code, if an insured risk materialises, the beneficiary (third party) can file a claim against the insured seeking compensation. Another type of remedy available for the insured is to seek replacement or repair of the insured good. In cases of this kind, the insurer will assess the claim and provide the appropriate benefit outlined in the insurance contract. However, this depends on the scope of the insurance contract and the conditions agreed by the parties in the insurance contract.

In general, the approach followed by the UAE courts in awarding compensation for material harm requires that there must have been an infringement of a property right of the aggrieved, and the harm must have materialised. For instance, the criterion as to whether there has been material damage to a person as a result of the death of another is whether the deceased was supporting that person at the time of death and in a permanent manner. In that

event, the court must assess the value of the loss of opportunity sustained by the aggrieved party through the loss of support and must award compensation on that basis. In a decision dated 1 February 2018 (Cassation Case No. 1/2018), the Dubai Court of Cassation upheld the decision issued by the court of appeal granting the aggrieved party compensation for an amount of 1.1 million UAE dirhams in addition to 9 per cent interest, against an insurance company for the loss of opportunity and physical inability caused by a motor accident.

In another decision dated 8 March 2018 (Cassation Case No. 3/2018), the Court of Cassation confirmed the Appeal Court's decision to reject a claim filed by a UAE entity that claimed damages owing to professional error in connection with its website and trademark protection (intangible assets). The court appointed expert, in the present case confirmed that there was no evidence to prove the alleged professional mistakes. The first instance court and the appeal court dismissed the case and the Court of Cassation affirmed the same.

The limitation period for claims under the insurance policy is a three-year time limit, commencing from the date of the occurrence of the incident or the date on which the person having an interest obtained knowledge about the incident (Article 1,036 of the Civil Code).

It is established by the UAE courts that the liability of the insurer to pay compensation is based on the contract of insurance and not on liability in tort. The UAE courts have in numerous cases held that the contract of insurance seeks to compensate the assured from the loss sustained by the insurer as a result of an insured risk but within the limits of the actual loss suffered and without exceeding it.

In a decision dated 26 April 2018 (Cassation Case No. 34/2018), the Court of Cassation upheld the decision by the Appeal Court that awarded an insurer an amount of 55,000 dirhams for a claim with respect to motor insurance. In this case, the claim raised by the insurer was for an amount of 250,000 dirhams, which was the total insurance sum covered. The Court of Appeal determined that the cost of the actual damage to the insurer was 55,000 dirhams, and accordingly the Appeal Court awarded the actual amount as damages rather than the total insurance sum.

There is no specific regulation governing the notice of claim, but in general the conditions set out in the insurance policy are applicable for the notice of claim. The UAE courts have established in numerous cases that the insured must give written notice to the insurance company of the occurrence of the events as a condition precedent to the company's liability under the policy. In the event of failure to meet this precondition, the insured cannot recover the indemnity paid to the aggrieved party from the insurance company (Dubai Court of Cassation Case No. 68-2010 dated 27 June 2010).

IV THE INTERNATIONAL ARENA

Articles 20 and 21 of the UAE Civil Procedure Law deal with the jurisdiction of the onshore UAE courts. The UAE courts have jurisdiction to hear disputes in the following cases, even if the parties agreed to a different jurisdiction. With the exception of actions *in rem* relating to real property abroad, the courts shall have jurisdiction to hear actions brought against nationals and claims brought against foreigners having domicile or a place of residence in the state if:

- a* the defendant has an elected domicile in the state;
- b* the action relates to property in the state or the inheritance of a national or an estate opened therein;

- c* the action relates to an obligation entered into or performed, or that is stipulated to be performed in the state; a contract intended to be notarised therein or to an event that occurred therein; or to a bankruptcy declared in one of its courts;
- d* the action is brought by a wife having domicile in the state against her husband who had domicile therein;
- e* the action relates to the maintenance of one of the parents or a wife or a person under restriction or a minor, or in connection with the guardianship of property or a person if the applicant for the maintenance or the wife or the minor or the person under restriction is domiciled in the state;
- f* it relates to personal status and the plaintiff is a national or a foreigner having a domicile in the state, if the defendant has no known domicile abroad or if national (UAE) law is mandatorily applicable in the action; or
- g* one of the defendants has a domicile or place of residence in the state.

The process and requirements for enforcing foreign judgments and orders onshore in the UAE are governed by the provisions of Articles 85, 86 and 88 set out under Chapter IV of Cabinet Resolution No. 57 of 2018 concerning the Executive Regulation of the Civil Procedure Law (the Cabinet Resolution). The aforementioned Articles replace the previous requirements provided under Article 235 to 238 of the Civil Procedures Code. Pursuant to Article 85(1) of the Cabinet Resolution, judgments and orders issued in a foreign country may be ordered to be enforced in the UAE on the same conditions as those prescribed in the laws of that country for the enforcement of similar judgments and orders issued in the UAE.

Article 85(2) of the Cabinet Resolution provides that an application for the recognition and enforcement of the foreign judgment before the onshore UAE courts shall be submitted before the execution judge and an order shall be issued no later than three days from the date of submission of the application. The order issued by the execution judge can be appealed in accordance with the rules and procedures provided for appealing a judgment. The onshore UAE courts may grant an order granting enforcement after verifying the following:

- a* The onshore UAE courts do not have exclusive jurisdiction over the dispute on which the judgment or order has been issued, and the foreign courts that issued the order have jurisdiction in accordance with the rules of international jurisdiction provided in their laws.
- b* The judgment or order has been issued by a court in accordance with the law of the country in which the judgment or order has been issued and duly certified.
- c* The parties to the lawsuit for which the foreign judgment or order is issued were properly summoned and duly appeared.
- d* The judgment or order has acquired the force of *res judicata* under the law of the court that issued it, and a certificate has been provided confirming that the judgment has acquired the force of *res judicata*, or this is confirmed in the judgment itself.
- e* The judgment does not conflict with a previous judgment or an order issued by a court in the UAE and it would not be contrary to public policy or morality.
- f* The enforcement judge has the authority to demand documents that support the application before an order for enforcement is issued.

Pursuant to Article 86 of the Cabinet Resolution, the aforementioned provisions of Article 85 shall apply to the enforcement of foreign arbitral awards, provided that the award is issued in a matter for which arbitration is permissible in accordance with UAE laws and is enforceable in the country where it was issued.

V TRENDS AND OUTLOOK

The insurance sector in the UAE has continued to witness growth in the year 2018. The introduction in 2017 of the unified motor vehicle insurance policies and compulsory health insurance for all residents in the UAE contributed to substantial growth in the health insurance sector.

The recently announced new infrastructure projects in Abu Dhabi and the upcoming Dubai Expo 2020 are viewed as driving factors boosting the UAE economy. Other sectors likely to witness growth are real estate, manufacturing, construction, education and tourism.

The areas that are likely to evolve and become more important to insurance disputes in the UAE largely relate to professional malpractice and the real estate and construction sectors. With the advancement of the Hyperloop system, transportation services are expected to progress and this is another evolving area that could further impact the insurance field. Similarly, rapid advancement in the area of integrated smart digital systems in the UAE is likely to result in more importance being attached to the field of the artificial intelligence.

A noteworthy development is the establishment of the insurance disputes resolution committee, operating under the supervision of the Insurance Authority and hearing insurance disputes. This committee helps to fast track the disposal of disputes in a cost-effective manner.

UNITED STATES

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I OVERVIEW

In the United States, insurance disputes are primarily governed by state law. Each state has its own statutory and common law applicable to insurance-related matters. Because the relevant law varies from state to state, practitioners must conduct a careful evaluation of potentially applicable law at the outset of an insurance dispute.

Most insurance disputes in the US are litigated in the first instance in state or federal trial courts. Disputes may also be subject to arbitration if the insurance contract contains an arbitration clause. Where an insurance contract requires the parties to arbitrate but applicable state statutory law prohibits insurance-related arbitration, courts will address whether state law supersedes or preempts federal law or treaties favouring arbitration.

US courts recently have addressed a number of significant insurance-related issues, including the proper allocation of losses arising from ‘long-tail’ liabilities between insurers and policyholders, coverage for disgorgement, malpractice claims by insurers against insurer-appointed counsel for policyholders and cyber insurance. Going forward, courts undoubtedly will continue to address the parameters of cyber-related coverage and issues related to long-tail claims. In addition, insurers may find themselves increasingly embroiled in coverage disputes arising out of climate change events.

II THE LEGAL FRAMEWORK

i Sources of insurance law and regulation

The regulation of insurance in the US is primarily performed by the states. In 1945, the US Congress passed the McCarran-Ferguson Act,² which provides that ‘No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance . . . unless such Act specifically relates to the business of insurance.’³ Under the McCarran-Ferguson Act, federal law preempts state insurance law only if it specifically relates to ‘the business of insurance’.

The law of insurance in the US generally falls into one of two broad categories: (1) the regulation of entities that participate in the business of insurance; and (2) the regulation of

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2 15 U.S.C. §§ 1011-15 (1945).

3 *Id.* § 1012(b).

the policyholder–insurer relationship. State law pertaining to the regulation of entities is generally comprised of statutes enacted by state legislatures and administrative regulations issued by state agencies, such as departments of insurance.

Each state also has statutory and common law applicable to the policyholder–insurer relationship. State statutes address a range of topics, including, among others, the disclosure obligations of the parties to an insurance contract, the nature of a policyholder’s notice obligations and the circumstances in which a victim of tortious conduct may sue a tortfeasor’s insurer directly. State common law is an important source of law for resolving disputes between policyholder and insurer. Practitioners must carefully assess potentially applicable law at the outset of a dispute, as insurance law (whether common law or statutory) varies by jurisdiction.

ii Insurable risk

In the US, the validity of an insurance contract ordinarily is premised on the existence of an insurable interest in the subject of the contract. An insurable interest may be defined as any lawful and substantial economic interest in the safety or preservation of the subject of the insurance free from loss, destruction or pecuniary damage.⁴ The insurable interest doctrine was first adopted by courts⁵ and has since been codified in state statutes.⁶ The purpose of the insurable interest requirement, as articulated by courts and commentators, is to discourage wagering and the destruction of life and property and avoid economic waste.

iii Fora and dispute resolution mechanics

Litigation of insurance disputes

The US judicial system is comprised of two separate court systems. The US itself has a system comprised of federal courts and each of the 50 states has its own system comprised of state courts. Although there are important differences between federal and state courts, they share some key characteristics. Each judicial system has trial courts in which cases are originally filed and tried, a smaller number of intermediate appellate courts that hear appeals from the trial courts and a single appellate court of final review.

Unlike state courts, which include courts of general jurisdiction that can address most kinds of cases, federal courts principally have jurisdiction over two types of civil cases. First, federal courts may hear cases arising out of the US Constitution, federal laws or treaties.⁷ Second, federal courts may address cases that fall under the federal ‘diversity’ statute, which generally authorises courts to hear controversies between citizens of different US states and controversies between citizens of the US and citizens of a foreign state.⁸ For diversity jurisdiction to exist, there must be ‘complete’ diversity between litigants (i.e., no plaintiff shares a state of citizenship with any defendant) and the ‘amount in controversy’ must exceed US\$75,000.

Most insurance disputes are litigated in the first instance in federal or state trial courts. Federal courts commonly exercise jurisdiction over insurance disputes under the diversity

4 See generally Steven Pitt *et al.*, Couch on Insurance § 41:1 (3rd ed. 2019).

5 See, e.g., *Kramer v. Phoenix Life Ins. Co.*, 940 N.E.2d 535 (N.Y. 2010) (discussing common law origins and codification of New York insurable interest requirement).

6 See, e.g., Cal. Ins. Code §§ 280, 281 (2019).

7 28 U.S.C. § 1331 (1980).

8 28 U.S.C. § 1332(a) (2011).

statute. 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.

An insurance action that is originally filed in state court may be ‘removed’ to federal court based on diversity of citizenship of the litigants. In the absence of diversity of citizenship or some other basis of federal court jurisdiction, insurance disputes are litigated in state 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. The law applied to the dispute may likewise be dictated by a choice-of-law clause in the insurance contract or, in the absence of such a clause, determined by a court based on relevant choice-of-law principles.

Arbitration of insurance disputes

Some insurance contracts contain arbitration clauses, which are usually strictly enforced. The Federal Arbitration Act (FAA)⁹ and similar state statutes empower courts to enforce arbitration agreements by compelling the parties to arbitrate. If an insurance contract contains a broadly worded arbitration clause, virtually every dispute related to or arising out of the contract typically may be resolved by arbitrators rather than a court of law.

While all US states recognise the validity and enforceability of arbitration agreements in general, some states have made a statutory exception for arbitration clauses in insurance contracts. Complex legal issues may arise when an insurance contract obligates parties to arbitrate but applicable state statutory law prohibits the arbitration of insurance-related disputes. Although state laws that prohibit arbitration are generally preempted by the FAA, by virtue of the Supremacy Clause in the US Constitution, state anti-insurance arbitration statutes may be saved from preemption by the McCarran-Ferguson Act. As noted, the McCarran-Ferguson Act provides that state laws enacted ‘for the purpose of regulating the business of insurance’ do not yield to conflicting federal statutes unless a federal statute specifically relates to the business of insurance. Because the FAA does not specifically relate to insurance, courts have held that the FAA may be ‘reverse preempted’ by a state anti-insurance arbitration statute if the state statute has the purpose of regulating the business of insurance.¹⁰ As discussed in Section IV, courts are split regarding whether the Convention on the Recognition and Enforcement of Foreign Arbitral Awards (the New York Convention), an international treaty that mandates the enforcement of arbitration agreements, may be reverse preempted pursuant to the McCarran-Ferguson Act.

Where an insurance dispute is resolved through arbitration, the resulting award is generally considered to be binding, although there are grounds to vacate or modify an award under the FAA, similar state statutes and the New York Convention. The FAA describes four limited circumstances in which an arbitration award may be vacated by a court: (1) where the award was procured by corruption, fraud or undue means; (2) where there was evident partiality or corruption in the arbitrators; (3) where the arbitrators were guilty of misconduct in refusing to postpone the hearing, upon sufficient cause shown or in refusing to hear evidence pertinent and material to the controversy; or if by any other misbehaviour the rights of any party have been prejudiced; or (4) where the arbitrators exceeded their powers or so

9 9 U.S.C. §§ 1-16 (1947).

10 See, e.g., *Standard Life Ins. v. West*, 267 F.3d 821 (8th Cir. 2001) (Missouri statute’s insurance arbitration bar reverse preempts FAA pursuant to McCarran-Ferguson Act).

imperfectly executed them that a mutual, final and definite award upon the subject matter submitted was not made.¹¹ One area of legal uncertainty is whether a court may vacate an award based on an arbitrator's 'manifest disregard' of the law. Although the manifest disregard standard is not listed in the FAA, some courts have ruled that an award may be vacated on this basis.

III RECENT CASES

US courts recently have addressed a number of significant insurance-related issues, including the proper allocation of long-tail losses between insurers and policyholders, coverage for disgorgement, malpractice claims by a defending insurers against insurer-selected counsel and cyber insurance.

i Unavailability exception to pro rata allocation

When injury or damage from long-tail liabilities, such as asbestos or environmental contamination, trigger coverage under more than one policy, courts are tasked with devising an appropriate method for allocating losses among multiple policies. The two primary methods of allocation recognised by US courts are: (1) finding each triggered policy to be jointly and severally liable for the entire loss (all sums); and (2) allocating the losses to each triggered policy on a pro rata basis. Pro rata allocation is based on the fact that some liability policies provide coverage only for losses occurring 'during the policy period'.

Under the pro rata allocation method, a policyholder generally must pay a share of its own long-tail liability costs for years when it had no policies in place. If an 'unavailability' exception is applied, however, the policyholder need not cover costs incurred during periods when insurance was unobtainable (either because it had not yet been offered by insurers or because the industry had adopted a pollution exclusion); instead, those costs are spread among the company's insurers.

The highest courts of two states – New York and New Jersey – recently addressed the question of whether an unavailability exception to pro rata allocation exists under their respective laws, and reached different conclusions. In *KeySpan Gas East Corp v. Munich Reinsurance America Inc*,¹² New York's highest court rejected an unavailability exception to pro rata allocation, holding that policyholders, not insurers, are responsible for damages that occurred during periods in which applicable insurance coverage was unavailable. The coverage dispute in *KeySpan* arose out of environmental contamination that took place over several decades. In declining to apply an unavailability exception, the court relied on policy language limiting coverage to losses that occurred during the policy period, explaining that there was no basis for exposing an insurer to risks beyond those contemplated by unambiguous policy language. The court also explained that the unavailability exception 'would effectively provide insurance coverage to policyholders for years in which no premiums were paid and in which insurers made the calculated choice not to accept premiums for the risk in question'.

By contrast, New Jersey's highest court affirmed the applicability of the unavailability exception in *Continental Insurance Company v. Honeywell International, Inc*.¹³ The coverage dispute in that case arose from Honeywell's production of asbestos-containing products from

11 9 U.S.C. § 10(a) (2002).

12 96 N.E.3d 209 (N.Y. 2018).

13 188 A.3d 297 (N.J. 2018).

1940 until 2001. The policies from 1986 to 2001 contained exclusions for asbestos-related liabilities. The court held that the unavailability exception to pro rata allocation was a matter of established law in New Jersey and that, while the court '[would] not hesitate to revisit' this approach if it proved 'inefficient or unrealistic', this case 'does not present a compelling vehicle to reconsider our precedent on allocation'.

A third case that implicates the unavailability exception is currently pending in Connecticut's highest court: *RT Vanderbilt Co, Inc v. Hartford Accident & Indem Co.*¹⁴

ii Disgorgement

Delaware's highest court and a New York intermediate appellate court recently addressed the ongoing debate over whether policyholders are entitled to coverage for losses characterised as 'disgorgement' of wrongfully obtained funds.

The Delaware court ruled that class action settlement payments made by TIAA-CREF – a provider of investment counselling – was not uninsurable disgorgement under New York law. *In re: TIAA-CREF Ins Appeals.*¹⁵ The court noted that New York public policy prohibits insurance coverage for disgorgement where 'payment is conclusively linked, in some fashion, to improperly acquired funds in the hands of the insured'. However, the court concluded that no conclusive showing of ill-gotten gains was made here. The court cited New York cases finding disgorgement uninsurable, explaining that those cases involved conclusive links between the insured's misconduct and the payment of funds, whereas here TIAA-CREF expressly denied any liability for its alleged failure to pay financial gains that had accrued in customers' accounts. Additionally, the court noted that New York cases finding disgorgement uninsurable involved claims brought by government or regulatory entities, whereas the claims against TIAA-CREF were brought in private civil actions.

Several months later, a New York appellate court ruled that no coverage existed for a policyholder's settlement payment to the US Securities and Exchange Commission (SEC) characterised as disgorgement. *JP Morgan Securities, Inc v. Vigilant Insurance Co.*¹⁶ The court ruled that the disgorgement payment was not a covered 'loss', defined by the operative liability policy to exclude 'fines or penalties imposed by law', because the payment constituted an excluded penalty. The court relied on the US Supreme Court's ruling in *Kokesh v. SEC*,¹⁷ which expressly held that 'SEC disgorgement constitutes a penalty.'

iii Malpractice actions by defending insurer against insurer-selected counsel for policyholder

Joining a majority of states to consider the issue, the South Carolina Supreme Court recently held that an insurer may pursue a legal malpractice claim against counsel it hired to defend its insured. In *Sentry Select Insurance Co v. Maybank Law Firm, LLC*,¹⁸ the Court ruled that an insurer's malpractice action concerning a law firm's alleged mishandling of litigation regarding a car crash involving its insureds was viable, notwithstanding the absence of an attorney-client relationship between counsel and the insurer. The Court explained that although counsel owes a fiduciary duty only to the insured, the 'unique position' of

14 156 A.3d 539 (Conn. App. Ct. 2017), review granted in part, 171 A.3d 63 (Conn. 2017).

15 192 A.3d 554 (Del. 2018).

16 84 N.Y.S.3d 436 (N.Y. App. Div. 2018).

17 137 S. Ct. 1635 (2017).

18 826 S.E.2d 270 (S.C. 2019).

the insurer in this context militates in favour of allowing a malpractice claim. Limiting its holding, the Court emphasised that an insurer may recover damages for an attorney's breach of duty to an insured client only where the insurer proves that its claim for damages arose proximately as a result of the breach, and that there can be no liability if the interests of the client 'are the slightest bit inconsistent with the insurer's interest'.

Florida's highest court recently agreed to consider a defending insurer's right to sue its insured's counsel for malpractice in *Arch Insurance Co v. Kubicki Draper, LLP*.¹⁹

iv Cyber insurance: social engineering and spoofing

Policyholders often seek coverage for cyber-related losses under general liability or crime policies that address coverage for computer fraud. As illustrated by four recent cases, in determining whether coverage exists in this context, courts have confronted the question of whether the underlying computer fraud qualifies as a 'cause' of the losses at issue, particularly where policy language requires the loss to arise 'directly' out of use of a computer.²⁰ Three of these cases involved 'spoofing' claims, in which a communication is sent from an unknown source disguised as a source known to the recipient in an attempt to trick the recipient into transferring funds or disclosing sensitive information.

In *Interactive Communications International, Inc v. Great American Insurance Co*,²¹ the Court of Appeals for the Eleventh Circuit recently ruled that a computer fraud policy does not cover losses caused by fraudulent debit card transactions because the losses did not result directly from computer fraud. Interactive Communications International (InComm) provided a service that allowed customers to fund prepaid debit cards using a computerised interactive telephone system. A vulnerability in InComm's processing centre allowed cardholders to add credit to their debit cards in multiples of the amount actually purchased, resulting in a loss of more than US\$11 million to various debit card users.

The operative computer fraud policy covered losses 'resulting directly from the use of any computer to fraudulently cause a transfer of money, securities or other property'. The Court of Appeals for the Eleventh Circuit first held that 'directly' requires a consequence that follows 'straightaway, immediately, and without any intervention or interruption'. The Court concluded that, while the fraudsters' use of the company's computerised interactive telephone system constituted sufficient use of a computer, the company's loss did not result directly from that use. Rather, two intervening steps took place between the computer fraud and InComm's loss of funds: the transfer of funds onto debit cardholders' accounts and the purchase of goods by a debit cardholder. The Court rejected InComm's assertion that the loss was immediate because it occurred at the moment the funds were transferred to the debit cardholders' accounts.

Two other courts of appeals recently reached contrary conclusions. In *Medidata Solutions Inc v. Federal Insurance Co*,²² the Second Circuit ruled that claims arising out of a wire transfer initiated by fraudulent emails or spoofing are covered by a computer fraud provision where the policyholder sustained a 'direct loss'. A Medidata employee received an email purportedly sent from Medidata's president advising her to follow a certain attorney's instructions in

19 No. SC19-673, 2019 WL 2386336 (Fla. Jun. 6, 2019).

20 Another important issue in this developing area of the law is whether computer fraud coverage applies solely to 'unauthorised' attacks on a policyholder's computer system (e.g., hacking) or something more.

21 731 F.App'x 929 (11th Cir. 2018).

22 729 F.App'x 117 (2d Cir. 2018).

connection with a potential corporate acquisition. That same day, the employee received a call from a man who identified himself as that attorney and requested a wire transfer. Thereafter, the employee received an email, purportedly from Metadata's president, confirming that the transfer should be made. It was later discovered that the emails were sent from an unknown source and then altered to appear as if they were sent by Metadata's president.

The computer fraud provision under which Metadata sought coverage applied to loss arising from the fraudulent entry of data into a computer system or change to data elements of a computer system. The Second Circuit held that the hackers' attack constituted fraudulent entry of data into the computer system and that Metadata sustained a direct loss because the spoofed emails were the proximate cause of the company's losses. The Court explained that the intervening employee actions to effectuate the transfer were not sufficient to 'sever the causal relationship between the spoofing attack and the losses incurred'.

In *American Tooling Center Inc v. Travelers Casualty & Surety Co of America*,²³ the Sixth Circuit similarly ruled that claims arising out of wire transfers are covered by a computer fraud policy because the vendor-impersonation spoofing scheme resulted in a direct loss to the company and that the loss was directly caused by the alleged computer fraud. American Tooling, a tool and die manufacturer, received an email purportedly sent by a vendor, but in actuality sent by an imposter, instructing it to send payment for outstanding invoices to a new bank account. American Tooling wired approximately US\$800,000 to the account without verifying the new instructions with the vendor.

The computer fraud provision covered the 'direct loss of, or direct loss from damage to, Money, Securities and other Property directly caused by Computer Fraud'. The court ruled that American Tooling had suffered a direct loss of funds when it transferred the money to the imposter, rejecting the insurer's argument that no such loss occurred because the insured contractually owed money to its vendor. The Sixth Circuit held that the loss was directly caused by computer fraud because the fraudulent email induced a series of internal actions that directly caused the transfer of money. The Court cited *Interactive Communications*, explaining that there were intervening steps and a time lapse between the computer fraud and the loss in that case whereas, in the present case, the loss occurred immediately upon the wire transfer, which was directly caused by the fraudulent email.

Finally, in *Aqua Star (USA) Corp v. Travelers Casualty & Surety Co of America*,²⁴ the Ninth Circuit ruled that crime policy exclusion barred coverage for losses stemming from a wire transfer initiated by a fraudulent email. The Court assumed, without deciding, that the losses were covered by a computer fraud provision, but that coverage was nonetheless barred by an exclusion that applied to 'loss or damage resulting directly or indirectly from the input of Electronic Data by a natural person having the authority to enter the Insured's Computer System'. The Court reasoned that the exclusion squarely applied because the employees that changed the payee information in the company's computers (albeit as a result of a fraudulent email) were authorised to enter the computer system and that the losses at issue were caused by the payment changes made by those authorised employees.

The causation issue addressed in these recent cases has been teed up for yet another federal appellate court in *Principle Solutions Group, LLC v. Ironshore Indemnity, Inc.*²⁵

23 895 F.3d 455 (6th Cir. 2018).

24 719 F.App'x 701 (9th Cir. 2018).

25 No. 17-11703 (11th Cir.).

IV THE INTERNATIONAL ARENA

Complex jurisdictional issues may arise when an international insurance contract mandates arbitration of disputes but applicable state law prohibits such arbitration. In these circumstances, courts must address the interplay between governing state law and the New York Convention, which obligates the enforcement of foreign arbitration agreements. More specifically, such disputes require a determination of whether the New York Convention preempts state law such that arbitration is required, or conversely, whether state law reverse preempts the New York Convention pursuant to the McCarran-Ferguson Act, such that disputes may be litigated in a court of law.

Federal courts of appeals are divided on this critical issue of international insurance law. In a decision issued this year, the Court of Appeals for the Fifth Circuit ruled that an arbitration clause was enforceable notwithstanding a state statute banning insurance arbitration and a 'conformity-to-statute' clause in the insurance policy. In *McDonnell Grp, LLC v. Great Lakes Ins SE, UK Branch*,²⁶ the insurers argued that the dispute, relating to the scope of coverage under a builder's risk policy, was subject to arbitration pursuant to the policy's arbitration provision. However, the policyholder argued that the arbitration provision was invalid because (1) Louisiana statutory law expressly prohibits arbitration agreements in insurance policies covering property located within the state, and (2) the operative policy contains a conformity-to-statute provision stating that '[i]n the event any terms of this Policy are in conflict with the statutes of the jurisdiction where the Insured Property is located, such terms are amended to conform to such statutes.'

The Fifth Circuit ruled that reverse preemption under the McCarran-Ferguson Act did not apply. The Court reasoned that reverse preemption is limited to US federal legislation and does not encompass an international treaty such as the New York Convention. The Court therefore dismissed the coverage dispute in favour of arbitration.

The two other federal appellate courts that have addressed whether reverse preemption pursuant to the McCarran-Ferguson Act extends to international disputes involving the New York Convention have reached conflicting conclusions. Compare *Stephens v. Am Int'l Ins Co*,²⁷ with *ESAB Grp Inc v. Zurich Ins PLC*.²⁸

V TRENDS AND OUTLOOK

i Third-party liability coverage

Asbestos and environmental coverage actions, along with products and construction defect coverage actions, remain the most significant in the complex third-party liability coverage space. In this context, future litigation is likely to continue to involve the proper method of allocating losses among multiple insurers and between insurers and policyholders. In fact, Ohio's highest court is poised to address the allocation of losses across numerous policy periods in *Lubrizol Advanced Materials v. National Union Fire Insurance Co of Pittsburgh, PA*.²⁹ In addition, given the continued proliferation of cases alleging widespread property damage or personal injury resulting from a policyholder's business or actions, courts are likely to be

26 923 F.3d 427 (5th Cir. 2019).

27 66 F.3d 41 (2d Cir. 1995).

28 685 F.3d 376 (4th Cir. 2012).

29 116 N.E.3d 151 (Ohio 2019).

faced with coverage disputes relating to the number of occurrences under general liability policies. Finally, as advancements in the fields of medicine, technology and science continue, litigation against companies whose products allegedly cause property damage or personal injury will continue to flood state and federal courts. Resulting coverage litigation is likely to require courts to address the applicability of pollution exclusions in non-traditional contexts (i.e., outside the traditional environmental contamination scenario). In recent years, courts have grappled with application of the pollution exclusion to novel contexts such as property damage caused by defective drywall and injuries caused by lead paint or by the release of carbon monoxide and other toxic fumes. These and other non-traditional contamination claims will continue to define the scope of a standard pollution exclusion across US jurisdictions.

ii Cyber breaches, data loss and computer fraud

Data breach incidents, cyberattacks and hacking activities designed to obtain financial gain or access to sensitive personal information continue to proliferate at an unprecedented rate. As such, courts undoubtedly will be called upon to address the parameters of both first-party property and third-party liability insurance coverage for myriad cyber-related claims. As discussed in Section III.iv, a small but growing body of case law is defining the scope of coverage for losses arising out of fraudulently induced wire transfers under computer fraud provisions. In the coming months and years, courts will continue to apply governing state law to decide whether various coverage or exclusionary provisions in general liability and crime policies encompass specific factual scenarios. Additionally, novel questions of law are likely to arise, such as whether cyber-related losses, including damage to software or other computer system components, constitutes covered 'property damage' under general liability or first-party policies; whether and under what circumstances hackers' intentional taking of sensitive data constitutes a publication of private information sufficient to trigger personal and advertising injury coverage; the timing and number of losses or occurrences under applicable policy language; and the scope of coverage under directors and officers policies for cyber-related claims against a company by its shareholders or by regulatory agencies. Furthermore, the applicability of certain exclusions, including those related to acts of war or terrorism, professional services or disputes based on contract, are likely to take centre stage in emerging cyber-coverage disputes.

iii Climate change

Climate change is an emerging concern for insurers, based on the increasing frequency of wildfires, storms, floods and other natural disasters.³⁰ As such, future litigation is likely to implicate the scope of coverage under both first-party property and third-party liability policies for the catastrophic losses – both physical and economic – associated with such natural disaster events.

With respect to first-party policies, disputes may involve interpretation of policy provisions relating to causation, particularly where losses are caused by a complex interaction of perils, such as wind, rain and storm surge. Given that property policies often provide coverage for certain perils while excluding others, future litigation arising from weather-related

30 Colin Dwyer, Footing The Bill For Climate Change: 'By The End of The Day, Someone Has to Pay', NPR (September 20, 2018), <https://www.npr.org/2018/09/20/648700837/price-tag-of-natural-disasters-grows>.

events are likely to implicate this issue. Indeed, complex issues of interrelated causation frequently took centre stage in prior coverage disputes arising out of Hurricane Katrina and other major storms to impact the US.

Other first-party issues that may become significant in disputes arising from natural disaster events include the extent of coverage for economic loss under business interruption expense income provisions. Emerging issues pertaining to calculation of damages involve interpretation of actual-cash-value (ACV) or replacement-cost clauses common to many property policies. Given the need to rebuild destroyed property and the escalating costs associated with weather-related property damage, parties are likely to litigate the meaning of phrases such as 'fair market value' and 'replacement cost, less depreciation'. In fact, the question of whether labour costs may be depreciated in calculating replacements costs has been a hot topic in recent years, resulting in divergent case law across US jurisdictions. See, for example, *Lammert v. Auto-Owners (Mut) Ins Co*³¹ (policy language did not permit the insurer to depreciate labour costs in calculating ACV); *Henn v. Am Family Mut Ins Co*³² (where a policy is silent on the issue, an insurer may consider the depreciation of labour costs in calculating ACV); *Shelter Mut Ins Co v. Goodner*³³ (state law prohibits including depreciation of labour costs in calculating ACV, even where a policy expressly permits such depreciation).

Coverage under third-party policies for damage caused by severe weather events are likely to be the source of litigation in coming years. In this context, a central issue for courts may be whether climate change or greenhouse gas emission claims give rise to a covered occurrence for purposes of liability coverage. The sole US court to address this issue thus far ruled that an insurer had no duty to defend or indemnify a policyholder for underlying nuisance claims relating to carbon dioxide and greenhouse gas emissions. In *AES Corp v. Steadfast Insurance Co*,³⁴ the court reasoned that the underlying claims did not allege an occurrence because the damage was not accidental, but rather the natural and foreseeable consequence of the policyholder's intentional emissions. Other courts may confront similar coverage claims arising out of policyholders' detrimental contributions to climate change. Outcomes are likely to depend on not only the particular factual scenario presented, but also policy language and applicable law. More specifically, future decisions are likely to turn, in part, on governing law relating to whether conduct may be deemed an accidental occurrence if the resulting harm is expected or foreseeable, even if not intended.

Similar coverage disputes may arise in connection with pending cases against oil and gas industry giants, who face civil and regulatory litigation over their alleged role in global warming. Litigation has also been filed against the federal government and various state governments based on the alleged failure to safeguard the environment. To the extent that these defendants seek insurance coverage, complicated issues pertaining to justiciability, fortuity, actual property damage and trigger and allocation of coverage are likely to follow.

31 572 S.W.3d 170 (Tenn. 2019).

32 894 N.W.2d 179 (Neb. 2017).

33 477 S.W.3d 512 (Ark. 2015).

34 725 S.E.2d 532 (Va. 2012).

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Laura Pelly is a senior associate in Matheson's insurance disputes team in the commercial litigation and dispute resolution department. Laura is a highly experienced coverage and insurance disputes lawyer with over 12 years of experience in Ireland and New Zealand. She has been building a strong reputation in these areas since she returned to Ireland in 2017, having practised as a barrister and solicitor working in the same field for a number of years in New Zealand. Laura is experienced in managing large and complex disputes from across the insurance, financial and health sectors.

In the insurance sector, Laura supports clients across a range of industries in relation to the entire spectrum of insurance-related issues. She advises insurance companies and corporate policyholders on policy wording interpretation and drafting, complex coverage disputes (in particular regarding financial lines and public liability policies), directors and officers (D&O) claims and subrogation claims. Laura has also managed a variety of high-value professional indemnity claims and litigation against professionals, including insurance brokers and financial advisers, for a variety of insurers. She also specialises in coverage advice and disputes relating to D&O liability insurance policies, income and mortgage protection policies and life insurance policies.

ANGÉLIQUE PFEIFFELMANN

Allen & Overy LLP

Angélique Pfeiffelmann is a senior associate in Allen & Overy's Frankfurt office, where she represents national and international companies from different industries in commercial and corporate disputes.

A main area of her practice lies on insurance litigation, often with cross-jurisdictional elements and complex issues of fact and law. In this regard, she advises large insurance companies as well as major international corporations on all questions concerning insurance law, mostly in relation to D&O insurance.

Angélique also has significant experience in professional liability disputes, which includes the representation of her clients in complex, high-value court proceedings, as well as in relation to their professional liability insurers.

She holds a Master of Laws degree from the University of Sydney and is admitted to the German Bar Association.

ERWAN POISSON

Allen & Overy LLP

Erwan Poisson is a partner in the litigation department at Allen & Overy in Paris. He advises international and domestic companies in complex commercial, civil and criminal disputes, from the pre-litigation stages of a matter, including alternative dispute resolution methods, to court trials. Erwan also handles contractual and distribution disputes, as well as product liability matters and insurance disputes, with a focus on the aviation sector. A general litigator, Erwan notably advises in the areas of banking and finance litigation, where his experience includes liability claims against banks, financial services and investment funds; and corporate litigation, including disputes between majority and minority shareholders and disputes related to shareholding agreements, as well as representations and warranties.

He has also developed specific expertise in conflicts of laws and jurisdictional issues (a subject he teaches at university), international judicial assistance, asset-tracing and recovery, and the enforcement of foreign judgments and arbitral awards on assets located in France.

RAJAT TAIMNI

Tuli & Co

Rajat Taimni heads the dispute resolution practice at Tuli & Co. He joined the firm in 2001 and has spent more than 17 years practising law. His core practice is handling litigation and arbitration disputes.

He specialises in high-profile, high-value and complex ad hoc arbitrations, as well as institutional arbitrations arising from LCIA, ICC, SIAC, DIAC, CIETAC, JAMS, ICA, International Cotton Association, American Arbitration Association Rules, UNCITRAL Arbitration Rules and International Centre for Dispute Resolution International Arbitration Rules, among others.

His core practice is handling disputes involving insurance and reinsurance matters, equity funds, investment treaties, sovereign funds, charter parties, sports and media, white-collar crimes, construction, inter-government litigation, joint venture disputes, railways, insolvency proceedings, aviation, defence contracts, personal injury, employment and harassment, joint venture disputes, railways, aviation and defence contracts.

He has represented clients before the Supreme Court, high courts, consumer courts and other tribunals on cases concerning anti-arbitration injunctions, suits for injunction against letters of credit and challenge, challenges to arbitration awards, enforcement of foreign arbitral awards under Indian law, interim relief pending arbitration, trade disputes and writ petitions.

NEERAJ TULI

Tuli & Co

Neeraj Tuli joined insurance law specialist Kennedys in London in 1988 and became a partner in the London office before returning to India in 2000 to set up Tuli & Co. Neeraj is the senior partner at Tuli & Co and has more than 28 years' experience in the contentious and non-contentious aspects of the insurance and reinsurance industry. His practice is recommended in various editions of *The Legal 500* and *Chambers* legal directories, with market sources describing him as having 'remarkable knowledge' (*The Legal 500*) and 'a name to be reckoned with, an authority' (*Chambers Asia-Pacific*).

Neeraj regularly assists clients with regulatory advice, product development and insurance coverage issues. Neeraj is also a director of Kennedys Dubai and divides his time between Dubai and India.

Neeraj also acts as an arbitrator and was invited to be the first president of the Insurance Law Association of India, formed in association with the British Insurance Law Association.

MEREL VAN DONGEN

Schuermans advocaten

In July 2016, Merel van Dongen graduated from the law school of the Katholieke Universiteit Leuven in Belgium. During her studies, she specialised mainly in criminal law, international and European law, and international trade law.

She had the honour of representing her university in two international moot courts. The first was the Frits Kalshoven Competition in international humanitarian law in 2015, in which Merel and her team reached the finals. The second moot court was the ELSA Moot Court Competition (EMC²) on the Law of the World Trade Organization (WTO). Her team won the regional round in the Czech Republic and received the awards for the Best Respondent's Written Submission and Best Overall Written Submissions. The team eventually reached the semi-finals of the final round in Geneva and was ranked fourth internationally.

After several summer internships (including at the Court of Appeal of Ghent and the office of the public prosecutor of Antwerp), Merel decided to start her professional life at the law firm Schuermans advocaten, where she has developed a special interest in insurance law. She is coached by Luc Schuermans, who has a profound expertise in the field from his academic career as an insurance law professor at the University of Antwerp and more than 50 years of experience as a lawyer.

Merel also pursues an academic career by publishing articles concerning insurance law. For example, she has studied the implementation of the Insurance Distribution Directive (IDD) into Belgian law, the implications of Article 25 of the IDD on product oversight and governance requirements, and the timely settlement of claims.

JYOTHI VENUGOPAL

Al Tamimi & Company

Jyothi Venugopal, MCIArb is a paralegal in the dispute resolution department of Al Tamimi & Company. Jyothi holds a law degree from the Mahatma Gandhi University, India and has practice diplomas in international arbitration law and international commercial law from the College of Law, United Kingdom. She is a member of the Chartered Institute of Arbitrators (CIArb) and assists in the conduct of litigation and arbitration matters.

YANG-HO YOON

Lee & Ko

Yang-Ho Yoon is a Korean attorney and partner in the insurance and reinsurance practice group at Lee & Ko. He primarily practises in the area of insurance litigation. His additional practice areas include product liability and consumer claims, white-collar crime, maritime and shipping, corporate, healthcare, insurance and real estate. Before joining Lee & Ko in 2010, he successfully completed a two-year legal training programme at the Judicial Research and Training Institute of the Supreme Court of Korea. In 2016, he completed his Master of Laws degree at the University of Southampton.

MARC ZIMMERLING

Allen & Overy LLP

Marc Zimmerling is a partner in the German dispute resolution practice group of Allen & Overy and has over 20 years of experience in the insurance industry.

He is regularly instructed by insurance companies, financial institutions and national and international clients from key industry sectors to act as adviser on a broad range of insurance-related issues. This includes advising on policy interpretation, insurance-related risk issues as well as monitoring and defence work. Marc also has significant experience in representing his clients in all types of national and cross-border disputes before state and arbitration courts, often with multiple parties and complex issues of fact and law.

A particular focus of his work is on professional indemnity, directors' liability and insolvency-related insurance litigation, including coverage disputes and recourse claims. Furthermore, he has broad experience in the area of risk prevention and risk management, as well as in various fields of alternative dispute resolution.

Chambers Europe 2018 highlights that Marc 'is particularly well known for his adeptness in D&O liability cases'. He holds a Doctor of Laws degree from Johann Wolfgang Goethe-University, Frankfurt, Germany and has repeatedly been named by German legal directory *JUVE* as a frequently recommended lawyer for insurance law, as well as for commercial, liability and corporate litigation; in the 2018/2019 edition, *JUVE* cites peers and clients who describe Marc as an 'experienced litigator with good standing with the "Big Four"' and 'the man for the big cases'.

Appendix 2

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