THE INSURANCE DISPUTES LAW REVIEW

Editor
Joanna Page

THE LAWREVIEWS

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PREFACE

This is the first 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.

Insurance is a vital part of the world's economy and critical to risk management in both the commercial and 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 and 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 their enthusiasm for this fascinating area. It has also been particularly interesting to note the trends that are developing in each jurisdiction. A strong theme in almost every jurisdiction is the increase in protections for policyholders. Much of the special nature of insurance law 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 modern era of Big 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 upon insurers to be specific in the questions to be answered by policyholders when they place insurance and in more targeted remedies to the insurer if full information is not provided, with variable remedies now imposed rather than insurers being able to resort to the nuclear option of rejection of the entire policy. The evolution of rules around motor insurance in each jurisdiction also reveals an area of continuous important change.

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.

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 on page 159 and highlight the wealth of experience and learning that they 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 Benjamin Scrace and Oliver Troen, who helped enormously in the research and liaison with our co-contributors.

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 2018

Chapter 1

AUSTRIA

Ralph Hofmann-Credner[1]

I OVERVIEW

This chapter shall provide 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 case of an international insurer being the defendant, and the most recent change of insureds' withdrawal right from an insurance agreement and why the Austrian legislator decided for this politically controversial move that only proved successful on a third attempt.

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] The most recent legislative changes in 2018 concern a simplification of the several withdrawal rights from insurance agreements.

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 sub-para 1 Insurance Contract Act.

In addition, general insurance terms and conditions play a key role. Such model insurance terms are elaborated and published by the Austrian Insurance Association (VVO),[6] 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 that have been elaborated by the VVO cover cyber risks (see also Section V below).

For these reasons, Austrian case law on insurance agreements predominantly deals with legal questions related to such 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 as specialist senate) handles disputed insurance contract cases.[7]

As a side note to this chapter, it shall 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 respective licence. Depending on whether it 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. Such EEA insurer may, upon notification of the competent supervisory body, conduct insurance business in Austria on a freedom-of-services basis or on an 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 in recent years, international legislative developments have answered the question of whether insurance can be taken out against specific (e.g., administrative) fines, such as under the Foreign Account Tax Compliance Act or the General Data Protection Regulation. The answer under Austrian law is that such fines are deemed to be uninsurable because any agreement between a tortfeasor and a third party that has been concluded before an infringement, and by which the third party shall be obliged to compensate the tortfeasor for any future penalty, is an immoral contract.[9]

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

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.

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 RIS – Justiz RS0016830.

does not exist at the outset of the insurance, or it certainly will not exist in the future.[10] As at 7 October 2018, in the database of the Legal Information System of the Republic of Austria[11] there are eight judgments of the Supreme Court of Justice, between the years 1938 and 2012, that relate to Section 68 of the Insurance Contract Act,[12] 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 above, 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 proceeding is concluded by the parties within the framework of the general terms and conditions, which is somehow harmonised within the several types of insurance because of the VVO model conditions. *Inter alia*, the following general insurance terms and conditions contain provisions for an expert procedure: non-life insurance,[13] legal expenses insurance[14] and accident insurance.[15]

The decision of an expert procedure shall be binding on the parties, except if the decision apparently deviates from actual facts.[16]

III RECENT CASES

On 20 April 2018, the Supreme Court of Justice released, *inter alia*, two rulings that are worth mentioning because they contain, at a glance, some general rules that the Supreme Court applied. However, looking into it in more detail, especially the first decision we explain, reveals the probably longer-lasting impact it may have on the Austrian market.

The first case, court file No. 7 Ob 44/18y, affects a credit risk insurance agreement of an Austrian limited liability company as insured. While the dispute between the parties had several angles, the most interesting one may be the claim of the insurer against its insured for a repayment of the insurance proceeds. The insurer argued that the insured was not entitled

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

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

12 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.

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

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

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

16 Section 64 sub-section 2 and Section 184 sub-section 2 of the Insurance Contract Act.

to insurance proceeds under the policy because the insolvency administrator of the insured's debtor contested the insured's claim and such a claim is deemed not to be covered by its credit risk policy.

Noting that the Insurance Contract Act does not contain specific provisions for credit insurance, the language of the policy wording, predominantly the general terms and conditions of insurance, became crucial in this case. The relevant wording that the Supreme Court of Justice looked at was the primary risk description, because Article 1 reads that the insurer would cover a shortfall in payment on 'legally justified payment claims' of the insured against one or more contractual partners from contracts, deliveries or services (covered contracts).

Contrary to the court of first instance and the court of appeals, and against the arguments brought forward by the claiming insurer, the Supreme Court of Justice referred the case back to the court of first instance because the defendant insured did not plead in court whether the claim against its debtor was legally justified. As this aspect has not been discussed with the defendant so far, the defendant is protected from a surprising decision. While at this point one can only anticipate the court's future decisions in the forthcoming proceeding, the arguments of the Supreme Court of Justice are clear. It stated that it would be inappropriate to follow the courts of lower instance and the argument of the insurer and apply German case law on the facts at hand because the typical credit risk insurance terms and conditions used in Germany read slightly but significantly differently as they grant insurance coverage for 'undisputed/unchallenged/titled' claims.

While the insurer may have thought that its wording for Austria is identical in terms of the scope of coverage with its wording for Germany, it probably now realised that using only a slightly different term in the Austrian wording results in a big difference on the risk that it accepted and the insurer should analyse its book of business for Austria to understand the risk that it carries. Likewise, Austrian insureds should expect that this and probably other credit risk insurers will adapt their wording for Austria accordingly to cover only 'undisputed' payment claims in the future. Therefore, any Austrian insureds taking out or keeping credit risk insurance should be aware that this ruling of April 2018 may have an impact of the scope of coverage from 2019 or whenever the respective insurer adapts its wording.

A second case (7 Ob 199/17s) that the Supreme Court of Justice made public in April 2018 concerned the applicability and scope of an exclusion (known as the secondary risk description) in a commercial third-party liability insurance. The relevant exclusion has been designed in a way that the insurer shall not be liable to pay if the insured event was caused as a result of gross negligence or if the insured acted contrary to regulations applicable for its business.

In the case at hand, an insured carried external personnel over many years in the cage of a working platform, knowing, *inter alia*, from the civil engineer who annually inspected the platform, that it was prohibited from any passenger transport. However, the insured argued in court that it was of the opinion that the safety appliances were sufficient for any passenger transport.

It is acknowledged in insurance contract law that gross negligent behaviour exists if the simplest obvious thoughts have not been considered and if those measures, which make sense to everybody, have not been taken. While the insured does not necessarily need to be aware of the scope and specific wording of the rule that prohibits certain behaviour, it must be aware that it violates a prohibition, which may also follow from individual instructions of an authority, such as an official order.

Based on the findings of the courts of lower instance and on the aforementioned legal environment, the Supreme Court of Justice concluded that the court of first instance and the court of appeal correctly decided that the exclusion had been satisfied by the insured and that the insurer is not liable to pay.

While the insurer could in this case successfully meet the burden of proof that the exclusion applies, the damage may probably not only stay with the insured. Of course, the decision has a huge impact on the insured, which has to satisfy the claims of the individuals who were carried in the cage of the working platform and suffered bodily injury. However, if the quantum of the (long-term) claims of the injured individuals exceeds the assets and the insured's ability to pay, then the damage finally remains with the injured individuals. This consequence, however, is exactly what third-party liability insurance should, in general, cover, and this decision therefore reminds insureds and third parties to pay careful heed to prohibitions so as not to lose insurance coverage.

IV THE INTERNATIONAL ARENA

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

However, international insurers that serve 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 on how the legal question would be answered under that foreign law.[17] Such 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 every now and then filed against an incorrect 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. Such situations have resulted in confusion and in naming the wrong defendant. 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.[18]

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

18 Zivilprozessordnung.

Since Austria is a member of the EU, jurisdiction in international insurance disputes is determined by the rules of Brussels I Regulation (recast).[19] 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,[20] 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.

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. In Austria, this is the case: according 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.

19 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.

20 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).

V TRENDS AND OUTLOOK

As mentioned above, one of the most recent legislative changes in 2018 concerned a modification of the withdrawal rights from insurance agreements. While the need for change was ultimately triggered by a decision of the European High Court of Justice in 2013,[21] it was only the subsequent decision of the Supreme Court of Justice in 2015[22] that resulted in difficulties for insurers of life insurance agreements under Austrian law because it ruled that inaccurate instructions of the insured's withdrawal right are to be treated as if no instructions had been provided, and therefore the insured has the benefit of an indefinite withdrawal right.

This precedent brought insurers difficulties insofar as litigation funding resulted in numerous claims being made against life insurers for repayment of premiums that had been paid over several years, plus a demand for interest of, in general, 4 per cent per year, which exceeded by far the amounts that the insurer could achieve in the low-interest period of recent years. Therefore, the legislator decided in 2018 to amend the laws that deal with an insured's withdrawal rights. Nevertheless, it can be expected that Austrian courts and life insurers will be kept busy with litigation related to this question for quite some more time.

Another development in Austria, which follows a rather global trend, stems from a wording template to cover cyber risks and that has been recently elaborated by the Austrian Insurance Association. While it is clear that the new template shall be used to provide insurance against cyber risks,[23] there are not many details of the new wording publicly available yet.[24] Needless to say, this new product will be tested in insurance litigation cases in the near future.

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

22 Supreme Court of Justice 2.9.2015, 7 Ob 107/15h.

23 The abbreviation for this wording template will most likely be 'ABC 2018'.

24 A presentation of this Cyber Risk wording has been announced for 15 October 2018: www.gvfw.at/gvfw/gvfw.nsf/sysPages/BD2A2ED15B271B98C12582B70033C773.

Chapter 2

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 amount of premium, the refusal of the insurer to provide coverage, claims handling and alleged violations of legal obligations such as information requirements.

The legislator is continuously working on legal solutions and trying to adapt existing legislation to fit contemporary practices and complaints. For example, new information requirements have been published concerning costs and charges of insurance mediation. Moreover, some discriminations have been eliminated by extending the mandatory insurance for architects to contractors and other actors in the construction sector.

It is not only legislation that is evolving, but also case law. Sometimes, the highest courts in Belgium reconsider previous judgments or provide for additional conditions, for example, the exclusion of cover for intentional damage. Moreover, courts can refine legal concepts such as right of redress, loss of an opportunity or apparent mandates. Belgium also relies upon European case law for defining certain concepts, such as insurance mediation, investment advice and agreements on jurisdiction.

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

II THE LEGAL FRAMEWORK

i Sources of insurance law and regulation

If Belgian law practitioners have to start their insurance law research, they initially rely upon the Act of 4 April 2014 concerning insurance (the Insurance Act), which contains provisions on the insurance contract, the obligations of the parties, limitation periods, insurance mediation and distribution, and supervision of insurance companies.

Apart from this rather long Insurance Act, Belgium has a number of 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).

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

1 Merel van Dongen is a lawyer at Schuermans advocaten.

a The Act on mandatory liability insurance of motor vehicles has changed significantly to adapt the legislation to the evolution of case law. The most notable changes are the following: (1) the definition of a motor vehicle has been adjusted to be relevant to the means by which we move today, (2) coverage of a person liable for someone else's actions is no longer limited to the employer, (3) the insurer no longer has to prove the causal link between the absence of a valid driver's licence and the accident to exercise his or her right of redress, and (4) only damage suffered by innocent victims and their beneficiaries has to be compensated when two or more vehicles are involved in a traffic accident and when it is impossible to determine which vehicle caused the accident.[2] On 2 May 2018, a Royal Decree of 16 April 2018 was published, imposing minimum conditions for the mandatory liability insurance of motor vehicles.

b On 7 March 2017, the new Indicative Table was published. This is used by parties and courts to estimate the damage caused by a liable party. While it contributes to a certain harmonisation throughout Belgium and promotes a more efficient and faster compensation for victims, the Indicative Table remains indicative and is not binding. Since it is used as a guideline, the call for change often arises.

c A Royal Decree of 2 May 2017 approved the Regulation of the Financial Services and Markets Authority of 24 February 2017 on the information on costs and charges that intermediaries must provide to their clients when providing insurance mediation services in Belgium. This regulation provides more transparency about the functioning and financing of the intermediary and entered into force on 1 January 2018.

d The Act of 31 May 2017 expanded the mandatory 10-year liability insurance for architects to contractors and other service providers in the construction sector for immovable works on buildings intended for residence. This insurance covers the liability of these professionals, which has a duration of 10 years starting from the acceptance of the works.

e On 4 August 2017, the Act of 18 July 2017 concerning the establishment of the statute of national solidarity, the allocation of a recovery pension and the reimbursement of medical care due to acts of terrorism was published. This Act develops a remuneration scheme for victims of terrorism and their relatives and was inspired by the terrorist attacks of 22 March 2016 in Brussels.

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.[3] However, the person who is legally liable for the perpetrator can insure such fines and settlements unless the insurance relates to road traffic or road transport.

Second, no insurer can be obliged to provide coverage for intentional damage.[4] 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.

2 Act of 31 May 2017 changing the Act 21 November 1989 concerning the mandatory liability insurance for motor vehicles.

3 Article 155 Insurance Act.

4 Articles 62 and 240 Insurance Act.

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

Fourth, some insurers might refuse to insure a risk owing to cost-benefit analysis. Insuring a certain risk might prove 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.[5] 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.[6]

Another distinction can be made between compulsory insurance and non-compulsory insurance. Belgium has introduced compulsory insurance for no less than 32 categories of risks. These categories are:

1 occupational accidents;
2 architects, contractors and other service providers in the construction sector in real estate;
3 investments;
4 mediation;
5 payment institutions and collective investment undertakings;
6 surveillance companies, internal surveillance services and security companies;
7 accounting and tax professions, insolvency practitioners and temporary administrators;
8 civil security;
9 audit agency;
10 service providers;
11 animals;
12 healthcare;
13 hunting;
14 fairground activities;
15 nuclear installations;
16 surveyor experts;
17 environment;
18 local public institutions;
19 notaries;
20 education, training and childminders;
21 public procurement;
22 publicly accessible institutions;
23 care homes;
24 social developments;
25 sports;
26 mine waste;
27 trustees of real estate;
28 tourism;
29 employment;

5 Article 63 Insurance Act.
6 Article 164 Insurance Act.

30 transport;
31 volunteers; and
32 health.

iii Fora and dispute resolution mechanisms

Insurance disputes are dealt with on 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 Ombudsman of Insurances, established by the Federal Public Service of Economy.[7] The Ombudsman of Insurances tries to settle the dispute and to obtain a favourable solution for every party and for the insurance sector in general.

Increasingly, parties try to resolve their dispute amicably, not only through the Ombudsman of Insurances, but also through binding third-party decisions[8] and mediation.[9]

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 the justice of the peace.[10]

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.[11] The labour court is competent for occupational accidents and group insurance (supplementary pensions).[12] If an insurer files a subrogation claim against a tenant, the claim has to be brought before the 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.

The Belgian legislator is not very fond of arbitration in the insurance sector. According to Article 90, Section 1 of the Insurance Act, the insurance contract cannot include an arbitration clause. However, the Royal Decree of 24 December 1992 makes an exception for certain types of insurances.[13]

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7 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.

8 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.

9 Articles 1730-1737 Judicial Code.

10 Article 590 Judicial Code.

11 Article 601 *bis* Judicial Code.

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

13 (1) The insurance contract 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

III RECENT CASES

i Intentional damage

As mentioned above, an insurer cannot be forced to cover a person who intentionally causes damage (Article 62 of the Insurance Act). One of the points of discussion is damage caused by suicide.

On 23 February 2017, the Belgian Court of Cassation had to answer the question of whether a fire insurer and a household insurer had to provide cover for a fire in a home and physical damage suffered by a third party as a result of a gas explosion caused by the policyholder.[14] That policyholder committed suicide by opening a gas cylinder and lighting a cigarette. His wife and daughter asked for compensation for the fire damage to their inherited home from the fire insurer. His son asked for compensation for his physical damage resulting from the explosions from the household insurer.

According to the Court of Cassation, the intentional fault presupposes the will to cause damage resulting from the realisation of the risk covered by the insurance contract. For the exclusion of Article 62 of the Insurance Act to be applied, the will of the insured to commit suicide must relate to damage covered by the insurance contract.

In other words, it does not suffice that the policyholder wanted to cause his death and that this death can be considered as damage. If, for example, the fire insurer wishes to rely on Article 62 of the Insurance Act, he or she has to prove that the policyholder wanted to cause fire damage.

This judgment adds an additional condition to the exclusion of intentional damage. Previously, is was presumed to be sufficient if the policyholder intended to cause damage.[15]

ii Burden of proof

According to Article 65 of the Insurance Act, a loss of right to insurance benefits can only be stipulated in the insurance contract for failure to comply with a specific obligation imposed by the contract and provided that there is a causal link between the failure to comply and the event that led to the damage.

In the dispute that led to the judgment of the Court of Cassation of 13 February 2017,[16] the general conditions of the theft insurer stipulated that, in the event of absence, all exterior doors of the building had to be closed with a key or by means of electronic security. If not, the insured would lose his right to insurance benefits, unless there was a case of theft by means of burglary.

The Court of Appeal of Brussels had ruled that the insured did not prove burglary sufficiently. The Court of Cassation annulled that judgment because it is the insurer who has to prove that the conditions of Article 65 are met. In other words, the insurer has to prove that the insured failed to comply with these preventive measures and that a causal link between this failure and the theft can be established.

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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 of which the duration is shorter than one year; (8) credit and bail insurance.

14 Cass. 23 February 2017, T.Verz. 2018, 2, 241, with annotation of J. Rogge.

15 Cass. 26 October 2011, Arr.Cass. 2011, 574, NJW 2012, 214, with annotation of G. Jocqué.

16 Cass. 13 February 2017, C.16.0280.F, JLMB 2017, 42, 1990, TBH 2018, 2, 178.

iii Subrogation rights and right of redress

Can an insurer exercise a right of redress against an insured?

Article 95, Section 1 of the Insurance Act determines that the insurer that has paid compensation may be subrogated to the rights and legal actions of the insured or the beneficiary against the liable third parties.

KBC Bank took out construction all risk insurance with AXA for the renovation of an office. One of the insured parties was the architect ES°TE. Separately, ES°TE also took out a professional liability insurance with PROTECT.

Owing to an error on the account of the architect, KBC suffered damage and AXA paid compensation to her. Subsequently, AXA wanted to exercise a right of redress with regard to ES°TE and its insurer, PROTECT.

However, the general conditions of the construction all risk insurance state that AXA does not have a right of redress with regard to the insured parties, unless these insured parties are insured separately.

AXA subpoenaed ES°TE and PROTECT for repayment of the compensation. ES°TE and PROTECT were of the opinion that a right of redress can only be exercised against a liable third party, not against an insured party, which they were. Accordingly, they argued that the general conditions could not apply.

The Court of Cassation ruled on 24 February 2017 that subrogation can only take place with regard to the liable third parties.[17] However, an insured party can be considered to be a third party if the insurer does not cover its activities. Therefore, an insurer can exercise a right of redress with regard to an insured party if the insurer provides coverage to another insured party.

Nature of the damage and subrogation

According to Article 136, Section 2 of the Act concerning the mandatory insurance for medical care and payments, coordinated on 14 July 1994, the health insurer may be subrogated to the rights of the insured, up to the amount of the provided benefits arising from incapacity to work caused by sickness, injuries, functional disorders or death.

In Belgium, a distinction can be made between material damage and the loss of an opportunity. The Court of First Instance of Antwerp held a hospital and two doctors liable for a medical error during the treatment of a patient. The Court of Appeal of Antwerp confirmed that liability and described the damage not as material damage but as a loss of an opportunity.

Subsequently, the Court ruled that the compensation needed to be paid to the health insurer of the patient, since that health insurer already paid compensation to the patient because of his incapacity to work caused by the medical error.

However, the Court of Cassation annulled that judgment on 23 September 2013 because Article 136 Section 2 of said Act only refers to material damage, not to a loss of an opportunity. The economic value of a loss of an opportunity cannot consist of the full amount of the ultimate loss or lost advantage or, in other words, the material damage.[18] The Court of Cassation referred the case to the Court of Appeal of Ghent.

17 Cass. 24 February 2017, C.16.0243.N, T.Verz. 2017, 4, 432.

18 Cass. 15 May 2015, Arr.Cass 2015, 311; Cass. 21 April 2016, C.15.0286.N.

That court was of the opinion that the health insurer had covered any damage caused by incapacity to work and that this is damage other than the economic value of a loss of an opportunity. Therefore, the health insurer cannot receive the compensation for the loss of an opportunity, even though it has subrogated to the right of its insured.

The health insurer was understandably not satisfied with this opinion and asked the court to pose preliminary questions to the Constitutional Court. These questions can be summarised as follows:

a Does this situation violate Articles 10 and 11 of the Constitution (the prohibition of discrimination)?

b Can it be considered discrimination when the health insurer can exercise a right of redress against the liable party when the compensation is based on material damage but not if it is based on a loss of an opportunity, while both compensations are calculated on the basis of the actual loss of income?

The Constitutional Court ruled on 30 March 2017 that this distinction is based on an objective criterion that is not related to the objective pursued. In principle, the victim has only a right to insurance benefits insofar as his damage is not compensated in another way. If Belgium does not allow health insurers to subrogate to the rights of the insured, this would impose an excessive burden on these institutions and the finances of health insurance, and it would lead to an unjustified difference in treatment of insured persons. Therefore, this situation violates Articles 10 and 11 of the Constitution.

The Belgian legislator has yet to change Article 136, Section 2 of the Act of 14 July 1994.

iv The apparent mandate

An insurance broker (and banking agent) misappropriated money of clients that was intended for investment products. The victims subpoenaed the broker, as well as the insurer (and the bank) since they considered the insurer to be jointly liable as principal, and at least on the basis of an apparent mandate.

Article 1998 of the Belgian Civil Code dictates that the represented entity is not bound by the legal acts concluded by the representative if the representative does not have the necessary representative authority. However, a number of exceptions exist, one of which is the apparent mandate.[19] If the semblance of representative authority is attributable to the represented entity and if the third party could reasonably assume this semblance to be the reality, the represented entity is bound by the legal acts concluded by the representative. The semblance is attributable to the represented entity if he or she has contributed to the creation of the semblance or maintained it by his or her own free will, statements or conduct.[20]

In this case, the insurer was of the opinion that an insurance broker cannot create a semblance that he or she represents an insurer because the broker is not tied to one particular insurer. An insurance broker is independent by definition.[21]

The Court of Cassation disagrees. This statutory independence does not preclude that the broker can create a semblance that he or she represents an insurer.

19 N. Portugaels and J. Van de Voorde, 'Het onbestaande rechtsbeginsel van het schijnmandaat en de goede trouw', *De Juristenkrant* 2018, 370, 4.

20 Cass. 22 February 2018, C.17.0302.N.

21 Article 1, 6° Act of 27 March 1995 concerning the insurance- and reinsurance mediation and the distribution of insurance.

Therefore, if the broker drafts proposals for insurance contracts of a particular insurer and transfers information brochures of life insurance products and investments products of that insurer to possible clients, the insurer can be held liable for the misappropriation of money by the insurance broker.

IV THE INTERNATIONAL ARENA

For the international and European areas, Belgium and other Member States often look to the European Court of Justice.

i A European interpretation: insurance mediation and investment advice

The interpretation of certain areas of European insurance law by the European Court of Justice might prove to be very meaningful for the Belgium practice.

On 31 May 2018, the European Court of Justice interpreted the notions of 'insurance mediation' and 'investment advice'.[22] The following two situations caused this judgment:

a A number of consumers entrusted sums to a registered insurance intermediary to be invested in corporate bond products that were to be linked to a capital life assurance. Sometime later, it transpired that the managing director of the insurance intermediary had stolen those sums. His estate and the insurance intermediary were declared insolvent and its insurer refused to pay compensation for any damage suffered by the consumers. According to the insurer, the conduct of the insurance intermediary did not constitute insurance mediation because the products involved were fictive. The money was never invested in corporate bond products linked to a capital life assurance.

b Following the advice given by an insurance mediation company, a man, as capital life assurance, invested a sum in an investment certificate that subsequently lost its entire value. This insurance mediation company was also declared insolvent and its insurer refused to pay compensation. According to this insurer, the advice did not concern the capital life assurance but only the investment in the financial instrument that was linked to it. Therefore, that advice was not covered by the professional indemnity insurance.

What is insurance mediation? There are two questions to be asked.

First, does the concept of 'insurance mediation' cover work preparatory to the conclusion of an insurance contract, even in the absence of any intention of the insurance intermediary to conclude a genuine insurance contract?

According to Directive 2002/92, insurance mediation can be defined as 'the activities of proposing or carrying out other work preparatory to the conclusion of contracts of insurance, or of concluding such contracts . . .'. It is of no importance whether or not a contract is concluded after the preparatory work.

It is also of no importance whether or not the insurance intermediary has the intention of concluding a genuine insurance contract since the realisation of preparatory work is an objective concept. In other words, even if the insurance intermediary has the intention of stealing the money, this is considered to be 'insurance mediation'.

22 European Court of Justice 31 May 2018, Länsförsäkringar Sak Försäkringsaktiebolag, C-542/16.

The European Court of Justice emphasises the wording, the context and the objective of Directive 2002/97. This Directive is intended to protect customers against any failure of the intermediary. Furthermore, the insurance intermediary cannot rely upon its own fraudulent behaviour.

Second, does the concept of 'insurance mediation' cover financial advice relating to the placement of capital given as part of insurance mediation concerning the conclusion of a capital life assurance contract?

In this case, the placement of capital formed an integral part of the insurance contract. The financial advice related to the placement of capital in an investment certificate and that capital consisted of insurance premiums. Therefore, the financial advice can be considered to be 'insurance mediation'.

By this judgment, the European Court of Justice expanded the protection of the customer yet again. Neither the intermediary, nor the insurer, can artificially exclude the application of Directive 2002/92.

ii Choice of forum

In a judgment of 31 July 2017, the European Court of Justice interpreted old Article 9-14 and old Article 13 of Regulation No. 44/2001.[23] Old Article 13 grants the opportunity to parties to assign the court competent to rule on any dispute regarding the insurance contract. However, such an agreement on jurisdiction cannot violate the provisions that protect the parties to an insurance dispute.

In 2007, a Swedish company transported sugar beet to a factory in Denmark, partly by ship. For this transport by ship, the Swedish company concluded a liability insurance, including a choice of forum in favour of the courts of England and Wales.

When one of the tugs arrived in the Port of Assens (the Port), damage was caused to the quay installations. The Port brought a direct action before a Danish court against the liability insurer of the Swedish company, which was presumably liable for the damage but had gone into liquidation.

That Court dismissed the action on the ground that the Danish courts did not have jurisdiction, referring to the agreement on jurisdiction. The Port filed an appeal against that judgment. According to the Port, it cannot be bound by an agreement on jurisdiction concluded between the liability insurer and the liable Swedish company.

The Supreme Court of Denmark referred the following question for a preliminary ruling: can an injured party who is permitted under national law to bring an action directly against a insurance company be bound by an agreement on jurisdiction concluded between the insurer and the policyholder?[24]

23 Council Regulation (EC) No. 44/2001 of 22 December 2000 on jurisdiction and the recognition and enforcement of judgments in civil and commercial matters; Now article 10-16 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 (recast).

24 'Must Article 13, point 5, read in conjunction with Article 14, point 2(a), of Regulation No. 44/2001 be interpreted as meaning that an injured party who is permitted under national law to bring an action directly against the company providing insurance cover for the party which caused the harm is bound by an agreement on jurisdiction validly concluded between the insurer and the policyholder in accordance with Article 13, point 5, read in conjunction with Artice 14, point 2(a), of that regulation?'

The answer is no. The European Court of Justice referred to the objective of the protective provisions, namely, to correct the imbalance between the parties to an insurance contract.[25] Furthermore, old Article 11(2) Regulation No. 44/2001 declares Article 8-10 applicable to direct actions brought by a victim against an insurer, but not Article 13-14 concerning an agreement on jurisdiction.

Therefore, an agreement on jurisdiction concluded between an insurer and an insured party cannot be invoked against a victim of insured damage who wishes to bring an action directly against the insurer.[26]

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 the 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 a liability insurance.

The same conclusion can be made for all complaints filed with the Ombudsman of Insurances.[27] In 2017, 1,373 complaints involved motor vehicles insurance, 989 fire insurance, 914 life insurance and 769 health insurance. The remaining complaints were about legal expenses insurance (516), various insurances (transport, credits and complaints not clearly defined, 458), other civil liability insurance (258), cancellation insurance (256), assistance insurance (177), all risks insurance (e.g., for mobile phones, 170), risks concerning credit cards (114), occupational accidents (76) and individual accidents (50).

According to the Ombudsman of Insurances, many questions arise regarding the cancellation of insurance contracts.[28] Consumers are not as loyal to a particular insurer as they used to be and are often exploring the best coverage for the best price. Any formalities for cancelling insurance contracts are more and more regarded as obstacles and disagreements between policyholder and insurer occur increasingly.

Policyholders often expect swift responses and a clear explanation of the insurer.[29] However, insurers increasingly introduce telework and call centres. This results in long waiting periods and an impersonal approach. Furthermore, the policyholders do not accept inertia in handling the dossiers. A slow payment by the insurer often results in financial problems. However, not only the insurer can be blamed for inertia and numerous codes of conduct exist.

25 European Court of Justice 26 May 2005, GIE Réunion européenne and Others, C-77/04, paragraph 22.

26 European Court of Justice 13 July 2017, Assens Havn, C-368/16, paragraph 40.

27 Annual Report of the Ombudsman of Insurance, available at: www.ombudsman-insurance-annualreport.be/2017-ombudsman-verzekeringen-jaarverslag/.

28 Annual Report of the Ombudsman of Insurance, available at: www.ombudsman-insurance-annualreport.be/2017-ombudsman-verzekeringen-jaarverslag/ p. 9.

29 Annual Report of the Ombudsman of Insurance, available at: www.ombudsman-insurance-annualreport.be/2017-ombudsman-verzekeringen-jaarverslag/ p. 10.

Insurance intermediaries are often confronted with complaints about alleged violations of their information requirements.[30] Most of these complaints arise in life insurance (e.g., the potential risk, the costs, capital protection or the consequences of tax legislation) and motor vehicles insurance (e.g., changing amount of the premium and the insured value of the vehicle).[31]

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 Insurance Distribution Directive (IDD).

Since the entry into force of the GDPR, insurers have had to change their privacy policy.[32] One of the most important changes is the protection against data breaches. Cyberattacks occur increasingly, and as a result, insurance against cyberattacks 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 insurances without guaranteed return (Branch 23). In the years before the financial crisis, these insurances were promoted by and concluded with the help of insurance intermediaries who were, at the time, not heavily regulated. The clients now start proceedings because rather recently it became clear that all the money was lost. They often claim that the insurance intermediaries or the insurer withheld information, and that if they had received that information they would have invested in another product.

Evidently, the European and national legislator have started to regulate the activities of insurance companies and intermediaries. 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, which has not yet been implemented in Belgian law.[33] This instrument is not only relevant for compliance officers, but also for clients who can expect certain behaviour of their contracting party.

Second, a general awareness of global problems, such as climate change, can result in new insurance policies. Currently, many insurers are reluctant to provide coverage for weather disasters – for example, in the agricultural sector, the renewable energy sector, the transport sector or the tourism sector – because of high costs and risks. However, these kind of insurance policies become 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 continues to negotiate in favour of affordable premiums together with several agricultural organisations.[34]

30 Annual Report of the Ombudsman of Insurance, available at: www.ombudsman-insurance-annualreport.be/2017-ombudsman-verzekeringen-jaarverslag/ p. 15.

31 Annual Report of the Ombudsman of Insurance, available at: www.ombudsman-insurance-annualreport.be/2017-ombudsman-verzekeringen-jaarverslag/ p. 15.

32 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).

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

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

Third, technological and scientific progress sparks new insurance policies. As mentioned above, the first cyber-insurance policy was concluded in 2010.[35] 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.[36]

Insurance law is an ongoing process of trial and error and a constant interaction between the legislator, 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 are relatively forced into a certain direction. Therefore, it is fairly possible that new topics will arise in the future, and we, as law practitioners, are looking forward to any evolution of insurance law.

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

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

Chapter 3

BERMUDA

John Wasty and Jessica Harris[1]

I OVERVIEW

Bermuda is one of the world's leading insurance and reinsurance jurisdictions. The legal framework of the insurance market in Bermuda is deliberately structured to facilitate innovation and creativity. As the type of insurance products in Bermuda experience consistent development, it would be natural to assume that the Bermuda courts are continuously entertaining insurance disputes. However, as insurance contracts are commonly subject to arbitration agreements, Bermuda jurisprudence concerning insurance disputes is fairly rare, particularly in recent years.

Those Bermuda cases that do concern insurance disputes generally relate to technical points of law such as the requisites for the removal of arbitrators or a strike-out application; these are explored further below.

II THE LEGAL FRAMEWORK

i Sources of insurance law and regulation

The Insurance Act

Aside from the Companies Act 1981, which is the principal piece of legislation governing companies in Bermuda, insurance and reinsurance companies in Bermuda are also governed by the provisions of the Insurance Act 1978 (the Insurance Act) and its related regulations. The Insurance Act applies to any person carrying on insurance business in or from within Bermuda, and provides for the registration of all insurers and insurance managers, brokers, agents and salesmen. If a long-term insurer issues life insurance policies that are made in Bermuda and governed by Bermuda Law, the Life Insurance Act 1978 (the Life Act) will apply. The Life Act contains a number of provisions that govern a variety of matters including policy issuance, and beneficiary rights and entitlements.

There have been several amendments to the Insurance Act over the past 12 months, namely through the implementation of the Insurance Amendment Act 2018 (First Amendment) and the Insurance Amendment (No. 2) Act 2018 (Second Amendment, together with the First Amendment: the 2018 Amendments).

The First Amendment brought about a number of changes to the Insurance Act to introduce a new class of innovative insurers and innovative insurance managers, brokers and agents (intermediaries).

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More significantly, the Second Amendment amends the Insurance Act by updating winding-up provisions for insurance business for the purpose of protecting policyholders during the winding up of an insurer. The amendment requires the accounts of long-term business and general business to be kept separate in that no payment from the insurer's long-term business fund shall be made directly or indirectly for any purpose other than the insurer's long-term business. The same applies to general business. In the event of winding-up, the assets of the long-term business fund must be discharged as a matter of priority to debts attributable to long-term business. The same applies to general business. The result of these changes is that unsecured policyholder creditors will rank in priority before all other non-preferential unsecured creditors.

The Second Amendment received Royal Assent and became operative, with respect to insurers carrying on long-term business, on 30 July 2018. The Second Amendment will become operative for general business insurers on 1 January 2019.

The Insurance Act is supplemented with various statutory rules and regulations as well as various addenda in respect of commercial insurers and long-term insurers. Bermuda's insurance regulator, the Bermuda Monetary Authority (the Authority) has also published various guidelines to reflect the minimum standards that the Authority expects insurers and other relevant parties to observe.

Derivative claims

Until this year, the right to pursue claims derivatively in Bermuda was governed exclusively by common law, and in particular, the various exceptions to the rule in *Foss v. Harbottle*.[2] As of July 2018, following an amendment to the Rules of the Supreme Court 1985, derivative actions commenced in Bermuda may not be continued without leave from the Supreme Court of Bermuda (the Supreme Court). The introduction of a formal requirement of judicial leave brings Bermuda into line with other offshore jurisdictions such as the Cayman Islands and BVI, and should provide additional protection against frivolous or vexatious shareholder claims.

Such an application must be made after the writ has been filed and a defendant has entered an appearance in the proceedings (i.e., filed a memorandum of appearance). The application must also be made within 21 days of the defendants' appearance.

On hearing the application, the Supreme Court may (1) grant leave to continue the action, for such period and upon such terms as it thinks fit, (2) dismiss the action, or (3) adjourn the application and give directions for the joinder of parties, the filing of further evidence, discovery, cross-examination of deponents and otherwise as it may consider expedient.

Third-party rights

Until 28 March 2016, the strict rules of privity applied to the enforcement of contracts under the law of Bermuda. The Contracts (Rights of Third Parties) Act 2016 (the Third Parties Act) provides that contracting parties may extend the ability to enforce the contract (or certain parts of it) to those outside the scope of privity. This change to the law will be welcomed by anyone attempting to extend the benefit of an indemnity to a designated person. Contracting parties must 'opt in' for the Third Parties Act to apply, for example:

2 (1843) 2 Hare 461.

a the third party must be identified in the contract by name, as a member of a class, or as answering a particular description; or

b the contract expressly provides in writing that the third party can enforce the terms.

ii Insurable risk

Pursuant to the Insurance Act, 'insurance business' is defined as the business of effecting and carrying out contracts (1) protecting persons against loss, or liability to loss in respect of risks to which such persons may be exposed; or (2) to pay a sum of money or render money's worth upon the happening of an event, and includes re-insurance business. The definition, which was deliberately drafted broadly, does not require there to be an insurable interest in effecting and carrying out insurance contracts.

That said, the Life Act requires there to be an insurable interest in the case of certain long-term business contracts.

iii Fora and dispute resolution mechanisms

Generally, insurance disputes in Bermuda are litigated through arbitration because insurance agreements commonly contain arbitration clauses.

The Bermuda International Conciliation and Arbitration Act 1993 (the 1993 Act) governs international commercial arbitration and the enforcement of foreign arbitral awards in Bermuda. The 1993 Act enacts the UNCITRAL Model Law on International Commercial Arbitration 1985. The 1993 Act provides for the recognition and enforcement of a 'Convention award', namely, an award made in pursuance of an arbitration agreement in a state or territory other than Bermuda that is a party to the New York Convention.

There are no legal impediments to arbitrating any kind of dispute, save where statute prescribes that the only relief available is by order of the Supreme Court. For example, pursuant to the Companies Act 1981 certain relief in respect of Bermuda-registered companies may only be granted by the Supreme Court.

In the case of an arbitration agreement in what would be an international commercial arbitration, the Supreme Court shall, if a party requests it no later than when submitting its first statement on the substance of the dispute, refer the parties to arbitration unless it finds that the agreement is null and void, inoperative or incapable of being performed. Where there is an arbitration agreement or clause, proceedings brought before the Supreme Court, in breach of the arbitration agreement will in the ordinary course be stayed.

Domestic arbitration is subject to the Arbitration Act 1986.

Where there is no arbitration agreement in place, insurance disputes will be heard by the Supreme Court, which is Bermuda's principal court. The Supreme Court hears all civil disputes with a value in excess of 25,000 Bermudian dollars and appeals from civil (and criminal) actions in the lower courts. The Bermuda Court of Appeal (Court of Appeal) hears appeals from the Supreme Court, and there is a further and ultimate right of appeal from the Court of Appeal to the Judicial Committee of the Privy Council in England. The Privy Council sits before a five-member panel comprising members of the English House of Lords and certain senior Commonwealth appellate judges. The Supreme Court is bound by the decisions of the Court of Appeal, which, in turn, is bound by decisions of the Privy Council.

Bermuda courts reserve the capacity to deviate from an English House of Lords decision if 'the social conditions of Bermuda make inappropriate the particular path of

development taken by the House of Lords against the background of British conditions'.[3] There are no known instances where a Bermuda court has failed to follow an English House of Lords decision. Furthermore, English Court of Appeal decisions are highly persuasive in the Bermuda courts and are invariably treated as authoritative statements of the common law. Similarly, other reported English decisions are persuasive and are generally treated as authoritative or highly persuasive. As to the interpretation of statutes, the Bermuda court will follow decisions of the English courts in cases where the Bermuda statute contains identical statutory language to that found in the equivalent English statute.

III RECENT CASES

Given that the majority of insurance disputes are litigated primarily through arbitration, jurisprudence on insurance disputes is quite scarce. Generally, when insurance disputes are referred to the Supreme Court, the substance of the proceedings is more technical in nature. Consequently, the significant cases that we will refer to below reflect technical developments raised in the context of insurance disputes.

i Removal of arbitrator

The English court of first instance,[4] and subsequently the English Court of Appeal,[5] heard applications for the removal of an arbitrator in respect of Bermuda Form insurances governed by New York law and subject to arbitration in London, whereby it was contended that the failure, by the arbitrator appointed in respect of three separate arbitral proceedings concerning liabilities stemming from the same event, to disclose his appointments gave rise to a real possibility that the appointed arbitrator was biased.

Popplewell J rejected the application, and his decision was upheld by the English Court of Appeal, who held:

a The test for potential bias was whether a fair-minded and informed observer, having considered the facts, would conclude that there was a real possibility that the arbitral tribunal was biased.

b There was no objection to an arbitrator accepting appointments in multiple references concerning the same or overlapping subject matter with only one common party, so there was no apparent bias on that ground.

c Disclosure should be given of facts and circumstances known to the arbitrator that would or might give rise to justifiable doubts as to his impartiality. In the present case, the arbitrator should have disclosed appointments, but his failure to do so did not automatically mean that he should be removed. The question was whether the failure to disclose, combined with other factors, would give the fair-minded and informed observer a basis for a reasonable apprehension of lack of impartiality. In the present

3 *Haley v. Crockwell* (1993) Civil Appeal No. 23 of 1992, Bermuda Court of Appeal.

4 *H v. L and Others* [2017] 1 Lloyd's Rep. 553; [2017] EWHC 137 (Comm), Queen's Bench Division, Commercial Court, 3 February 2017.

5 *Halliburton Company v. Chubb Bermuda Insurance Ltd* [2018] EWCA Civ 817, Court of Appeal, 19 April 2018; [2018] 1 Lloyd's Rep. 638.

case, the failure to disclose was accidental and the degree of overlap was limited, so the fair-minded observer would not consider the failure to disclose to give rise to justifiable doubts as to impartiality.[6]

While not decisions of the Supreme Court, as set out above, this English decision is highly persuasive in Bermuda, and it is likely that the Supreme Court would apply the same approach in application for the removal of an arbitrator on the grounds of potential bias.

ii Taxation and privilege

In *Chubb Bermuda Insurance Ltd (formerly known as Ace Bermuda Insurance Ltd) v. Ford Motor Company*,[7] the Supreme Court assessed whether and to what extent: (1) a bill of costs and other material produced on taxation is subject to an implied undertaking that prohibits other parties from using it for purposes other than the taxation; (2) a bill of costs produced on taxation is a privileged document; and (3) a party producing privileged material on taxation waives privilege for the purposes of that taxation only or alternatively waives privilege generally.

By way of background, Chubb provided excess liability cover to Ford. Ford made a claim under the policy but Chubb declined coverage. This gave rise to a dispute between the parties as to whether the policy covered the claim. By an Originating Summons, Chubb sought to restrain Ford from litigating the dispute in the United States as Chubb claimed that this would breach an arbitration clause in the policy. A consent order was granted, *inter alia*, (1) staying the Originating Summons generally on terms that Ford gave undertakings not to litigate the dispute in the United States and (2) awarding costs to Chubb, to be taxed forthwith on the standard basis, if not agreed.

The parties were unable to agree costs and Chubb commenced taxation proceedings. The taxation proceedings were adjourned part heard because the question arose as to what use could Ford make in the arbitration of the material disclosed by Chubb on the taxation. The Supreme Court held that:

a the stay of the Originating Summons was lifted to the extent necessary to enable Chubb to make the application contained in the summons relating to the Bill of Costs;

b the Bill of Costs and any other material that Chubb might produce on taxation was: (1) subject to an implied undertaking by Ford not to use it for purposes other than the taxation; and (2) privileged, save to the extent that privilege had been waived for purposes of the taxation; and

c Ford was prohibited from using any material produced by Chubb on taxation for any purposes other than that of the taxation, including, but not limited to, the arbitration between the parties relating to the underlying dispute that gave rise to this action.

iii Payment into court

In the matter of *Jose Munoz-Vargas v. Sun Life Assurance Company of Canada*,[8] the Supreme Court clarified the procedure in which payment may be made into court, particularly in

6 2018] 1 *Lloyd's Rep*. 638.

7 [2017] SC (Bda) 88 Civ.

8 [2018] SC (Bda) 28 Comm (27 March 2018).

respect of (1) who is responsible for making the application for payment out, (2) who is an 'interested party' for the purposes of being put on notice of the payment into court and (3) the discretion of the courts regarding pay out before the relevant notice period has expired.

The facts of this matter are summarised as follows. Given that the policy owner was now dissolved, the defendant insurer (Sun Life) paid certain funds into court in satisfaction for insurance money payable in respect of a life insurance policy owned by E S Venture Limited (policy owner) (dissolved), with Jose Munoz-Vargas named therein as the life insured, on the basis that there was no person capable of giving valid discharge. Under the policy, Mr Vargas had no rights until it matures; the maturity date being when Mr Vargas reached 99 years of age.

The Supreme Court held as follows:

a It is for potential interested parties to make an application to obtain payment out.

b The term 'interested parties' is to be construed broadly. As such, the insurer, upon paying money into court, is required to identify anyone who might have a possible claim. It is then for those persons who have a sufficient conviction in the strength of their claim to apply to the court to obtain payment out.

c The court has discretion, based on the facts of the case, to shorten the length of time required for notice to 'interested parties'. On the facts of this case, it was held that 28 days' notice should be allowed for the liquidator of the policy owner.

IV THE INTERNATIONAL ARENA

In Bermuda, subject to certain requirements, a foreign civil judgment may be registered or enforced pursuant to:

a the Judgments (Reciprocal Enforcement) Act 1958 (Reciprocal Judgments Act); or

b the principles of recognition and enforcement pursuant to Bermuda's common law.

In Bermuda, under the Reciprocal Judgments Act, any judgment of a superior court in the United Kingdom or other designated common law jurisdiction that is (1) final and conclusive as between the parties and (2) is for a fixed sum of money (not being in respect of taxes or in respect of fines or penalties) (qualifying foreign judgment) may be registered as a judgment in the Supreme Court.

A qualifying foreign judgment may be registered any time within six years after the date it was rendered, or if it was appealed, within six years of the date of the last appeal. Upon registration, the qualifying foreign judgment is enforceable in the same manner as a judgment given by the Bermuda court, and is treated for all practical purposes as if it had been given by the Supreme Court on the date of its registration in Bermuda.

Under Bermuda's common law, the Bermuda court may recognise the US judgment (or any other judgments of a foreign jurisdiction that are not otherwise qualifying foreign judgments) for a liquidated sum by way of summary judgment.

The Rules of the Supreme Court of Bermuda do not provide any specific procedure for the recognition of foreign judgments. That being said, however, it has long been recognised that the Bermuda court may enforce foreign judgments under the 'Doctrine of Obligation', by way of summary proceeding (i.e., on the basis that the guarantor has no *bona fide* defence to the claim).

To qualify for enforcement under Bermuda's common law, the US judgment must meet the following criteria:

a the foreign court is a court of competent jurisdiction in relation to the issues in dispute;

b the foreign judgment is final and conclusive as between the parties;
c the foreign judgment is for a fixed sum of money, not being a sum payable in respect of taxes or other charges of a like nature in respect of a fine or penalty or in respect of multiple damages;
d the foreign judgment was not obtained by fraud and the defendant put or was entitled to put his or her defence and be heard; and
e the foreign judgment is not otherwise contrary to Bermuda law or public policy.

An example of proceedings in which the Bermuda court recognised a US judgment against a guarantor is *Desarrollo Inmobiliaro Y Negocios Industriales De Alta Tecnologia De Hermosillo Sa De Cv v. Kader Holdings Company Limited*.[9] That case involved an Arizonian Superior Court money judgment (the Arizona Judgment) against Kader Holdings Company Limited (Kader) (a Bermuda company), in respect of a guarantee given by Kader to the plaintiff concerning certain obligations under a lease. The Bermuda court recognised the Arizona Judgment pursuant to Bermuda's common law, granting summary judgment in respect of the plaintiff's claim to enforce the Arizona Judgment. We note, however, that *Desarrollo* was later set aside on the basis that Kader had not submitted to the jurisdiction of the Arizonian court.

More recently, in 2017, Bermuda's Commercial Court joined the Judicial Insolvency Network formed in Singapore linking various courts with which Bermuda has close ties. Building on these connections, in September 2017, the Supreme Court entered into two agreements with the Supreme Court of Singapore designed to facilitate cooperation between the two courts, namely:

a a Memorandum of Guidance as to Enforcement of Money Judgments, which confirms that the courts will apply similar common law principles to enforcing money judgments from Singapore in Bermuda and from Bermuda in Singapore; and
b a Memorandum of Understanding on References of Questions of Law, which confirms a willingness of each court to entertain applications from parties to civil litigation for questions of Singapore law arising in Bermudian proceedings to be referred to Singapore for determination, and vice versa as regards questions of Bermuda law arising in Singaporean proceedings.[10]

V TRENDS AND OUTLOOK

In the wake of the 2017 losses from hurricanes Harvey, Irma and Maria, catastrophe indemnity is currently the busiest area of claims in Bermuda. The 2017 hurricanes are estimated to have caused around 90 billion Bermudian dollars of insurance and reinsurance industry-wide losses.[11]

Commercial market claims data aggregated by the Authority show that Bermudian reinsurance firms paid out a huge 208.7 billion Bermudian dollars to policyholders and cedants from the United States for losses from large catastrophes, related property insurance

9 [2013] Bda LR 55.
10 Ian R C Kawaley CJ (as he then was), Judiciary Press Release, 3 October 2017.
11 ARTEMIS, 'Bermuda reinsurance & ILS to pay 30% of hurricane losses', 22 November 2017.

and general liability over the past 20 years.[12] Accordingly, we would expect the volume of catastrophes, related property insurance and general liability claims to continue to have a large hold on the area of claims in Bermuda.

Over the past few years the insurance and reinsurance markets have experienced significant consolidation, with a number of mergers and acquisitions. Companies are keen to improve their bottom lines by increasing the scope of their books, both in terms of the volume of business and the variety of insurance and reinsurance being offered. We expect this trend to continue, with smaller insurance and reinsurance companies being targeted for acquisition by the larger names in the market. From a litigation perspective, this consolidation is likely to result in a greater number of employment disputes (usually proceeding by way of arbitration) and potentially litigation resulting from the mergers and acquisitions themselves.

While 2017 saw impressive gains in the Bermuda life sectors,[13] 2018 has been marked by a large portion of life insurers in a wind-down state or selling or consolidating portions of their books. Consequently, we would expect insurers to make increasing numbers of applications to the Supreme Court for payments into court of policy funds that cannot be paid out to beneficiaries (for example, because those beneficiaries cannot be located), and conversely applications by purported beneficiaries for the payment out of court of those insurance policy proceeds.

The Authority is becoming increasingly active in its enforcement of anti-money laundering (AML) and anti-terrorist financing (ATF) regulatory requirements as they apply to Bermuda-based insurers. In early 2017, a Bermuda investment company was fined 1.5 million Bermudian dollars by the Authority and its licence was restricted owing to failures to comply with the relevant AML and ATF legislation. We expect the Authority's increasingly rigorous approach to these matters will impact on its regulation of insurers and that insurers are likely to face similar enforcement action and decisions in the coming years.

The Authority's increase in enforcement is particularly projected in light of the Authority's publication of the Enforcement Guide – Statement of Principles and Guidance on the Exercise of Enforcement Powers (the Enforcement Guide). The purpose of the Enforcement Guide is to:

a satisfy the requirement of the Regulatory Acts[14] to publish a statement of principles in accordance with which the Authority will exercise its formal enforcement powers;

b explain when and in what circumstances the Authority will consider taking enforcement action;

c explain how enforcement action is taken by the Authority;

d encourage effective alignment and coordination of regulatory processes within the Authority; and

e ensure consistent, proportionate, effective and dissuasive enforcement outcomes.

12 ibid.

13 www.reinsurancene.ws/bermuda-re-insurance-industry-shows-steady-growth-2017/.

14 Section 2A(1) Insurance Act 1978, Section 9(1) Banks & Deposit Companies Act 1999, Section 9(1) Investment Business Act 2003, Section 2B Investment Funds Act 2006, Section 6(1) Trusts (Regulation of Trust Business) Act 2001, Section 6(1) Corporate Service Provider Business Act 2012, Section 6(1) Money Service Business Act 2016, Section 7(1) Proceeds of Crime (Anti-Money Laundering & Anti-Terrorist Financing, Supervision, & Enforcement) Act 2008, Section 5(1) Credit Unions Act 2010, and Section 5(1) Digital Business Act 2018.

The Enforcement Guide replaced the following documents, which no longer have effect, with a unified statement of principle on the Authority's exercise of its enforcement powers:

a the 2010 'Statement of Principles on the Use of Enforcement Powers – Proceeds of Crime (Anti-Money Laundering & Anti-Terrorist Financing Supervision and Enforcement) Act 2008'; and

b the 2012 Statement of Principles on the Use of Enforcement Powers.

Chapter 4

BRAZIL

Cassio Amaral, Thomaz Kastrup, Anthony Novaes, Stefano Motta and Thales Dominguez[1]

I OVERVIEW

Brazil is the fifth most densely populated country[2] and among the biggest countries in the world in terms of territory. These facts speak for themselves, making Brazil one of the most promising insurance markets of the globe, especially when we consider the percentage of Brazilian Gross Domestic Product (GDP) represented by its insurance market (close to 4 per cent, as per 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 National Congress, such as the Brazilian Data Protection Law (Law No. 13709/18) and the Brazilian Code of Civil Procedure of 2015, as well as Bill of Law No. 29/2017 (designated by market experts and scholars as the New Brazilian Insurance Law), certainly anticipate significant changes in the manner in which local and foreign accredited players of 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 forth the general guidelines and rules of the Brazilian local insurance and reinsurance market, SUSEP has oversight over the activities of all players belonging to this market, monitoring their respective businesses and, when applicable, giving prior approval to certain transactions involving regulated entities.

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1 Cassio Amaral and Thomaz Kastrup are partners and Anthony Novaes, Stefano Motta and Thales Dominguez are associates at Mattos Filho, Veiga Filho, Marrey Jr and Quiroga Advogados.

2 U.S. Census Bureau, 2018.

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

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 of the reinsurance market, sets forth the ground rules that must be met by each type of reinsurer (as previously explained), as well as for the taking out of insurance abroad by residents in Brazil and companies headquartered in the country;

b the Brazilian Civil Code (Law No. 10406/2002) (BCC), which dedicates an entire chapter to insurance contracts and the main principles that regulate the insured–insurer relationship;

c the Brazilian Consumer Protection Code (Law No. 8078/1990), since the insured is considered as a 'consumer' for legal purposes;

d the Brazilian Code of Civil Procedure of 2015 (Law No. 13105/2015), 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 Brazilian Data Protection Law, which regulates the use of personal data of a given individual or legal entity in Brazil. Its impacts are still being assessed by companies that handle this data, but it certainly will influence and dramatically change the manner of 'doing business' in the insurance and reinsurance market; and

f Bill of Law No. 29/2017 (still under examination by National Congress), which sets out a whole new legal framework for SNSP players, triggering the need of new regulation to be enacted by the CNSP and SUSEP. The analysis of this bill by the National Congress was, up until recently, being made at a very fast pace, but, given the presidential elections and the new legislature, it is unclear as to whether it will eventually be approved by the new government in the short (or even long) term.

ii Insurable risk

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

The legitimate interest must: (1) be licit, since the BCC prohibits any transaction (including, but not limited to, agreements of any nature) concerning illicit purposes;[4] (2) be economic, since a given value must be attributed by the person retaining insurance to

4 Brazilian Civil Code. Section 104. The requirements for the validity of a juridical 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.

the object of the insurance coverage, either limited to the sum 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);[5] and (3) precede the contract and remain effective throughout its term of effectiveness.[6]

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 regulation, 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). By 'civil' and 'administrative' sanctions, regulation means any penalty except for those arising from criminal offences (such as imprisonment). There is no restriction for anticipating defence costs in this type of insurance with litigation in criminal cases, which is common and widely used. SUSEP has also stated that coverage for ransom does not breach applicable law, as long as the insurance product is previously approved by SUSEP (per 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 the remaining issues. Since specialised courts do not include 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 involved parties: 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.

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.

5 Tzirulnik, Ernesto. *The insurance contract according to the Brazilian civil code*. 3rd Edition. São Paulo. Roncarati, 2016, p. 53.

6 Franco, Vera Helena de Mello. *Contracts: civil and corporate law*. 5th Edition. São Paulo. Revista dos Tribunais. 2014, p. 340.

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 the appellant is required to provide evidence that the constitutional issues addressed in the appeal have widespread repercussions in order to be given leave to appeal.

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 procedure, as it involves rights that can be the object of a transaction (Section 1 of the Brazilian Arbitration Law).

The Brazilian Arbitration Law was inspired by the UNCITRAL Model Law, adopting a favourable regime to arbitration following international standards, such as the separability of the arbitration agreement, the *Kompetenz-Kompetenz* principle, and the impossibility of reviewing the arbitral award in 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 following the receipt of an award or a decision clarifying the award. Among the reasons for annulment or setting aside an arbitral award, we highlight:

a the arbitration agreement is null and void;
b the award is 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 proceeding.

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

Besides the judicial claims, there are administrative insurance disputes pending before regulatory agencies, such as SUSEP and the Consumer Protection Office (PROCON). These agencies are responsible for reviewing administrative procedures concerning the breach of their respective regulation by insurers, reinsurers and brokers triggering the imposition of penalties and other sanctions.

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's to guarantee the reimbursement of a hefty indemnification, and (2) the discussion about the subrogation of the insurer to the arbitration clause in the insured 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 before the State Court of São Paulo against the principal and guarantors, who are the shareholders of a famous airline company.

Owing to the proofs of commingling of assets and misuse of legal entity, the State Court of São Paulo granted the request for piercing the guarantors' corporate veil and 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 suffers from lack of jurisdiction to rule 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 payment of the indemnity subrogated the insurers in all rights of the insured. As a result, the insurers would be obligated to comply with all clauses established in the contracts entered between the policyholder and insured, including the arbitration clause.

Furthermore, the guarantors filed an action requesting a provisional remedy to revoke the attachment order granted by the State Court of São Paulo based on the lack of jurisdiction of this Court. Later, the guarantors filed a statement of claim requiring the commencement of the arbitration based on the arbitration clause established solely in the secured contracts entered by the policyholder and insured.

Because of the actions filed by the guarantors, a conflict of jurisdiction was established in the Superior Court of Justice. Although a final and binding decision has not yet been issued, the state courts and the judge-rapporteur of the proceeding 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 bonds subjecting the principal, guarantors and insurers to arbitration, the conflicts between the parties must be ruled by the judiciary system. The final decision rendered by the Superior Court of Justice in the conflict of jurisdiction will influence all the future decisions from state courts in Brazil.

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 (Law No. 11101/2005), the enforcement procedures filed to collect the debts against the telecommunication company were immediately stayed for 180 days (tax credits are not subject to the proceeding).

Furthermore, the Bankruptcy Court issued an order suspending any payment under the judicial bonds posted under labour and civil lawsuits, as the credits would be paid according

to the company's reorganisation plan. However, the Bankruptcy Court decision was ignored and the courts responsible for the enforcement procedures determined the payment of the indemnities.

Because of the conflicting decisions, the insurer filed a proceeding of conflict of jurisdiction between labour and civil courts, and the Bankruptcy Court, before the Superior Court of Justice. The Supreme Court of Justice has not decided the conflict of jurisdiction yet, but the judge-rapporteur of the proceeding granted a preliminary order recognising the Bankruptcy Court 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; (2) the judicial bonds are an autonomous obligation of payment and are not subject to the novation effects and, as a result, cannot be enforced and must be terminated.

The final decision rendered by the Superior Court of Justice in the conflict of jurisdiction will also influence all future decisions from state courts in Brazil.

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 purposes of taking out insurance products. The motto was to restrict this as much as possible to prevent the local market being emptied by foreign competitors.

This was the main reason justifying 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 for 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 of a debate when it comes to reinsurance agreements and treaties. According to the Law of Introduction to the Brazilian Civil Code (Decree-Law No. 4657/1942), 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 the 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 such 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 that requires 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 forth therein are bound to insurance policies or bonds issued by a local accredited insurer and governed by local law. This debacle will only increase upon the enactment of the Bill of Law No. 29/2017, 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 the need of any 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.

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, not being 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 Brazilian Central Bank (BCB) and the Securities and Exchange Commission (CVM). Now the BCB may impose fines to financial institutions (and its officers and directors) whose sum may reach 2 billion reais, and the CVM may impose fines on publicly held companies (and other entities it regulates, and respective directors and officers) whose sum may reach 50 million reais.

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

In recent years, D&O insurance claims have risen as a result of a significant increase of federal investigations scrutinising public contracts, which led to an unprecedented increase in the public auditing of public administration activities and biddings. 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 might bring claims upon irregularities against the private counterparts involved in the bids. 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 ranged from investigations by public bodies to judicial claims associated with securities litigation, tax debts, corporate disputes, contractual breaches and bankruptcy law.

ii Surety bonds demand and increasing loss ratios

The Brazilian Code of Civil Procedure of 2015 has expressly established the right to offer judicial bonds to secure the 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, which entailed numerous claims in the sureties market for breach of contracts, bringing up the search 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 brings with it various innovations that will significantly alter the way insurers do business, leading to the adaptation of operational aspects (such as the need of insureds' prior consent in order to implement certain transactions – e.g., portfolio transfers), changes in the wording of insurance policies and modification of loss adjustment procedures.

Chapter 5

CHINA

Frank Fulong Huang, Shouzhi An and Dan Liu[1]

I OVERVIEW

The insurance market in China has continued its stable development in 2018.

The State Council's cabinet reshuffle plan has been passed and adopted by the first session of the 13th National People's Congress, which ended on 20 March 2018. The reshuffle plan aims to make the government better structured, more efficient and service-oriented. After merging, restructuring, creating and dissolving, there are 26 ministries and commissions.

The China Banking and Insurance Regulatory Commission (CBIRC) is one of the new entities, formed to replace the China Banking Regulatory Commission and the China Insurance Regulatory Commission (CIRC).

On 8 April 2018, the CBIRC was formally unveiled in Beijing, marking the official launch of the new regulatory authority's operation. The insurance-related regulation will be issued by the CBIRC in future instead of the CIRC.

The CBIRC issued Notice of Expediting Taking Measures to Open up Banking and Insurance Sectors on 27 April 2018. According to this Notice, China will implement further reform measures for insurance sectors, and the key policy priorities are summarised below.

a To make it easier for foreign insurance companies to invest in China: the total foreign equity holding limits in the life insurance companies will be lifted to 51 per cent. And the foreign equity holding limit will be removed three years later.

b To make it easier for the foreign insurance companies to set up new presences in China: to remove the nationwide requirement for a foreign insurance company to have a representative office in China for two years before being eligible to set up a foreign invested insurance company in China.

c To broaden the business scope of foreign-funded companies: to allow the qualified foreign investors to operate insurance agency and loss adjustment business.

CBIRC also announced that various regulations will be issued to ensure that the above reforms are implemented.

On the same date of issuing the above Notice, the CBRIC also issued the Notice of Relaxing Restrictions on the Business Scope of Foreign-funded Insurance Brokers, which provides that all foreign-invested insurance brokers in China who have acquired the insurance brokers business permit issued by the CIRC will be able to conduct the same business activities as the domestic brokers companies in China.

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The CBRIC further issued the Notice of Permitting Foreign Investors to Operate Insurance Agency Business in China and Notice of Permitting Foreign Investors to Operate Insurance Loss Adjustment Business in China on 19 June 2018. The two Notices allow the establishment of the foreign-funded insurance agency and loss adjustment companies in China.

Apart from the above measures to open up China's insurance market, the CIRC has also issued Provisions on the Supervision and Administration of Insurance Brokers, Provisions on the Supervision and Administration of Insurance Loss Adjusters on 1 February 2018, and the CBIRC issued Basic Rules for Insurance Loss Adjustment to regulate the domestic insurance brokers and loss adjustment operations on 2 May 2018. A series of measures show the country's determination to deepen the reform of insurance market for the purpose of establishing an open, improved and legal environment.

II THE LEGAL FRAMEWORK

i Sources of insurance law and regulation

China is a civil law country. The main sources of insurance law and regulation are: (1) statutory laws and regulations issued by the Standing Committee of the National People's Congress; (2) the Interpretations, Replies and Regulations issued by the Supreme People's Court; (3) the Regulations and Replies issued by the CBRIC; and (4) the Regulations and Provisions, etc., issued by the other governments and authorities.

The important and generally applicable insurance laws and regulations are set out below:

a the Insurance Law (2015 Amendment);
b the Interpretation I, II, III and IV on Several Issues concerning the Application of the Insurance Law (2009, 2013, 2015, 2018);
c the General Provisions of the Civil Law (Effective on 1 October 2017);
d the General Principles of the Civil Law (2009 Amendment);
e the Contract Law (1999); and
f the Civil Procedure Law (2017 Amendment).

With regard to marine insurance, the Chinese Maritime Code (1992), the Special Maritime Procedure Law (1999) and Provisions on Several Issues about the Trial of Cases Concerning Marine Insurance Disputes, as special laws and regulations governing the marine insurance disputes, shall apply as priority. If there are no provisions in these special laws and regulations, then the above general provisions of the Insurance Law and other laws and regulations apply.

The basic and fundamental law, the General Provisions of the Civil Law (the General Provisions), has been issued and took effect on 1 October 2017. As the General Principles also cover the stipulations in respect of contracts, proprietary rights, and other property and intellectual rights, etc., that have not totally been reflected in the General Provisions and will be absorbed in other chapters of the China Civil Code, the General Principles are still effective and binding in the aspects that are not covered by the General Provisions.

One of the important changes in the General Provisions that will affect the insurance disputes is the time limit. According to the General Provisions, the time limit for civil claims is three years, unless otherwise provided in law. This three-year time limit counts from the

date when the person knows or should have known that his or her rights had been infringed and who has infringed upon his or her rights. The time limit in the General Provisions has been prolonged from the two-year time limit stipulated in the General Principles.

Because of the different time limit regimes in the General Provisions and General Principles, and in order to clarify which time limit shall be applied for disputes arising before the General Provisions took effect, the Supreme People's Court issued the Interpretation on Several Issues in respect of Application of the Time Limit Regime in the General Provisions of the Civil Law on 18 July 2018 to provide guidance in this respect.

If the time limit for civil claims only commences running after the General Provisions were implemented (i.e., 1 October 2017), the three-year time limit shall apply for such claims. If the time limit for civil claims already commenced running but had not expired on 1 October 2017, the three-year time limit shall apply. However, if the two-year time limit provided in the General Principles already expired on 1 October 2017, then the Courts shall not apply the three-year time limit.

Further, the Supreme Court has issued the Interpretation IV on Several Issues concerning the Application of the Insurance Law on 31 July 2018 (Interpretation IV). The Interpretation IV took effect on 1 September 2018. It gives further guidelines on the issues in respect of transfer of the subject matter insured, the rights and obligations of the parties to the insurance contract, the subrogated claims and liability insurance. The relevant provisions in the particular sections will be discussed below.

ii Insurable risk

According to the Insurance Law, the term 'insurance' means the commercial insurance activities where an insurance applicant pays insurance premium to an insurer under an insurance contract, and the insurer pays indemnity for the property loss caused by the occurrence of a potential incident specified in the insurance contract or pays insurance benefits when the insured dies, becomes disabled or sick or reaches a specified age, time period or any other condition specified in the contract.

The insurable risk, therefore, should be potential and an incidental accident that is not inevitable or has already occurred.

The Chinese Maritime Code defines 'the covered perils' as any maritime perils agreed upon between the insurer and the insured, including perils that occur in inland rivers or on land that is related to a maritime adventure.

Apart from the above, the Chinese law and regulation do not specifically stipulate the 'insurable risk' or clarify which risks can and cannot be insured.

The insurable risk is usually numerated in the insurance contract or policy and agreed upon by the parties to the insurance contract. Different types of insurance may cover different insurable risks. Only when the loss of or damage to the subject matter insured is caused by such insurable risk set out in the insurance contract or policy, then the insurer shall assume liability.

To define or confirm the insurable risk, it would also be necessary to understand which risk is not covered. In respect of the marine insurance, the Chinese Maritime Code stipulates the specific circumstances under which the insurer shall not assume liability.

Article 243 of the Chinese Maritime Code provides that unless otherwise agreed in the insurance contract, the insurer shall not be liable for the loss of or damage to the cargo insured arising from any of the following causes:

a delay in the voyage or in delivery of cargo or change of market price;

b fair wear and tear, inherent vice or nature of the cargo; and
c improper packing.

Article 244 of the Chinese Maritime Code further provides that unless otherwise agreed in the insurance contract, the insurer shall not be liable for the loss of or damage to the insured ship arising from any of the following causes:

a unseaworthiness of the ship at the time of the commencement of the voyage, unless where under a time policy the insured has no knowledge thereof; and
b wear and tear or corrosion of the ship.

The provisions of this Article shall apply *mutatis mutandis* to the insurance of freight.

iii Fora and dispute resolution mechanisms

Jurisdiction

To confirm which court has jurisdiction over an insurance dispute, both hierarchical jurisdiction and territorial jurisdiction shall be applied.

The hierarchical jurisdiction in China has four levels: (1) the primary courts, (2) the intermediate courts, (3) the higher courts and (4) the Supreme People's Court. All four levels of courts may hear the first instance civil cases (including the insurance disputes), subject to the claim amount involved, whether it is foreign-related and the influence of the case in the area or country.

To clarify the jurisdiction of the intermediate courts and higher courts, the Supreme People's Court issued the Notice on Adjusting the Standards for the Jurisdiction of the Higher Courts and Intermediate Courts over the First Instance Civil and Commercial Cases (2015).

The Supreme People's Court has also issued various replies each year in response to the applications submitted by various higher courts in respect of adjustment of jurisdiction of the primary courts and intermediate courts in their respective jurisdictions.

In respect of the territorial jurisdiction, the basic principle for general civil cases is that the courts at the place where the defendant is domiciled shall have jurisdiction. For the insurance disputes, in addition to the courts at the place where the defendant is domiciled, the courts at the place where the subject matter insured is located also have the jurisdiction.

The Interpretation on the Application of the Civil Procedure Law (2015) issued by the Supreme People's Court further provides that: (1) for the disputes arising from the property insurance contract, if the subject matter insured is a transportation vehicle or the cargo in transit, the courts at the place where the transportation vehicle is registered, the place of destination, and the place where the insurance accident occurs shall have jurisdiction; and (2) for the disputes arising from the personal insurance contract, the courts at the place where the insured is domiciled shall have jurisdiction. These provisions provide more choices of jurisdiction and convenience for the insured.

In respect of the subrogated claim against the third party, the jurisdiction shall be ascertained on the basis of the legal relationship between the insured and the third party in accordance with the Interpretation IV on Several Issues concerning the Application of the Insurance Law.

Dispute resolution

Most of the insurance disputes are resolved through litigation or arbitration in China. The insurance contract or policy usually agrees that any disputes shall be negotiated first between the parties. If no settlement is reached, then either party could start legal action or commence arbitration proceedings.

The Supreme People's Court and the CIRC jointly issued Opinions on Comprehensively Advancing the Building of the Mechanism Linking Litigation with Mediation for Insurance Disputes, which was implemented on 4 November 2016. This aims to build and improve a diversified insurance dispute settlement mechanism, provide the parties with more alternative dispute settlement channels and establish the regime linking litigation with mediation.

Before the case is formally registered by the court, the court will usually persuade the parties to mediate. If mediation fails, then the court may proceed with litigation. However, mediation shall be subject to the agreement by the parties, if the parties do not agree to mediate, the court may still have to proceed with the formal litigation procedures.

III RECENT CASES

As discussed above, China has a civil law system and does not adopt the principle of binding case precedents. The fact that a court has arrived at a particular decision earlier has no or very little binding effect on another similar court or elsewhere. From experience, it is likely that the local Chinese courts will approach each claim on a case-by-case basis, and the eventual decision will be up to the discretion of the judges.

The Supreme People's Court may issue the guiding cases that the other courts shall make reference to. But such guiding cases are limited and cannot cover all the unclear provisions or disputed issues.

If there are no guiding cases issued by the Supreme People's Court, cases reported or published by the other courts in different jurisdictions may also be helpful to understand how the basic principle, law and regulations are comprehended and implemented in different areas and what the main disputes and issues in the judicial practices are.

i The applicable time limit

The time limit for the claims arising from the disputes between the insurer and the insured

As discussed above, the General Provisions provide a three-year time limit for general civil claims, which replaces the two-year time limit under the General Principles.

The Insurance Law has its own provisions in respect of the time limit. According to Article 26 of the Insurance Law, except for life insurance, the time limit for an insured or beneficiary to commence legal proceedings against the insurer is two years, counting from the date when the insured or beneficiary knows or should have known the occurrence of the insured incident.

The time limit for an insured or beneficiary in a life insurance contract to commence legal proceedings is five years, counting from the date when the insured or beneficiary knows or should have known the occurrence of the insured incident.

In respect of the marine insurance, Article 264 of the Chinese Maritime Code provides that 'The time limit for claims with regard to marine insurance contract is 2 years, counting from the day on which the peril insured against occurred.'

It is obvious from the above stipulations that there is conflict between the general law, the General Provisions and the special laws, the Insurance Law and the Chinese Maritime Code in respect of the time limit.

No further interpretations or regulations have been issued to resolve the above conflict or clarify how to apply the time limits in different laws to date. The Tribunal No. 1 of the Beijing Higher Court issued the Reference Opinions in respect of Application of the Time Limit after the General Provisions were Implemented (the Reference Opinions) in December 2017.

The Insurance Law is a special law compared to the General Provisions in respect of the insurance disputes. The Chinese Maritime Code is a further special law compared to the Insurance Law in respect of the marine insurance disputes. In light of the principle that a special law is in priority over a basic or general law, the time limits in the Insurance Law and Chinese Maritime Code seem to be applicable for insurance and marine insurance claims respectively.

However, according to the Reference Opinions, if the special law also provides a two-year time limit that has the same characteristics as the two-year time limit provided in the General Principles, then such two-year time limit in the special law shall be replaced by the three-year time limit in the General Provisions.

Although it seems that the two-year time limit in the Insurance Law and Chinese Maritime Code is similar to the two-year time limit under the General Principles, it is still uncertain how the local courts would consider this issue and which time limit shall be applied for the claims arising from the disputes between the insurer and insured owing to lack of the formal law or regulation and interpretation made by the Supreme People's Court or relevant authorities. The Reference Opinions only give some reference on how to apply different time limits, but such reference has no binding effect on the courts in other jurisdictions, and the issues still need to be considered in each particular case and are subject to the discretion of the judges.

It may be prudent to suggest to adopt a two-year time limit for insurance and marine insurance disputes before judicial practices are certain and consolidated.

For life insurance, the five-year time limit in the Insurance Law is special and aimed to provide a better protection to the insured. It is very likely that the five-year time limit will be applied for the claims arising from the personal insurance instead of the three-year time limit in the General Provisions.

The time limit for the subrogated claims

The insurer's subrogated claim is based on the insured's cause of action against the third parties. The cause of action is either a tortious claim or a contractual claim. For the tortious claim, the time limit shall be three years under the General Provisions or ascertained according to the special laws (e.g., the Chinese Maritime Code). For the contractual claims, it would be necessary to confirm the type of the contract between the insured and the third party and whether there is any special law governing such type of contract.

ii The remedies available for insured and insurer

The remedies available for insured and insurer are reflected in different laws and regulations. We set out the main remedies below.

The remedies available for the insured

After the insurance contract is formed, the insurance applicant may rescind the contract except as otherwise provided in the law or agreed upon in the insurance contract. In principle, the insurance applicant may rescind the contract at any time.

However, in respect of a cargo transportation insurance contract or a voyage insurance contract for a means of transport, once the insurance liability commences, the insured cannot rescind the contract.

The remedies available for the insurer

The insurer cannot rescind the contract unless this is clearly provided in law. Some primary circumstances (excluding the life insurance) under which the insurer could rescind the contract or refuse to pay the insurance indemnity are set out below.

When the insured fails to perform the disclosure obligation, the insurer may rescind the contract. This will be discussed below in more detail.

When the insurance applicant, the insured or the beneficiary fails to notify the insurer intentionally or for gross negligence, which makes it difficult to determine the nature, cause, extent of damage, etc., of the insured incident, the insurer need not pay indemnity or insurance benefits for the undeterminable part, unless the insurer has known or should have known the incident in a timely manner through any other channel. This will be discussed below in more detail.

If the insured or beneficiary lies about the occurrence of an insured incident that has never actually occurred, and claims indemnity or insurance benefits against the insurer, the insurer shall have the right to rescind the insurance contract and not to return the insurance premium.

Where the insurance applicant or insured intentionally causes an insured incident, the insurer shall have the right to rescind the insurance contract, not to pay indemnity or insurance benefits, and not to refund the insurance premium.

Where, after the occurrence of an insured incident, the insurance applicant, insured or beneficiary fabricates the cause of incident or exaggerates the degree of damage by forging or altering the relevant certificates or materials or any other evidence, the insurer shall not be liable to pay indemnity or insurance benefits for the false part.

Where the degree of peril of the subject matter insured greatly increases during the term of validity of the contract, the insured shall notify the insurer in a timely manner as agreed upon in the contract, and the insurer may increase the insurance premium or rescind the contract as agreed upon in the contract.

iii Duty of disclosure

There are generally two types of duty of disclosure under Chinese law: (1) disclosure of all the material facts by the insured voluntarily, and (2) disclosure of only the facts that have been enquired by the insurer.

The Insurance Law has adopted (2), and according to Article 16 of the Insurance Law, where the insurer enquires about the subject matter insured or the insured when entering into the insurance contract, the insurance applicant shall truthfully disclose the information.

The Interpretation II on Several Issues concerning the Application of the Insurance Law issued by the Supreme People's Court further clarifies that the information that is known by the insurance applicant regarding the subject matter insured or the insured shall be the information that the insurance applicant 'shall truthfully disclose'.

If the insurance applicant fails to disclose the information (that is known to it) intentionally or as a consequence of gross negligence, and this affects the insurer's decision on whether to underwrite the insurance or raise the insurance premium, the insurer shall have the right to rescind the insurance contract.

The right to rescind an insurance contract shall be annulled 30 days after the insurer knows the cause of rescission. Two years after an insurance contract is concluded, the insurer may not rescind the contract; and where an insured incident occurs, the insurer shall pay indemnity or insurance benefits.

Where the insurance applicant intentionally fails to disclose the information as requested by the insurer, the insurer shall not be liable for paying indemnity or insurance benefits for an insured incident that occurs before the contract is rescinded, and shall not refund the insurance premium.

Where the insurance applicant fails to disclose the information because of gross negligence, materially affecting the occurrence of an insured incident, the insurer shall not be liable for paying indemnity or insurance benefits for an insured incident that occurs before the contract is rescinded, but shall refund the insurance premium.

Where the insurer knows the truth that the insurance applicant fails to tell when they enter into an insurance contract, the insurer shall not rescind the contract; and if an insured incident occurs, the insurer shall pay indemnity or insurance benefits.

In the appeal case *Disputes over Property Insurance Contract between Liberty Insurance Co Ltd and Chongqing Pingwei Vehicle Mould Group Co Ltd* (2015 YuGaoFaMinZhongZi No. 00025), the Chongqing Higher Court issued appeal and final judgment in 2015. In this case, Pingwei was the buyer of two sets of gantry machines and entrusted Gaoshi Supply Chain to arrange insurance and transportation. Gaoshi Supply Chain then applied for insurance with Liberty Insurance and the cargo insured was described as 'Italy-imported two sets of gantry machine'. The cargo was damaged thereafter during the inland transportation. Liberty Insurance rejected the claim as the cargo is a precision machine that would not be covered under the insurance policy. Pingwei and Gaoshi Supply Chain failed to disclose such information to Liberty Insurance and they were entitled to rescind the insurance contract.

The Chongqing Higher Court considers that the definition and types of the precision machine are not clear. The insurer shall decide whether the cargo is a precision machine instead of the insurance applicant or insured. The information known to the insured does not necessarily mean that the insurance applicant also knows it. Based on Article 6 of The Interpretation II on Several Issues concerning the Application of the Insurance Law – 'The insurance applicant's obligation of disclosure is limited to the extent and content as enquired by the insurer. Where the parties are in dispute over the extent and content of enquiries, the insurer shall bear the burden of proof' – the Court considered that Gaoshi Supply Chain already performed the duty of disclosure.

In view of the above, the information disclosed by the insurance applicant will very much depend on the enquiries by the insurer. If the insurer considers which information is important, it needs to make clear explanations and enquiries with the insurance applicant, and if there is any dispute arising thereafter, the insurer also needs to prove it has already made such explanations and enquiries. Further, the insurance applicant is not necessarily the same as the insured. Some Chinese courts may consider the information known to the insured is not necessarily known to the insurance applicant and the duty to disclose is only on the insurance applicant. However, different courts may take different views in this regard and decisions may be different from case to case.

In respect of marine insurance, the Chinese Maritime Code adopts disclosure of all the material facts by the insured voluntarily. Before the marine insurance contract is concluded, the insured shall truthfully inform the insurer of the material facts that the insured has knowledge of or ought to have knowledge of in his or her ordinary business practice and that may have an impact on the insurer in deciding the premium or whether he or she agrees to insure or not. As to the facts that the insurer has known of or the insurer ought to have knowledge of in his or her ordinary business practice, the insured does not need to disclose these if they have not been enquired about by the insurer.

The consequence of failure to perform the duty of disclosure under the Chinese Maritime Code is similar to that in the Insurance Law.

The Chinese Maritime Code provides that if the insured fails to truthfully inform the insurer of the material facts owing to his or her intentional act, the insurer has the right to rescind the contract without refunding the premium. The insurer shall not be liable for any loss arising from the perils insured against before the contract is rescinded.

If, not as a result the insured's intentional act, the insured did not truthfully inform the insurer of the material facts, the insurer has the right to rescind the contract or demand a corresponding increase in the premium. If the contract is rescinded by the insurer, the insurer shall be liable for the loss arising from the perils insured against that occurred before the rescission of the contract, except where the material circumstances that were uninformed or wrongly informed of have an impact on the occurrence of such perils.

iv Notice of claims and consequence of late notice

Article 21 of the Insurance Law provides that after knowing the occurrence of an insured incident, the insurance applicant, insured or beneficiary shall notify the insurer in a timely manner. Where the insurance applicant, insured or beneficiary fails to do so intentionally or for gross negligence, which makes it difficult to determine the nature, cause, extent of damage, etc., of the insured incident, the insurer need not pay indemnity or insurance benefits for the undeterminable part, unless the insurer has known or should have known the incident in a timely manner through any other channel.

There are two conditions that must be satisfied before the insurer can argue not to pay the insurance indemnity. First is that the late notice shall be due to the insured's intention or gross negligence. The other is that such late notice makes the insurer unable to determine, *inter alia*, the nature, cause and extent of damage.

In the appeal case *The disputes over the property insurance contract between Hua'an Property Insurance Group Co Ltd Guangdong Dongguan Branch and Wang Juancai* (2018) Yue19MinZhong No. 1148, the Guangdong Dongguan Intermediate Court issued final and appeal judgment in March 2018. Wang Juan insured her car with Hua'an Property Insurance and the car was involved in an accident on 11 March 2017. The car was dismantled and inspected on 23 April 2017 and she only notified insurer of the accident on 24 April 2017. The appeal court confirms the decision of the first instance court that Wang Jun failed to notify the insurer of the accident in a timely manner and as a result, the insurer was not able to attend on inspection and confirm the extent of damage and loss. The court, therefore, did not support Wang Juan's claim amount for repair costs, etc., for 171,726 yuan, but considered that 137,381 yuan was more reasonable. The judges were of the view that as the insured did not notify the insurer in a timely manner, the insurer was not obliged to make full payment for the insured's loss.

How to decide the extent to which the insurer's right was affected? What shall be the reasonable compensation amount? There are no criteria in this respect. These issues have not been clarified in the judgment and may still need to be subject to the discretion of the judges and facts on a case-by-case basis.

With regard to marine insurance, the Chinese Maritime Code requires the insured to notify the insurer immediately and take necessary and reasonable measures to avoid or minimise the loss. The insurer shall not be liable for the extended loss caused by the insured's breach of the immediate notice and failure to mitigate losses.

The obligation to give immediate notice seems to be more stringent than the timely notice provided in the Insurance Law. In addition, the insured also needs to take necessary and reasonable measures to avoid or minimise the loss. This requirement is in compliance with the specialities and characteristics of marine transportation. The insured is usually in control of the vessel and cargo during ocean transportation. When the accident occurs, it may take time for the salvor to reach the vessel at sea and carry out the salvage operations. The insurer also cannot send agents or surveyors on-site immediately. As the insured is professional and experienced in managing and operating the cargo and vessel, it shall take necessary and reasonable measures to avoid and mitigate loss in the first instance so as not to miss the best salvage time. The insurer could only exempt from liability for the losses that are extended owing to the insured's failure to take reasonable measures to mitigate such losses.

v Application and scope of insurer's subrogation rights and duty to defend

Article 60 of the Insurance Law provides that where an insured incident occurs for any damage caused by a third party to the subject matter insured, the insurer shall, after it pays indemnity to the insured, be subrogated with the insured's right to claim for indemnity against the third party within the extent of the indemnity amount.

The insurer's subrogation right shall be established on the following basis:

a the subject matter insured was damaged by a third party, either in tort or on a contractual basis;

b the insurer has paid the insurance indemnity for such damage;

c the insurer shall exercise the subrogation right in its own name (legal proceedings for the subrogated claim shall be started in the insurer's own name);

d the insurer shall not recover any amount that is more than the amount paid to the insured; and

e the insurer's right to claim and defend shall be based on the insured's right to claim and defend on a tortious or contractual basis.

Where the insured waives the right to claim indemnity against the third party without the consent of the insurer after the insurer pays indemnity to the insured, the waiver shall be null and void.

Where the insured, intentionally or for gross negligence, causes the insurer to be unable to exercise the right of subrogation to a claim for indemnity, the insurer may deduct or require the insured to refund the corresponding amount of indemnity.

Pursuant to the Interpretation IV on Several Issues concerning the Application of the Insurance Law, if the insured has waived its right to claim against the third party before the insurance contract is formed, such waiver shall be valid and the subrogated insurer shall not file any claim against the third party for the part waived by the insured.

Another consideration is whether the insurer could ask the insured to compensate such losses owing to the latter's waiver of right to claim against the third party. The Interpretation IV provides that at the time when the insurance contract is formed, if the insurer makes enquiries regarding whether the insured has waived any right to claim against the third party but the insured has not truthfully disclosed such information, the insurer could ask the insured to return the insurance indemnity. However, if the insurer knows or should have known the above situation and still agrees to insure the subject matter, the insurer cannot ask the insured to return the insurance indemnity.

If the insurer does not make enquiries regarding whether the insured has waived the right to claim against the third party at the time the insurance contract is formed, the insured is not obliged to disclose such information voluntarily and the insurer may not ask the insured to return the insurance indemnity afterwards.

The Chinese Maritime Code requires the insured to disclose all the material facts insured voluntarily. The insured shall disclose all the material information before the insurance contract is entered into without enquiries from the insurer. There is conflict between the Interpretation IV and the duty of disclosure in the Chinese Maritime Code and it seems that it is not proper to apply such provisions of the Interpretation IV for marine insurance at the moment.

IV THE INTERNATIONAL ARENA

i Jurisdiction of foreign-related insurance disputes

For foreign-related insurance disputes, if legal action is started against a Chinese party, the jurisdiction shall be confirmed as set out in Section II.iii above.

With regard to contract disputes or any other proprietary right disputes against a defendant who is not domiciled in China, if the contract is signed or performed in China, the subject matter in dispute is located in China, the defendant has any property that could be mortgaged in China, or the defendant has any representative office in China, jurisdiction may be held by the court at the place where the contract is signed or performed, where the subject matter in dispute is located, where the property is located, where the tortious act occurs, or where the representative office is located.

ii Which law is applied to foreign-related insurance disputes

For insurance disputes involving foreign parties, the parties can expressly agree on the governing law. If the parties fail to reach agreement on the governing law, the law of the country to which the contract is most closely connected shall be applied.

For a foreign-related contractual relationship, the parties may choose the law applicable to contracts by agreement. If the parties do not reach agreement, the law at the place of habitual residence of the party whose fulfilment of obligations can best reflect the characteristics of this contract or other laws that are most closely connected with this contract shall apply.

For the foreign-related tortious relationship, the laws at the place where the tortious act was carried out shall be applied, but if the parties have the same habitual residence, the laws of their habitual residence shall apply. If the parties choose the applicable laws by agreement after the tortious act was carried out, the agreement shall prevail.

The arbitral tribunal or administrative organ shall verify or ascertain the foreign law that is applicable to foreign-related civil relations. If either party chooses the applicable foreign law, it shall provide the laws of this country. If foreign laws cannot be verified or ascertained, or there are no provisions in the laws of that country, Chinese law shall be applied.

iii Enforcement of foreign judgments or arbitration awards against insurers domiciled in China

The foreign judgments or arbitration awards need to be recognised first by the Chinese court before the court will enforce the same. The intermediate court at the place where the party against whom the application is made or at the place where the property to be enforced is located shall have jurisdiction. The party may also apply before the foreign courts and ask them to request recognition and enforcement by the Chinese court in accordance with the provisions of an international treaty concluded or acceded to by China or under the principle of reciprocity.

If there is no judicial assistance treaty between China and the other country, no mutual treaty that both countries enter into, and no reciprocity relationship between the two countries, the court may dismiss the application for recognition and enforcement of the judgment issued in that country.

After examining an application for recognition and enforcement of an effective foreign judgment in accordance with an international treaty concluded or acceded to by China or under the principle of reciprocity, the court shall issue an order to recognise the judgment and issue an order to enforce the judgment if the court deems that the judgment does not violate the basic principles of Chinese law and the sovereignty, security and public interests of China. If the judgment violates the basic principles of the Chinese law or the sovereignty, security or public interests of the China, the court shall not recognise and enforce the same.

In respect of the arbitration award, as China is one of the contracting parties to the New York Convention on the Recognition and Enforcement of Foreign Arbitral Awards (1958), the arbitration award issued in other contracting countries will, in principle, be recognised and enforced in China.

The party may apply directly to the intermediate court at the place of domicile of the party against whom the application is made or at the place where the property is located.

The time limit for the party to apply for recognition and enforcement of foreign judgment or arbitration award is two years, counting from the last performance date set out in the foreign judgment or arbitration award.

V TRENDS AND OUTLOOK

More and more claims in respect of insurance disputes are now filed before the courts. In 2013, the number of first instance cases that were registered by various courts is 82,564, while the number reached 127,611 in 2017. The number is still increasing.

The disputes arising from the motor policy account for a large proportion of insurance dispute cases. According to the reported cases, the disputes arising from traditional insurance, including property insurance, liability insurance, personal injury or death insurance, and insurer's subrogated cases are still major parts.

Traditional insurance will be gradually changing. Electric and automated vehicles are progressing at an unprecedented rate in China. The traditional risks arising from third-party

liability and mechanical breakdown may be replaced by risks arising from battery breakdown, vehicle software issues, etc., in the near future. The product liability, renewable energy and agriculture areas may need innovative insurance to cover the potential risks.

According to the updated data issued by the China Export & Credit Insurance Corporation, the insured amount for the export credit insurance also increased dramatically over the past year, especially in the Belt and Road countries and regions. The credit insurance disputes and the subrogated claims arising therefrom will also increase and may involve more international parties and elements.

Traditional insurance companies will expand their online sales channels and cooperate with internet giants, for example, by establishing joint ventures. More internet insurance products will be sold online, and this will inevitably bring more disputes in this regard.

To cope with the aging society in China, more commercial insurance products would potentially be provided to meet the rising and differentiated needs of the aging population. This would no doubt require implementation of the relevant law or regulation and supervision from the relevant authorities. Disputes may also arise as the aging population increases in the future.

Chapter 6

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 Danish Insurance Contracts Act[2] governing insurance contracts.[3] Like any other contract, insurance contracts are subject to the Danish 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 Danish Insurance Contracts Act but are governed by general contract law.

No statutory law provides rules specifically designed to resolve insurance disputes in courts. In Denmark, insurance dispute resolution is subject to the same procedural rules applying to any other civil law proceedings by way of the statutory provisions following from the Danish Administration of Justice Act[4] or rules on arbitration. Many commercial

1 Anne Buhl Bjelke is a partner at Bech-Bruun Law Firm P/S.

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

3 Furthermore, the financial and prudential regulation (the Danish Financial Business Act, Consolidated Act No. 1140 of 26 September 2017, and the Danish Insurance Distribution Act, Consolidated Act No. 1065 of 22 August 2013, including executive orders) governs insurance business and insurance distribution activities. Such regulation 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 insurance distribution directive is implemented in Denmark, cf. Act No. 41 of 22 January 2018.

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

insurance policies adopt arbitration. Arbitration taking place in Denmark is governed by the Danish Arbitration Act,[5] which is partly mandatory. Arbitral decisions are not usually published.

Interpretation of insurance contracts and the burden of proof

As the Danish 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 Danish 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 Danish Insurance Contract Act Section 18 (1), the insurer is entitled to refuse cover if the insurance event was caused by the insured's intent.[6] In case 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 having implied '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 kroner. There were no signs of forced entry

5 Act No. 553 of 24 June 2005 ('Voldgiftsloven').
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 case of gross negligence (Article 18 (2)), but not in 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 Danish 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 initially marked with a 'U'. Reference to these 'numbers' will be made in the footnotes of this chapter.
9 U.1998.1693 H.

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 Danish Supreme Court found that storing the key under such circumstances leaving it highly accessible entailed such 'an obvious danger' in respect of the burglary occurring that the insured had acted with gross negligence, 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 Danish Insurance Contract 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 Sections 4 (fraud) and 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 cases where the insured has participated in increasing the risk of the insurance event occurring.

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.

In such cases, the insurer is entitled to refuse cover pursuant to Section 45 of the Danish 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 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.

Of practical relevance, Section 46 of the Danish Insurance Contracts Act states that if the insured becomes aware of such 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 such requirements, 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 non-observance.[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 Danish Insurance Contract 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 such 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 such omission.[17]

Vice versa, if expenses are associated with fulfilling the insured's duty to mitigate the loss, such 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 Danish 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 Danish 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 elaborated upon below in the subsection 'Limitation according to the Danish Insurance Contracts Act'.

ii Insurable risk

According to Section 35 of the Danish 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 Danish 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 it is the only court in Denmark that specialises 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

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).

by 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 Danish 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 orally[24] 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 Danish 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[30]

In 2017, the average processing time of court hearings at the City Court of Copenhagen, including preparatory work, was approximately 10 months. For appeal cases pending before the high courts, the average processing time was approximately 12 months.[31] For disputes pending before the Supreme Court, the average processing time was approximately 11 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[32]

This case 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 case 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 at 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 Danish Administration of Justice Act had an average processing time of 22–36 months.

32 The Maritime and Commercial High Court's 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 Danish Insurance Contracts Act

Section 29(2)–(6) of the Danish Insurance Contracts Act deviates from the general statutory provisions of the Danish Limitation Act. Section 29(5) provides that claims filed against an insurer the earliest are forfeited 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 Danish 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 a statutory third-party access), and thus that Section 29(5) was applicable to the injured third party's claim against the insurer extending the limitation period for the injured third party's claim. Recently, the Danish Supreme Court advanced this interpretation further in the two following cases.

The Supreme Court's judgment in case 93/2017 of 23 January 2018[34]

This matter related to an injury for which the claimant sought to claim damages from the insurers of a policy taken out by the insured tortfeasor. The question became whether the claimant's claim had been forfeited even after the claim had been notified to the insurers. The claimant argued that the provision of Section 29(5) applied, thus extending the limitation period. The Supreme Court held that Section 29(5) applies in cases where the insurer is subject to a direct third-party action. As opposed to the case from 2016, no such direct third-party action applied towards the insurer.

33 U 2016.133/2 H.

34 U 2018.1506 H.

Thus, Section 29(5) applies to claims notified by the insured (in case of first-party insurance), and to claims notified by a third party only if such party has a statutory direct access to claim against the insurers.

Judgment in case 223/2017 rendered by the Supreme Court on 29 May 2018[35]

This case concerned two claimants having 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 implying that the insurer was 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 preparatoires* did not contain any grounds implying that a notice of a claim to an 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.

iii Assens Havn v. Navigators Management (UK) Ltd[36]

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 Danish Supreme Court. The Supreme Court stated that, according to Section 95(2) of the Danish Insurance Contracts Act,[37] 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[38]

The Danish Supreme Court's decision was recently followed by a ruling of the Danish Maritime and Commercial High Court on 10 November 2017.

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 2018.100 H.

36 Case C-368/16.

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

38 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 Danish 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 Danish 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.[39] 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 Danish 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.

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,[40] whereas the jurisdiction of the Danish courts to decide on the matter is regulated by the Danish Administration of Justice Act,[41] provided that the company is situated outside the EU.

ii Choice of law

Insurance disputes often involve parties from different jurisdictions. However, the Danish Insurance Contracts Act does not contain any provision stating to which extent 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.[42] However, insurance contracts are governed by EU Directives.[43] The directives have been implemented by a ministerial order[44] providing that the rules of the EU Directives precede the choice of law rules laid down in the Rome Convention.[45] Consequently, if the insurance

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.

40 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).

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

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

43 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.

44 Ministerial order No. 560 of 27 June 1994.

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

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 arbitration 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 declaration[46] 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 Danish home owners from being left without insurance coverage, the Danish 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. The claim is announced to be 96 million kroner.[47] These proceedings will probably 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. Further, a lawyer's report has pointed out that the management of the insurance intermediaries of Gable Insurance AG may be criticised for mis-selling. Thus, insurance litigation in Denmark may be taken to another field in the future.

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

47 http://skadesgarantifonden.dk/ Press release of 12 January 2018.

Chapter 7

ENGLAND AND WALES

Joanna Page and Russell Butland[1]

I OVERVIEW

English insurance law has traditionally been perceived as very 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 information asymmetry between the insured and the insurer was especially acute. To resolve that asymmetry, English insurance law developed to place onerous duties of disclosure and compliance with warranties on insureds, with potentially drastic consequences for failure.

However, that historic imbalance has recently 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. However, at the time of writing there have been very few disputes under the new law, 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, 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, many of its sections

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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.

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 1777 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 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 (Right 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 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 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 a 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 the 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 recent cases in the English courts, including three recent decisions of the Supreme Court relating to aggregation of claims, exclusion clauses and fraudulent claims, respectively. We summarise below the key recent cases in the order of the life of an insurance policy and claim – from the insured's duty of disclosure before the inception of the policy, through key policy terms and issues around the notification and aggregation of claims, to issues that arise in the course of disputes including dishonest and fraudulent claims, the measure of loss and procedural issues.

i Non-disclosure and inducement

In *Axa v. Arab Insurance Group (ARIG),*[3] the Court of Appeal gave guidance on the approach to be taken to assessing inducement where a breach of the insured's duty of disclosure is

3 [2017] EWCA Civ 96.

established. *Axa* is a case on the pre-Insurance Act duties of disclosure,[4] but as the Insurance Act has not altered the test of inducement, this guidance will be equally relevant in disputes where breach of the insured's duty to make fair presentation of the risk under the Insurance Act is in issue.

Axa concerned a first loss reinsurance treaty for marine energy construction risks, which Axa sought to avoid on the grounds that ARIG had failed to disclose its loss history. ARIG argued that disclosure would not have influenced a prudent underwriter, and so there was no inducement. The three questions the court needs to ask and answer when considering inducement are:

a What did the insured need to disclose in order to make the presentation of the risk fair? This is an objective question to be answered by reference to what a reasonable and prudent insurer would have required.

b If the additional information identified in answer to the first question had been disclosed, what additional matters would the insured or the broker have then said to the insurer to encourage it to write the risk?

c How would the additional information in answer to the first two questions have influenced the decision to insure or the terms on which the policy was written? This is a subjective question as to the approach the actual insurer would have taken, not the approach a reasonable and prudent insurer would necessarily have taken.

The court also clarified that the burden of proof in relation to questions (a) and (c) is on the insurer, but that there is an evidential burden on the insured to show what additional matters, if any, should form the answer to question (b). On the facts of *Axa*, the Court of Appeal upheld the High Court's finding that the (re)insurer had not discharged the burden of proof in relation to question (c) to show that disclosure of the loss history would have influenced the insurance decision.

ii Compliance with policy conditions

In two recent cases, the English courts have considered the consequences of a failure by a policyholder to comply with claims cooperation conditions, in particular conditions requiring the provision of information to insurers in the event of a claim, but with very different outcomes.

In *Denso Manufacturing v. Great Lakes Reinsurance*,[5] the High Court held that clauses in an ATE policy requiring the insured to cooperate with insurers in the defence of claims, and to provide information to insurers when requested, were conditions precedent to insurers' liability under the policy. As a result, the insured's failure to comply with those cooperation clauses allowed the insurers to reject payment of a claim.

In contrast, in *Ted Baker v. AXA*,[6] in investigating a claim the insurer had requested certain accounting information from the insured relying upon a condition to the policy requiring its provision. The insured did not provide the information and the insurer sought to reject the claim for breach of the condition. The insured argued that the insurer could not reject the claim as there had been an agreement to waive provision of the information until

4 Strictly, *Axa* concerns a reinsurance policy, but on inducement the same principles apply in insurance and reinsurance.

5 [2017] EWHC 391 (Comm).

6 [2017] EWCA Civ 4097.

other preliminary matters had been determined. The Court of Appeal held that there had been a breach of the policy condition, which would ordinarily entitle the insurer to reject the claim. It also held that there was no binding agreement to waive provision of the information, nor a general obligation on an insurer to warn an insured of the need to comply with policy conditions. However, on the facts, the insurer was under a duty to speak to prevent the insured from breaching the condition under the misapprehension that it was not obligated to do so as a result of the perceived agreement. The insurer's failure to tell the insured that the accounting information was still required, instead allowing the insured to breach the condition on the mistaken understanding that the information was not yet required, gave rise to an estoppel by acquiescence that prevented the insurer from relying on the breach of condition to reject the claim.

iii Exclusion clauses

In *Impact Funding Solutions v. AIG Europe Insurance Ltd*,[7] the Supreme Court held that exclusion clauses in insurance policies are not subject to the general rule of construction in English law that clauses that purport to exclude one party's liability to another should be interpreted narrowly. Unlike such clauses in more general contracts, the purpose of an exclusion clause in insurance is to delineate the scope of the cover, not to limit the scope of liability one party has to another in the event of a breach of contract. As a result, the policy reasons for construing such clauses narrowly do not apply to exclusion clauses in insurance policies, which are to be construed in the same manner as any other clause in a contract.

iv Notification and aggregation

There have been a number of recent cases in England considering both the insured's rights and obligations to notify claims to its insurer, and whether multiple claims arising out of similar circumstances are to be treated as one claim – and thus subject to only one deductible and one policy limit – for insurance purposes. The meaning of any particular notification and aggregation clause will turn on the particular words used, but the following recent cases give some guidance as to the approach the English courts are taking to these clauses.

In *The Cultural Foundation (t/a American School of Dubai) and another v. Beazley Furlonge Ltd and others*[8] the High Court stated that the existence of a notification to an earlier policy did not preclude a claim on a later policy, providing that a valid notification was also made during that policy period and the later policy did not contain a clause excluding prior notified circumstances. In such a case an insured could potentially be in a position to make an election as to which policy they pursued the claim under.

In *Maccaferri Ltd v. Zurich Insurance Plc* [2016] EWCA Civ 1302, the policy required the insured to notify insurers 'as soon as possible after the occurrence of any event likely to give rise to a claim'. The Court of Appeal held that this wording did not impose an obligation on the insured to carry out a rolling assessment as to whether a past event was likely to give rise to a claim, but only to ascertain at the time the event occurred whether it was likely to give rise to a claim (and if so, to notify). If a particular event was, at the time, not likely to give rise to a claim, but subsequently did, the insured would not be in breach of the notification

7 [2016] UKSC 57.

8 [2018] EWHC 1083 (Comm).

condition if it only notified insurers once the claim was received. Equally, an insured could not be required to give notice of an event until he had actual knowledge of its occurrence, even if that knowledge was only gained some time after the event occurred.

In *AIG Europe Ltd v. OC320301 LLP*[9] the Supreme Court interpreted the meaning of the phrase 'a series of related matters or transactions' in the aggregation clause of a standard form solicitor's professional indemnity policy. Its findings in the case were fact-specific, but it also laid down a general principle for the interpretation of aggregation clauses. The court noted that such clauses can operate in favour of either the insurer or the insured, depending on the quantum of the claims involved. In other words, such clauses are not typically pro-insurer or pro-insured, but very much depend upon the relevant facts. The court, therefore, found that 'they are not to be approached with a predisposition towards either a broad or a narrow interpretation'.

Spire Healthcare Ltd v. Royal & Sun Alliance Insurance Plc [2018] EWCA Civ 317 considered whether claims arising out of 700 separate operations performed by one surgeon should be aggregated as one claim. The schedule to the policy set the coverage limits at £10 million for any one claim, and £20 million for all claims. However, a proviso in the policy described the lower £10 million limit as applying to all claims 'consequent on or attributable to one source or originating cause'. Applying the principle in *AIG*, the Court of Appeal held that the proviso intended to introduce aggregation wording into the concept of a claim, and thus the reference to one claim in the schedule was to be read in light of the aggregation wording. All of the over 700 claims arose from the same source or originating cause (the same surgeon), and therefore were to be aggregated as one claim.

v Fraudulent claims

Before the Insurance Act, under English common law it had long been established that if an insured made a claim tainted by fraud, the insurer was not liable to pay any part of the claim.[10] The Insurance Act places the remedies available to an insurer for a fraudulent claim on a statutory footing, but does not define what constitutes a fraudulent claim. The Supreme Court has recently considered that question in *Versloot Dredging BV and Another v. HDI Gerling Industrie Versicherung AG and Others*.[11] It is well established that claims that are entirely fabricated, or that are part genuine but part dishonestly exaggerated, are fraudulent claims for the purposes of the common law rule and now the Insurance Act.[12] However, the Supreme Court had to consider whether a claim in which the insured dishonestly embellished information to try to establish cover, but where such information was in fact irrelevant to the merits and quantum of the claim, was nevertheless a fraudulent claim. The Supreme Court categorised such irrelevant embellishments as 'collateral lies', and held that they do not deprive the insured of its claim, provided that the collateral lie was not material to the merits of the insured's claim.

9 [2017] UKSC 18.

10 Since at least *Britton v. Royal Insurance Co* (1866) 4 F&F 905.

11 [2016] UKSC 45.

12 *Manifest Shipping Co Ltd v. Uni-Polari Insurance Co Ltd (The 'Star Sea')* [2003] 1 AC 469.

However, *Aviva Insurance Ltd v. Ahmed*[13] serves as a stark warning that the consequences of making a fraudulent insurance claim may not end with the failure of the claim and the avoidance of the policy. In that case an individual who pursued a fraudulent claim at trial was also found to be in contempt of court, and was imprisoned for nine months.

vi Recoverable loss

In *Engelhart CTP v. Lloyd's syndicate 1221 and others*,[14] the High Court held that an all risks policy did not cover losses resulting from fraud when the goods that were the subject of the fraud did not exist at all. The claimant had insured a cargo of copper ingots, but when it took delivery discovered that the cargo contained no copper at all. The relevant cargo all risks policy provided cover for 'physical loss of or damage to goods . . . [insured hereunder through the acceptance by the Assured and/or the Shippers of fraudulent documents of title]'. The High Court held that fraudulent absence of the copper did not equate to a 'physical loss of or damage to goods'. For there to be a physical loss of goods, the goods had to exist in the first place. Therefore, where the fraud perpetrated by fraudulent documents of title was a total absence of the relevant goods, the losses were purely economic and there was nothing that was physically lost.

vii Security for costs

One of the more common interim remedies sought in disputes before the English courts is security for costs. An order for security for costs is an order that one party pay into court a sum to be held by the court as security for that party's potential costs liability to the other party, in the event they are unsuccessful in the dispute. One of the most common grounds on which a party will seek an order for security for costs is that there is reason to believe that the other party will be unable to pay the legal costs of the winning party, if ordered to do so (this correlates with the general rule in English law that the loser will be ordered to pay a substantial proportion of the winner's costs).[15] Among the factors that the English court will take into account in exercising its discretion to make an order for security will be the merits of the claim, and whether the potential inability to pay costs has been caused by the conduct of the party seeking the order. In *Deleclass Shipping v. Ingosstrakh Insurance*,[16] the High Court confirmed that, in a security for costs application made by an insurer against an insured, the insurer's failure to pay the insured's arguable claim can be considered a cause of the insured's impecuniosity. It was thus a relevant factor for the court to take into account in deciding whether to grant the insurer's application for security for costs.

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

13 [2018] EWHC 423 (QB).

14 [2018] EWHC 900 (Comm).

15 Civil Procedure Rules Rule 25.13(2)(c).

16 [2018] EWHC 1135 (Comm).

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. Finally, in cases where the defendant is domiciled outside of 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.

Where the defendant (which in insurance disputes is usually, though not always, the insurer) is domiciled outside of 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 of 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).

The United Kingdom's exit from the European Union is unlikely to significantly alter the position in England with respect to jurisdiction and governing law. At the time of writing, the UK government has publicly confirmed that it will implement the Rome I Regulation into English law on the United Kingdom's exit date. It has also confirmed that it intends to continue to participate in the Lugano Convention, and seek an agreement with the EU27 that will allow continued civil judicial cooperation on a reciprocal basis that reflects closely the substantive principles of the current Recast Brussels Regulation framework. The Recast Brussels Regulation is likely to continue to apply during the proposed transition period.

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*[17] 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 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.

17 [2018] EWCA Civ 817.

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.

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.

Chapter 8

FRANCE

Erwan Poisson and Delphine Dendievel[1]

I OVERVIEW

New legal developments have not resulted in major changes this year, except for car insurance. 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 need 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.

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

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 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

It was recently held that the special limitation period applied to a breach committed by the manager of an insurance portfolio as this action derived from the insurance contract in *Mr X v. Financial Management Investment.*[6]

The court found that there was a very close link between the mandate and the insurance policy. It then allowed a hedge fund that made high-risk investments while managing an insurance portfolio to benefit from the two-year limitation period. This case testifies that the special limitation period may extend to other contracts closely linked to the insurance policy, especially when a group of contracts exists.

Practitioners must also be aware that certain actions arising from the insurance relationship are not subject to the two-year limitation period.[7]

Conducting an 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).[8] 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'.[9]

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 Cour de cassation, (civ.2nd) No. 17-11659, 8 February 2018.

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

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

9 Decision of the Cour de cassation, (civ.1st), No. 95-12817, 8 July 1997.

This distinction can be very hard to make in practice and needs frequent clarifications from courts. For instance, in *Perron company and others v. Allianz IARD*,[10] 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*,[11] the Cour de 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 in the settlement. On the contrary, 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.[12] In the matter at hand, the court decided that the abandonment theory should prevail because the settlement agreement stated that 'the victim declares to be satisfied of all of his/her 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 *C.R.A.M.A v. Mr X*,[13] 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 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.[14]

10 Decision of the Cour de cassation, No. 15-25241, 5 January 2017.

11 Decision of the Cour de cassation, (crim.) No. 16-83545, 13 June 2017.

12 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.

13 Decision of the Cour de cassation, (civ.2nd), No. 16-20951, 8 February 2018.

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

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.[15] The insurer 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,[16] the insurer loses any defence based on the imprecise answer given.

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, an appellate court recently denied the insurability of administrative penalties imposed on a director by the Financial Markets Authority for misleading market information and market manipulation in *DLP/IC and Jacques R v. AIG Europe Ltd*.[17]

One should note that, in this case, the court did not contend that administrative penalties are not insurable *per se* as contrary to the public policy. On the contrary, the court took the time to determine whether the breaches committed were intentional or not. Thus, this case seems to confirm a position the Cour de cassation began to establish in 2012.[18] Beforehand, it was often stated that administrative penalties boiled down to criminal sanctions and were not insurable. Now the position seems to have been amended: administrative penalties seem to be excluded from the insurance coverage when the policyholder has committed an intentional breach.

In *Family'Immo v. Lloyd's*,[19] the Cour de 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 to defective goods

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 need to be 'formal and limited'. A significant part of the insurance litigation in France is related to this issue. A recent application of the rule to insurance of defective goods in *Carrières de Voutré Ltd v. Allianz IARD*[20] is particularly instructive.

In this case, Matco Ltd concluded an 'industrial and commercial liability' insurance policy with Allianz IARD. Matco sold a crusher to Carrières de Voutré Ltd (Carrières). The crusher broke down twice. Carrières initially repaired the defective crusher itself. The second

15 Example: *Quatrem v. Raymond X*, Decision of the Cour de cassation (civ.2nd), No. 16-18975, 29 June 2017.

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

17 Appeal decision (Dijon), No. 16/00598, 24 April 2018.

18 Decision of the Cour de cassation (civ.2nd), No. 11-17367, 14 June 2012.

19 Decision of the Cour de cassation (civ.2nd), No. 16-10042, 12 January 2017.

20 Decision of the Cour de cassation (civ.2nd), No. 16-12120, 2 March 2017.

time, Carrières initiated a direct action against the insurer. But the applicable insurance policy excluded 'repair and replacement costs'. Carrières tried to defeat this exclusion by stating that the clause did not comply with the requirements of Article L.113-1 of the Insurance Code as it did not specify whether the exclusion concerned the costs incurred by the policyholder or by the person who suffered the loss. The court ruled that the exclusion was sufficiently precise and that it covered the repair and replacement costs incurred by the victim itself, not only the repair and replacement costs incurred by the policyholder.

On this occasion, the insurer succeeded. However, insurers must find a balance to avoid two traps: a vague clause would be considered as unlimited and consequently unenforceable, while a too precise clause would be useless.[21]

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*.[22]

In this case, a nightclub owned and operated by La Riviera was ravaged by a fire. It appeared that La Riviera, which had entered a P&C insurance with Alpha Insurance, did not comply with precautionary measures listed in the contract. La Riviera raised plenty of defences to override the condition 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*,[23] in which the Cour de cassation decided that a contractor cannot limit his or her essential obligation to the point that the said 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 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.[24]

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*,[25] the Court of Justice of the European Union stated that the European Directive 72/166/CEE of

21 M. Asselain, Insurers should be precise, but not too much!, *General Insurance Law Review*, No. 4, p.290, April 2017.

22 Decision of the Cour de cassation (civ.2nd), No. 16-22869, 18 January 2018.

23 Decision of the Cour de cassation (com.), No. 93-18632, 22 October 1996.

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

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

24 April 1972 that 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.

This ruling has thus invalidated the French system that currently provides that certain defences, such as the invalidity of the policy, can be raised against the victim.[26] A large part of litigation related to this issue is therefore likely to disappear in the long run.[27]

Scope of the insurance policy: the PIP case

The Poly Implant Prostheses (PIP) breast prostheses scandal is another ongoing legal saga, which has lasted over eight years in France. In 2010, PIP placed breast prostheses on the market that were produced in disregard of 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*,[28] the Cour de 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 Cour de cassation rejected the argument and held that the 'harmful event' was the breaking of the prostheses, which occurred out of 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 ground of force majeure. This trend was recently illustrated in *Swisslife Insurance v. SNCF and the State*.[29]

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, Swisslife Insurance exercised recourse against SNCF and the French state. However, the State Council, 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.

26 Article R.421-5 of the Insurance Code.

27 H.Groutel, Car insurance: the great change, Liability and Insurances, No. 12, survey No. 13, December 2017.

28 Decision of the Cour de cassation (civ.2nd), No. 16-14951, 8 June 2017.

29 Decision of the Council of the State (Conseil d'Etat) (Div.7th), No. 403367, 15 November 2017.

IV THE INTERNATIONAL ARENA

i International jurisdiction: the measures of inquiry in futurum

In *Ergo Versicherung AG v. EPMD*,[30] 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 by Regulation Brussels I bis No. 1215/2012 of 12 December 2012 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.[31] Therefore, the issue was whether those measures of inquiry in futurum are 'protective measures' in the meaning of Regulation 'Brussels I bis'. The Cour de cassation found measures of inquiry in futurum consisted in 'protective measures' and then fell within the scope of Article 35 of Regulation Brussels I *bis*.

ii Applicable law: recent developments within transport insurance

The Cour de 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*.[32]

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

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.[33]

30 Decision of the Cour de cassation (civ.1st), No. 16-19731, 14 March 2018.

31 Article 145 of the Civil Procedure Code.

32 Decision of the Cour de cassation (com.), No. 15-13384, 15-13386, 15-14272, 8 March 2017.

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

The case *National Confederation of Housing v. 3F Real estate company*[34] 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 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 Act No. 2016-41, 26 January 2016, extended class actions to damages caused by healthcare products, which is a growing concern for insurers.

Information due to the policyholder

The Distribution Insurance Act No. 2018-361 of 17 May 2018 has significantly developed the insurer's duty of information. The text provides for some vague standards. For instance, it states that 'distributors of insurance products act in an honest, impartial and professional way'. It is also required that the insurer provides 'objective information about the offered insurance product in an understandable form'. Ever-growing litigation may arise from this text, which offers a great leverage to policyholders to obtain remedies for breach of pre-contractual information.

ii Evolving sectors of insurance litigation

Car insurance

As stated above, a recent ruling from the European Court of Justice has forbidden insurers from raising almost all defences available against victims of car accidents. In practice, this issue has contributed to a large part of car insurance litigation, so this is likely to disappear in the long run.

Climate change

As illustrated by *Swisslife Insurance v. SNCF and the State*, insurers may be required to provide compensation for major damage without any recourse against third parties, provided that the damage was inevitable. Climate change has consequently become a hot topic for insurers. The increase in climate-related disasters will undoubtedly lead to extensive defences on the ground of force majeure within insurance litigation.

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),[35] which is financed by a contribution on insurance premiums.[36]

34 Appeal (Paris), div.4, ch.3, 9 November 2017, No. 16/05321. Proceedings are still pending before the French Cour de cassation.

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

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

Material damages are left to the insurance sector. Certain insurance policies must mandatorily cover material damages arising from terrorism.[37] 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*,[38] 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. It consists of hacking into an IT system, disabling it, and then demanding a ransom to restore the system to its normal state. To face this risk and other risks related to cyberattacks, insurers have issued customised insurance policies that cover this kind of risk. Although the risk is reported to be underestimated by consumers in France,[39] an increasing number of cyber-risk policies were taken out last year. 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 under discussion as well. 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.[40] 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 such guarantees: the insurability of the risk and the scope of the coverage.

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

38 Decision of the Cour de cassation, No. 17-10456, 8 February 2018.

39 The market of cyber-insurance: risked for insurers?, Les Echos, 28 March 2017.

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

Chapter 9

GERMANY

Marc Zimmerling and Angélique Pfeiffelmann[1]

I OVERVIEW

The German insurance market contributes substantially to Germany's prosperity and economic growth.[2] In 2015, the insurance industry generated around €90 billion of Germany's gross value added and 1.2 million jobs were linked to the industry. Between 1995 and 2014, 0.1 percentage points of Germany's yearly economic growth were directly allocated to the insurance industry. Furthermore, the insurance industry plays an important role for the German economy in general as it minimises the economic risks of companies and acts as an institutional investor.[3]

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 the trust that is placed into the sector. The following essay will give an overview of the legal framework for insurance disputes in Germany and highlight 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.[4] The objective of the reform was to modernise German insurance law and improve the position of the insured person.[5]

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);

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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 www.prognos.com/publikationen/alle-publikationen/688/show/288ea05be5faba014c4511664f33e9a0/.

4 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.

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

b the introduction of certain advisory, documentation and information duties of the insurer (Sections 6 et seq. VVG);

c the abolition of the 'all or nothing' principle[6] in favour of the 'more or less' principle[7] (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.[8] 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.[9] 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. Sections 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 in case 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 Sections 195 et seq. BGB apply. The limitation period is three years,[10] 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 such knowledge if it had not shown gross negligence).[11] An exception applies if the limitation

6 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.

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

8 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.

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

10 Section 195 BGB.

11 Section 199(1) BGB.

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 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 Sections 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 it is entitled to demand the surrender or production of the respective 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 in case 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.[12]

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

12 Rixecker in Römer/Langheid, VVG, 4th edition 2014, Section 31 [1].

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.

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,[13] the place of performance of the contract[14] or the place of the insurer's branch office.[15] 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.[16] The purpose of this change was to guarantee the policyholder access to a court near his or her domicile.[17] 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 (Directive 2009/138/EC of 25 November 2009 on the taking up and pursuit of the business of Insurance and Reinsurance (Solvency II) (recast)). 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 institutions[20] 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,

13 Section 17 ZPO.

14 Section 29 ZPO.

15 Section 21(1) ZPO.

16 Section 38(3) ZPO, Section 215(3) VVG.

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

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 funds[25] 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 case 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. The most prominent example of compulsory liability insurance is the third-party vehicle insurance, from which the other compulsory insurances evolved.[32] 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. Such benefits of 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 Langheid/Wandt, *Recast Brussels Regulation 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 Sections 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 e.V.' (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 19,754 complaints, of which it settled 15,599.[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

In the past 18 months, the Federal Court of Justice (BGH) handed down a number of landmark decisions for insurance disputes.

i Judgment of 8 November 2017, IV ZR 551/15, regarding the applicability of Section 215(1) VVG to legal entities

In a recent judgment of 8 November 2017, the BGH affirmed the applicability of Section 215(1) VVG to legal entities under private law,[48] which had been a highly controversial issue since the introduction of Section 215 VVG in 2008.

In the case at hand, the question was whether the insured company could sue its insurer at the place of its registered seat according to Section 215(1) VVG in conjunction with Section 17 ZPO, or whether the general terms and conditions of the insurance contract applied, according to which the insurer would have to be sued at the place of the insurer's office. The BGH found that, although the wording of Section 215(1) VVG was ambiguous regarding its application to legal entities, it had not been the objective of the legislator to make a distinction between natural persons and legal entities.[49] The intention of the VVG was to protect the insured person regardless of its legal form or status as a consumer. Another objective of the legislator had been to provide a place of jurisdiction that is closest to the facts of the dispute to make the ordering of evidence easier and faster.[50] According to the BGH, this purpose applied to natural persons and legal entities alike. Therefore, it came to the conclusion that in the case at hand, Section 215(1) VVG could not have been derogated by the general terms and conditions of the insurer. The insurer could be sued at the place of the insured company's registered seat.

This decision by the BGH did not only clarify one of the most disputed questions since the VVG reform in 2008,[51] but also provided clarification regarding the application of Council Regulation (EC) No. 44/2001 of 22 December 2000 on jurisdiction and the recognition and enforcement of judgments in civil and commercial matters (the Regulation) to insurance disputes against an insurer that has its registered seat outside of the European Union.[52] The BGH affirmed that the Regulation did not apply in such a case as it was only applicable to insurance disputes against a defendant domiciled in a Member State. According to its reasoning, the Regulation did not, in contrast to consumer or employment contracts, extend its application to non-Member States for insurance-related matters. These clarifications were highly welcomed by commentators and practitioners.[53]

48 BGH, Judgment of 8 November 2017, IV ZR 551/15.

49 BGH, Judgment of 8 November 2017 [18].

50 BGH, Judgment of 8 November 2017 [23].

51 Armbrüster, EWiR 2018, 63 [64].

52 Mankowski, VersR 2018, 182 [184].

53 Armbrüster, EWiR 2018, 63 [64]; Mankowski, VersR 2018, 182 [184].

ii Judgment of 8 March 2017, IV ZR 435/15, regarding the applicability of Section 215(1) VVG to tort and unjust enrichment claims

Another recent judgment of the BGH on Section 215 VVG concerned the question whether the section only applied to contractual claims arising under the insurance contract or whether it was also applicable to tort and unjust enrichment claims.[54]

In the case at hand, the plaintiff had demanded repayment from his life assurance because of a wrongful consultation before concluding the contract, based on prospectus liability and unjust enrichment claims. The question was therefore whether the wording of Section 215(1) VVG had to be understood in a narrower sense as referring to contractual claims only, or in a broader sense as referring to all claims arising in connection with the insurance contract. The BGH decided that the wording was to be understood broadly, ruling that all claims with a close connection to the insurance contract are covered by Section 215(1) VVG.[55]

iii Judgment of 14 March 2017, VI ZR 226/16, regarding the suspension of the statute of limitations according to Section 115(2) VVG / 15 VVG

A further disputed issue recently decided by the BGH concerned the suspension of the statutory limitation period under Section 115(2) VVG.[56] It stipulates for direct claims of a third party against the insurer – in conformity with Section 15 VVG – that the limitation period is suspended until the claimant receives the insurer's decision in writing.

In the case at hand, a third party had suffered damages from a car accident with the insured person. The social insurance company of the third party had made claims to the insurer of the insured person in 2007. The insurer had covered the costs in 2009. In 2013, the social insurance company of the third party demanded further payment. The insurer denied this on the basis that the claim had become time-barred, arguing that the suspension of the limitation period had ended with the acceptance of the first claim in 2009. It was therefore for the BGH to decide what requirements the insurer's decision had to fulfil to end the suspension under Section 115(2) VVG.

The BGH came to the conclusion that the insurer's acceptance of payment in 2009 had not ended the suspension of the limitation period.[57] According to its reasoning, it was not sufficient for the fulfilment of the requirements of Section 115(2) VVG that the insurer's decision had been positive. The BGH stated that in case of a claim for all damages in relation to the insured event, the suspension would only end if the insurer's decision made a clear and full statement regarding all potential (future) claims.[58] This followed from the purpose of Section 115(2) VVG, which required that a decision from the insurer guaranteed the injured party that all future claims arising out of the insured event will be paid for voluntarily. Such a guarantee could not be seen in the first payment of the insurer as it had made no further statement regarding future claims. Hence, the limitation period had still been suspended under Section 115(2) VVG at the time the social insurance company had raised the second claim. It could therefore still claim payment under the insurance contract.

54 BGH, Judgment of 14 March 2017, IV ZR 435/15.

55 BGH, Judgment of 14 March 2017, IV ZR 435/15 [15].

56 BGH, Judgment of 14 March 2017, VI ZR 226/16.

57 BGH, Judgment of 14 March 2017, VI ZR 226/16 [13].

58 BGH, Judgment of 14 March 2017, VI ZR 226/16 [10].

iv Judgment of 5 April 2017, IV ZR 360/15, regarding the assertion of claims under a D&O insurance policy by the insured company

In another noteworthy case recently decided by the BGH, the court affirmed the right of the policy-holding company under a D&O policy to take direct legal action against the insurer.[59]

In the case at hand, the insurer had refused to cover the company's damage claim resulting from a breach of contract by its directors and officers. The liable directors and officers had remained inactive. Therefore, the company had filed a declaratory action against the insurer to receive a judgment on the insurer's obligation to cover the damage claim. However, it was questionable whether the company was entitled to raise such a direct claim as the general terms and conditions of the insurance contract set out that only the insured persons could make a claim for coverage under the insurance contract.

The BGH affirmed this with its decision of 5 April 2017 and held that under certain conditions, it would be contrary to the principle of good faith and the objectives of the indemnity insurance to invoke such a clause.[60] This was the case here as the insurer had already denied to cover the company's damage claim and the insured persons had refused to pursue the claim against the insurer.[61] It had led to a risk for the claim to become time-barred.[62] The BGH therefore came to the conclusion that it would cause the company considerable harm if it were denied the opportunity to make a direct claim against the insurer. Under the circumstances at hand, the company could not be required to file a claim against its directors and officers to force them to raise a claim for coverage against the insurer.[63] Furthermore, it did not constitute any disadvantage for the insurer or the insured persons that the company pursued the claim for coverage directly. After all, the insured persons had already refused to make use of their right and the insurer was therefore not in danger of being sued twice.[64] Hence, it was justified in allowing the company a direct claim under the insurance contract.

With this decision, the BGH affirmed its already established position on two previously disputed issues: (1) whether, under a liability insurance, a third party may initiate court proceedings for a declaratory judgment against the insurer regarding its obligation to cover the third party's damage claim in case the insured person did not take action against its insurer;[65] and (2) whether the policyholder under a D&O insurance may be deemed a 'third party' in case it suffers damages from a conduct by the insured person.[66] It was therefore expected and welcomed by legal commentators that the BGH clarified these two principles in the case at hand.[67]

A further interesting aspect of the case concerned the instructions of the BGH to the court of lower instance, to which it referred the case back for a final decision. As there had been no judgment on the liability claim against the company's directors and officers, the

59 BGH, Judgment of 5 April 2017, IV ZR 360/15.
60 BGH, Judgment of 5 April 2017, IV ZR 360/15 [17].
61 BGH, Judgment of 5 April 2017, IV ZR 360/15 [19].
62 BGH, Judgment of 5 April 2017, IV ZR 360/15 [25].
63 BGH, Judgment of 5 April 2017, IV ZR 360/15 [20].
64 BGH, Judgment of 5 April 2017, IV ZR 360/15 [32].
65 BGH, Judgment of 15 November 2000, IV ZR 223/99.
66 BGH, Judgment of 13 April 2016, IV ZR 304/13.
67 Thiel and Seitz, NJW 2017, 2466 [2468]–[2469].

BGH pointed out that the court of lower instance would have to take the alleged liability as a given.[68] In this regard, the BGH also followed its previous rulings on third-party claims under a liability insurance.[69]

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) (Recast Brussels Regulation)[70] 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 of the territory of a Member State as well as reinsurance contracts, the general rules of Article 3–6 Rome I apply.[71]

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 domicile[72] 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, 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 (ZPO)'). 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.[73] However, the Recast Brussels Regulation does not apply to

68 BGH, Judgment of 5 April 2017, IV ZR 360/15 [38].

69 BGH, Judgment of 15 November 2000, IV ZR 223/99.

70 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).

71 Rome I does, however, 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.

72 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.

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

the enforcement of arbitral awards.[74] 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.[75] Regarding the recognition and enforcement of domestic awards, the rules of the ZPO apply.

V TRENDS AND OUTLOOK

In view of the current jurisprudence of the BGH and German higher regional courts, there seems to be an increasing number of landmark decisions on insurance-related disputes. Accordingly, it seems that parties to insurance disputes have become less reluctant to receive a final and binding decision in state court proceedings. Whether this is a trend that will continue in the future, however, cannot yet be predicted.

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

75 Section 1061 ZPO.

Chapter 10

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 players, along with various foreign players exploring options of setting up insurance joint ventures in India. Moreover, there has been a noteworthy increase in the number of players in the reinsurance space, where several foreign reinsurers have recently been permitted to set up branches in India. Lloyd's of London has set up a branch office in India under the Lloyd's India Regulations. It is also relevant to note that with insurers being permitted to issue products under the 'use-and-file' process for commercial risks, there is an increase in product development and innovation in India.

Over the past two to three years, there has been an upsurge in the frequency and severity of claims, specifically those made under professional indemnity, directors' and officers' liability, employment practice liability and cyber policies. We see the trend only going upwards in the years to come as the awareness of risks associated with any business increases.

However, we do see the government taking initiative to improve the business environment as, 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 Indian court of first instance to decide a case is anywhere between six 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 Insurance Regulatory and Development Authority of India (IRDAI). The primary legislation regulating the Indian insurance sector comprises the Insurance Act 1938 (the Insurance Act) and the

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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 for governing the licensing and functioning of insurers, reinsurers and insurance intermediaries.

The IRDAI has also released the IRDAI (Registration and Operations of Branch Offices of Foreign Reinsurers other than Lloyd's) Regulations 2015, which govern the establishment and functioning of branch offices in India set up by foreign reinsurers (foreign reinsurer branch), and notified regulations pertaining to the entry of Lloyd's into the Indian market.

Although the Insurance Laws (Amendment) Act 2015, which was passed in March 2015, introduced a plethora of changes to the Insurance Act and the insurance regulatory framework in general, the primary insurance regulator continues to be the IRDAI. Appeals from orders issued and decisions made by the IRDAI may be referred before the Securities Appellate Tribunal (SAT). Subsequently, the procedural rules for filing appeals from the IRDAI orders or decisions with the SAT were also notified.

The year 2017 was significant for the insurance sector as it witnessed the notification of several regulations and guidelines issued by the IRDAI, including:

a The IRDAI (Outsourcing of Activities by Indian Insurers) Regulations 2017, which were issued to prescribe the norms applicable to insurers with regard to arrangements with third-party service providers regarding such activities that an insurer is ordinarily required to perform itself. These regulations also expressly set out the list of activities that an insurer is prohibited from outsourcing to third-party service providers.

b The IRDAI (Protection of Policyholders' Interests) Regulations 2017 (Policyholder Regulations) were issued to revise the standards for the sale, servicing and claim procedure to be followed with respect to insurance policies.

c The IRDAI (Insurance Web Aggregators) Regulations 2017 were issued to replace the erstwhile IRDA (Web Aggregators) Regulations 2013.

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

The IRDAI also notified the Guidelines on Motor Insurance Service Providers of 31 August 2017 (the MISP Guidelines) to regulate the role of the automobile dealers in the distribution and servicing of motor insurance products. Pursuant to the notification of the MISP Guidelines, a duly registered motor insurance provider is permitted to solicit, procure and service motor insurance policies for insurers or insurance intermediaries, as the case may be, in accordance with the provisions of the MISP Guidelines.

The IRDAI also issued the Exposure Draft on Insurance Regulatory Authority of India (Reinsurance) Regulations 2018 of 5 January 2018 (the Reinsurance Exposure Draft), which proposes to prescribe a new Order of Preference of cessions for Indian insurers that will replace the old Order of Preference and describe the new hierarchy between various entities with which an insurer can place its reinsurance business. These regulations are much awaited.

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 that 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 Guidelines[5] 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 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

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.

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. Further, the IRDAI has recently issued the Reinsurance Exposure Draft, which will apply to both life insurers and general insurers and proposes to revise the norms to be followed for reinsurance placements, and also proposes a revised order of preference of cessions for reinsurance placements by Indian insurers.

The restrictions on non-admitted insurers means 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 court 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 before which the matter is decided, depend on the value of the dispute and the geographical limits of the defendant insurance company that the cause of action for the dispute arises within.

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 can accept

claims up to a value of approximately 2 million rupees. There are 36 state consumer disputes redressal commissions, which can accept 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), which accepts matters with a value of over 10 million rupees and appeals against the decisions of the state commissions.

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, the quantum payable under the policy, the applicability of exclusions or compliance with the policy terms and conditions.

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]

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.[8] 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.*

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

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

> *§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:

a Recently in *Charanjit Singh v. Life Insurance Corporation of India and Ors*,[9] the NCDRC upheld the repudiation of a claim on the above basis and observed that:

- The 'contract of insurance is in the nature of "uberrima fides" i.e. utmost good faith and the person purchasing the insurance policy is under legal obligation to furnish every material information which could have influence on the decision of the Insurance Company to accept or not to accept the proposal'.
- The 'insured had taken insurance cover by practising fraud and concealing the material information regarding her physical health. Therefore, the repudiation of the insurance contract justified.'

b Similarly, in *Max New York Life Insurance Co Ltd v. Gitaben Rajeshbhai Kanparia*,[10] the NCDRC held that non-disclosure of information in the proposal form amounts to concealment of material fact. The NCDRC relied on *Satwant Kaur Sandhu v. New India Assurance Co Ltd*,[11] and observed that '[g]ood faith forbids either party from nondisclosure of the facts which the party privately knows, to draw the other into a bargain, from his ignorance of that fact.'

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'.

9 MANU/CF/0309/2018.

10 MANU/CF/0119/2018.

11 (2009) 8 SCC 316.

12 MANU/SC/0891/2018.

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 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).

We do not believe that there are as such any rules governing insurer's duty to defend, and whether such a duty exists depends on the policy language. The policy will set out whether the insured has the duty or insurer, 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.

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.

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 governing law of contracts. If the contract is silent on governing law and 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 such 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. For enforcing a foreign judgment, a suit in terms of the foreign decree has to be filed. The courts before enforcement will examine if the judgment or decree is 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 such a 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 and motor insurance, over the past decade or so the Indian insurance market has evolved and we have seen liability products such as professional indemnity (PI), directors and officers (D&O), cyber policies and employment practice liability (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 against the insured, which means that claims severity is also on the rise. The highest value claim that we saw in 2017 was four times the highest value claim seen in 2014. The sort of numbers that are at play can be gauged from the recent settlements entered into by Indian tech companies in the United States that have

attracted media attention. Another reason for increased exposure is the high legal fee that needs to be spent in the defence of a claim, which could 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 earlier claims used to usually be made in outside jurisdictions, but we have recently seen claims being made in India, with high-value settlements demanded.

Chapter 11

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. However, the Consumer Insurance Contracts Bill 2017 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.

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. We expect to see an increase in 2019 of Irish companies either taking out cyber cover or increasing the limits of their existing cover, and related coverage disputes. In the next few years, we also anticipate litigation from insureds challenging the claims decisions made by automated claims processing systems, and regarding the interpretation of the specific GDPR Articles that confer rights on individuals in relation to automated decision making.

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

Finally, 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.

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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 is 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. However, the Consumer Insurance Contracts Bill 2017 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.

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

Save for the changes to Irish law to transpose EU legislation, there have been very few legislative amendments in insurance law in recent years. The most relevant amendments are set out below.

The Insurance Distribution Directive

On 27 June 2018, the Insurance Distribution Directive (Recast) 2016/97 (IDD) was transposed into Irish law by the European Union (Insurance Distribution) Regulations 2018 (the IDD Regulations). The IDD replaces the Insurance Mediation Directive (2002/91/EC) (IMD), and the IDD Regulations revoke the European Communities (Insurance Mediation) Regulations 2005, which transposed the IMD into Irish law. However, following requests from the European Parliament and Member States for a postponement of the application date, the European Commission decided to push back the application date of the IDD to 1 October 2018.

The IDD creates a minimum legislative framework for the distribution of insurance and reinsurance products within the EU and aims to facilitate market integration and

enhance consumer protection. Of particular note is the fact that the IDD aims to strengthen consumer protection for consumers by ensuring that insurance distributors act honestly, fairly and professionally and in accordance with the best interests of the customer. The IDD introduces strict requirements on remuneration disclosure and in relation to the insurance contract to the consumer. Further, insurance distributors may not incentivise or remunerate their employees in a manner that would conflict with their duty to act in the consumer's best interests.

Insurance undertakings and intermediaries that manufacture any insurance product for sale to customers are required to implement product oversight and governance procedures before distributing or marketing an insurance product to customers. A target market must be identified for each product to ensure that the relevant risks to that target are identified, assessed and regularly reviewed. Insurance undertakings are also required to ensure that the relevant personnel in designing insurance products possess the necessary skills.

The Insurance (Amendment) Act 2018

The Insurance (Amendment) Act 2018, which came into force in July 2018, amends and extends the law in Ireland relating to insolvent insurers. The Act establishes the Motor Insurers Insolvency Compensation Fund and prescribes a rate of contribution towards that fund by insurers, currently set at 2 per cent contribution of gross written motor premiums.

The Consumer Insurance Contracts Bill 2017

The Consumer Insurance Contracts Bill 2017 (the Bill), seeks to make a number of reforms to the area of consumer insurance law. The Bill is based on recommendations contained in a report by the Law Reform Commission in its report of Consumer Insurance Contracts 2015.

The Bill will apply to consumer insurance contracts only. One of the most significant reforms contained in the 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 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 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.

There is currently no clear timeline for implementation of the Bill.

The Financial Services and Pensions Ombudsman Act 2017

The Financial Services and Pensions Ombudsman Act 2017 (the FSPO Act) extends the limitation period for customers to bring a complaint against financial services providers, including insurers, regarding long-term financial services to either: (1) six years from the date of the conduct giving rise to the complaint, (2) three years from the date on which the person making the complaint first became or ought to have become aware of that act

or conduct, or (3) such longer period as may be permitted by the Financial Services and Pensions Ombudsman (FSPO). A long-term financial service means a financial service with a fixed term of five years and one month or more, or life assurance.

The FSPO Act caps damages at €26,000 per annum where the subject of the complaint is an annuity, and €250,000 in respect of all other complaints.

The Civil Liability Amendment Act 2017

The Civil Liability Amendment Act 2017 came into effect on 1 October 2018.[2] The Act introduces a legislative basis for the courts to make periodic payment orders in catastrophic injury cases, and is of importance where insurers, or their insured, are meeting awards of damages. At present, damages are awarded as a lump sum at the conclusion of the action, however, periodic payment orders allow a plaintiff to have their compensation paid in a series of index-linked payments, over the course of their life, limiting the possibility that they are under-compensated.

The Mediation Act 2017

The Mediation Act 2017 imposes an obligation on legal practitioners to advise their clients to consider mediation before commencing court proceedings, and gives the courts the power to suspend proceedings to facilitate mediation. In addition, under Section 16 of the Act, a party may bring a motion seeking for the court to invite the parties to mediate.

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*).[3]

The leading Irish case of *International Commercial Bank plc v. Insurance Corporation of Ireland plc*[4] 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 happening 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.

2 Parts 1, 2 & 3. Part 4 came into effect on 3 July 2018.
3 [1904] 2 KB 658.
4 [1991] ILRM 726.

Insurable interest

One of the most recognisable aspects of insurance law is the concept of insurable interest. The seminal case of *Lucena v. Crauford*[5] 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,[6] 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'.[7]

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*,[8] 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.

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.[9] 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.

5 (1808) 127 E.R. 858

6 *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.

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

8 [1987] IR 618.

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

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 Consumer Insurance Contracts Bill 2017 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 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 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 FSPO is the amalgamation of the Financial Services Ombudsman and the Pensions Ombudsman, pursuant to the Financial Services and Ombudsman Act 2017. This is an

independent body established for the purposes of resolving disputes between consumers and insurance providers either informally through mediation or by way of formal investigation. The FSPO's decision is legally binding, with a right of appeal to the High Court.

III RECENT CASES

i Claiming litigation privilege over reports prepared by insurers

Artisan Glass Studio v. Liffey Trust Limited[10] concerned a claim of privilege by the defendants in respect of two reports prepared by consulting engineers returned by their insurer's loss adjuster following a fire at a warehouse. The plaintiff was the occupier of another unit in the building and claimed to have sustained property damage as a result of the fire.

In his judgment in May 2018, Mr Justice McDonald set out the factors that must be considered when determining whether litigation privilege applies as: (1) whether litigation was reasonably apprehended at the time the documents were brought into being; (2) whether the documents were brought into being for the purpose of that litigation; (3) if they were created for more than one purpose, was the litigation the dominant purpose; and (4) whether the onus of proof is on the party claiming privilege.

In this case, it was found that litigation was not the dominant purpose of the record of inspection (i.e., the first report prepared), as it was prepared equally as an inquiry by the insurance company as to its own insured, rather than solely for third-party claims. As a result, it was held not to be privileged.

ii Joining an insurer to proceedings against the will of the plaintiff

In the April 2018 decision of *Bin Sun v. Jason Price*,[11] the High Court overruled the decision of the Master's Court and allowed an insurance company to be joined as co-defendant to proceedings involving the insured, despite objections by the plaintiff.

The defendant, who was insured by Bump Insurance (Bump), was involved in a road traffic accident. Bump conducted an investigation that uncovered, among other things, that the occupants of the vehicles were known to each other, and refused to indemnify the defendant. Bump was concerned that if the plaintiff succeeded in the action, he would claim the award from Bump (under Section 76 of the Road Traffic Act 1961) and wanted to bring these matters to the attention of the Court.

In granting Bump's appeal, Mr Justice Barrett summarised the 'exceptional circumstances' required to join a defendant to private *inter partes* proceedings where a plaintiff objects. These are that the would-be defendant (1) should have been joined as a defendant; (2) will, as a matter of probability, be necessary to allow the court effectively adjudicate the matter; (3) may have his or her proprietary or pecuniary rights affected, either legally or financially, by any order in the action; and (4) may be rendered liable to satisfy any judgment (directly or indirectly).

Once any of these circumstances are present, the party may be joined, provided that the interests of justice are served by adding the would-be defendant, and it would serve the court's interest in seeing that litigation is properly conducted and its processes are operated in such a way that is just and fair and in the interest of the would-be party.

10 [2018] IEHC 278.

11 [2018] IEHC 201.

In this case, the Court was satisfied that factors (3) and (4) were present, and allowed Bump to be joined to the proceedings.

This decision provides useful clarity for insurers as to the circumstances in which an insurer can seek to be joined to proceedings, in particular to avoid a Section 76 liability arising.

iii Ability of a third party to claim directly against an insurer

Section 62 of the Civil Liability Act 1961 allows a party wronged by an insured to claim directly from the insurer, but only where the insured (if an individual) is dead or bankrupt, or (if a company) wound up or dissolved.

In *Kennedy & Ors v. Casey t/a Casey & Co*,[12] a group of fishermen sought to join the insurers of their allegedly negligent solicitors to proceedings; however, the application was refused on the basis that the plaintiffs had no contractual relationship with the insurer. Section 62 was found not to apply in these circumstances, and the court held that the only scenario in which the plaintiffs would be entitled to claim against the insurers was if they obtained judgment against the solicitors in the first instance.

Similarly, in the 2017 case of *Shi v. Ernst and Young Ltd and RMC Leisure t/a Event Works*,[13] the plaintiff was not entitled to rely on the general principles of case law relating to Section 62, as the plaintiff had not specifically pleaded Section 62. This follows a chain of cases clarifying Section 62 in recent years.

iv Limitation period for latent defect

The Statute of Limitations 1957 prescribes the time limits applicable to proceedings under Irish law. These time limits run from the time the cause of action accrued except in cases of concealment, fraud or mistake, where the limitation periods may be extended. The nature of a particular insurance dispute will govern the applicable time limit.

Generally, there is a six-year time limit to institute proceedings based in contract, from the date on which the cause of action accrued, unless otherwise provided in the contract. A 12-year limitation period operates for contracts executed as a deed.

A six-year time limit applies to bring an action in tort, from the date on which the cause of action accrued. There are separate time limits for personal injuries actions.

The recent decision of the Supreme Court in *Brandley and WJB Developments Limited v. Deane t/a Hubert Deane & Associates and John Lohan t/a John Lohan Groundworks Contractors & Anor*[14] has insurance implications for construction professionals as there is potential for claims being successfully brought against them outside the traditional six-year limitation period on the basis that the damage in question manifested at a later date. This may lead to an increase in litigation by plaintiffs who previously believed their claims were statute-barred. The case also highlights the necessity for sufficient run-off cover to be obtained.

Brandley involved a claim for damages against an engineer and a builder for breach of contract and negligence arising from defective foundations. The High Court dismissed the claim on the basis that it was statute barred as the structural defects complained of occurred more than six years after the foundations were laid and the certifications issued. However,

12 [2015] IEHC 690.

13 [2017] IEHC 804.

14 [2017] IESC 83.

the Supreme Court upheld the Court of Appeal's finding that the point at which the damage occurred was when the cracks appeared in the building and thus the claim was not in fact statute barred. The Supreme Court concluded that the date of manifestation of the damage is the appropriate starting point in property damage claims and the Statute of Limitations 1957 should be construed accordingly. The Court found there was a distinction between a 'defect' and the subsequent damage it causes. Damage is manifest when it is capable of being discovered. Time runs from the manifestation of the damage rather than the underlying defect (and thus it is the subsequent physical damage caused by the latent defect, rather than the latent defect itself, which must be capable of discovery).

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).

V TRENDS AND OUTLOOK

i Increase in regulatory litigation and previously statute-barred claims

Ireland is seeing an increase in insurance regulatory litigation and enforcement, with the central bank investigating potential breaches of the Insurance Mediation Directive and the Consumer Protection Code 2012, and in respect of breaches of the IDD Regulations. Additionally, in 2017, the European Commission dawn raided the Irish insurance market and began an investigation into possible concerted practices between insurers and brokers in the commercial motor insurance industry in Ireland. The investigation is ongoing and has the potential to extend to other areas of insurance.

In addition, recent legislative developments and judicial decisions (most notably *Brandley v. Deane*, as discussed above) may result in plaintiffs bringing actions that would previously have been considered to be statute barred.

In the payment protection insurance (PPI) sphere, following the decision of the UK Supreme Court in *Plevin v. Paragon Personal Finance Ltd*,[15] a further redress scheme in relation to PPI is under way in the United Kingdom. It is possible, particularly as a result of the changes to the limitation period for FSPO claims for long-term financial products, that there may be further litigation in relation to the sale of PPI in Ireland.

Finally, the Supreme Court has called on the government to legislate for litigation funding in Ireland, in both *Persona Digital*[16] and *Optimal SUS*.[17] While there is currently no discussion of Irish legislation in this area, the European Commission published recommendations in 2013 that all Member States adopt collective redress schemes, which allow for certain types of litigation funding. Once implemented, this is likely to give rise to an increase in litigation.

ii Brexit

The triggering of Article 50 by the UK government confirmed that the United Kingdom will leave the European Union in March 2019. Because of the 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 EU27 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 as discussed above) 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.

iii Increased use of technology

Emerging technologies also present opportunities and challenges for insurers and professionals. The insurance industry is increasingly investing in new technologies and automation. There is likely to be litigation challenging the claims decisions made by automated claims processing systems and regarding the interpretation of the specific GDPR Articles that confer rights on individuals in relation to automated decision-making.

The technology surrounding the use of drones is rapidly developing, and to mirror the emerging technology in this area, legislative reform is proposed. The (draft) Small Unmanned Aircraft (Drones) Bill 2017 proposes to place an obligation on commercial drone operators to have insurance in place, and imposes criminal liability for certain drone offences. It prohibits the use of a drone for surveillance, capturing images, videos, etc., where there is a reasonable expectation of privacy and without consent. There is currently no timeline for implementation.

Cyberattacks are on the rise in Ireland. While cyber cover has been available for some time, it is still very much a new product for the Irish market. We expect to see an increase in 2019 for Irish companies either taking out cyber cover or increasing the limits of their existing cover, and related coverage disputes.

15 [2014] UKSC 61.

16 *Persona Digital Telephony Ltd v. Minister for Public Enterprise*, Ireland [2017] IESC 27. (Unreported, Supreme Court, 23 May 2017.)

17 *SPV Osus Ltd v. HSBC Institutional Trust Services (Ireland) Ltd* [2018] IESC 44.

Chapter 12

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 misselling 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 Articles 1882 and ff. the general rules related to contracts and obligations, as well as the specific rules governing insurance contracts;

b the Insurance Code,[3] which provides for 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 Code[5] 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 41[7] of 2018 and CONSOB Regulation No. 20307/2018,[8] which implemented EU Directive No. 2016/97[9] on insurance distribution, 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 below).

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 case 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).

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 officers.

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. Such a 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, which tend to be decided predominantly in front of 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).

With reference to international disputes, it shall be noted that the jurisdiction of the Italian courts is established pursuant to the Brussels Regulation (Reg. 1215/2012) and thus Italian ordinary courts may have jurisdiction depending on the cross-border elements contained in the insurance contract (e.g., whether 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 it may be 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 regulation on distribution of insurance investment policies – claimants may refer the dispute 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 professionals and cover 'large risks'. In any case, parties are also free to agree for their dispute to be 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 – as established under the recently introduced Article 187 *ter* of the Insurance Code – a further alternative dispute resolution mechanism, 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 – which repeatedly stressed the insurance nature of these kinds of products – the debate in Italy is still open, and this is also owing to the case-by-case approach preferred by the Italian Supreme Court, whereby unit- and index-linked policies may be classified as insurance products only if the demographic risk undertaken by the insurer prevails over the financial risk upon 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 premium is not granted.

The issue of the qualification of those products is indeed very relevant, as it results in the application of rules (those of TUF) that are different to those 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 case of disputes. A law was

passed with the aim of solving this problem, including unit- and index-linked products in the TUF,[12] 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 such uncertainty (that should be superseded – in the legislator's intention – through the implementation of the IDD directive) clearly impacted the different approaches of the Italian courts.

Investors who lost (or partially lost) the invested premiums generally raised several different claims in order 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 upon the insured, the policy has a financial nature.[13] Accordingly, the informative duties provided by the TUF and relevant regulatory provisions should apply, under penalty of damage compensation, rather than of repayment of the invested premium for 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 informative duties does not result in the nullity of policy, but rather in the obligation to pay damages.[14]

The ground on which the claim is brought is particularly significant since, in case of repayment of the invested premium for nullity of the policy, the obligation to pay back would be, in principle, upon the insurer. Quite to the contrary, 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 period of limitation, while five years of limitation apply – according to prevailing case law – to claims addressing pre-contractual liability.

Another common request is to declare unit-linked policies null and void, as stipulated in breach of mandatory rules or without a written form (as required by Article 23 TUF).

Indeed, by decision of 20 October 2017,[15] the Court of Treviso considered that the lack of a framework agreement leads to the nullity of the policy, as concluded 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 (the provision should no longer apply to unit-linked policies after the implementation of the IDD). In such case, the court also ordered the insurance company to reimburse the paid premium. However, the topic is debated as other courts ruled (more reasonably in our view) that the framework agreement is not required if the policy contains all relevant information provided for under Article 23

12 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.

13 Court of Appeal of Milan, 11 May 2016.

14 Supreme Court, Joint Divisions, 19 December 2007, No. 26724; Supreme Court, Joint Divisions, 19 December 2007, No. 26725.

15 Court of Treviso, 20 October 2017.

TUF.[16] Some others took 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 insurer[17] (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.[18] In particular, the Supreme Court applied the relevant provisions of the TUF and relevant secondary legislation, which provide for precise informative duties to be carried out at the moment of the distribution of financial products, confirming a previous decision of 2012.[19] In its decision the Supreme Court pointed out that in case of unit-linked policies, the judge shall assess on a case-by-case basis whether they shall be considered as an insurance or financial product. In the latter case, it shall apply the relevant provisions established by TUF related to the informative and conduct duties lying upon the intermediary.

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,[20] the European Court of Justice (ECJ) stated that unit-linked policies can be considered falling within the concept of 'insurance contracts'.[21] Indeed, to be qualified as insurance contracts, 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 case of 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 mediation[22] rather than EU Directive 2004/39 on financial intermediation.[23]

ii Third-party insurance

With regard to claims related to third-party insurance, one of the most debated issues recently has been claims-made clauses, which was finally settled by a very recent decision of the Supreme Court.

16 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.

17 Court of Salerno, 24 May 2016; Court of Bari, 3 March 2011, No. 801.

18 Supreme Court, 30 April 2018, No. 10,333.

19 Supreme Court, 18 April 2012, No. 6,061.

20 European Court of Justice, 1 March 2012, C-166/11.

21 European Court of Justice, 31 May 2018, C-542/16.

22 Directive 2002/92/EC of the European Parliament and of the Council of 9 December 2002 on insurance mediation, currently repealed by Directive (EU) 2016/97 of the European Parliament and of the Council of 20 January 2016 on insurance distribution.

23 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.

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 the consequent need of an explicit written consent by the insured for their validity.

In some other cases, the validity of the whole contract was challenged, as it would have allegedly constituted an agreement that was outside of 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.[24]

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, by decision of 4 May 2018,[25] held that the indemnification should cover not only the legal costs that the losing party shall pay 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 was indeed focused on this topic in the framework of civil liability litigation, and in particular on the possibility for a damaged party to sue in his or her own country the foreign insurance company of the counterparty. The Italian court applied EU Regulation No. 44/2001,[26] which establishes different alternative criteria for identifying the court that has jurisdiction to decide on the case. The analysis of the judgment considered

24 Supreme Court, Joint Divisions, 24 September 2018, No. 22,437.

25 Supreme Court, 4 May 2018, No. 10,595.

26 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 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.

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 in the alternative 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 Reg. 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. The court concluded – following a case law precedent of the European Court of Justice – that, pursuant to Article 11 of Reg. 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 former (which it is for Italy).

ii Representatives of foreign insurance companies

With reference to third-party insurance, and precisely on the point of standing, a topic recently addressed by both EU and Italian courts is the one of the possibility to directly sue the claims representative of a foreign company. Pursuant to Article 1 of Directive 2000/26/CE,[27] every insurance company that issues its policies in foreign states has to appoint a claims 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 if it is possible for the insured to directly sue the claims representative. 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 directly sued).[28] 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.[29]

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'.

By decisions rendered in 2016 and 2015, the Courts of Turin and Milan rejected the policyholders' requests for the declaration of nullity of unit-linked policies, as these were linked to hedge funds not allowed under Italian law.[30] The decisions were grounded on the

27 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 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.

28 European Court of Justice, 10 October 2013, C-306/12.

29 Supreme Court, 18 May 2015, No. 10,124.

30 Court of Turin, 17 March 2016; Court of Milan, 11 February 2015, No. 1,884.

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.

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.[31] The decision was rendered in the framework of the enforcement of a US judgment in Italy and substantially introduced the possibility to recognise the award of punitive damages in a foreign judgment against an Italian company. However, the issue did not touch upon the insurance field and is not likely to have an impact on existing Italian insurance contracts, as punitive damages are still not insurable under Italian law. Indeed, the decision won't result in the possibility for Italian judges to award punitive damages either, as a specific law would be required for that purpose.

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 relevant impact on insurance litigation, as reported by preliminary data, which register an increase of disputes in the medical field since its entry into force 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, the former are now obliged to conclude a policy that covers the risk related to damage requests that may stem from such liability. The subjects who allegedly suffered damage can bring an action against the insurance company directly. Under certain conditions and within certain limits, the healthcare facilities have the possibility to reverse the potential damage on the healthcare operator responsible for the illicit event.

Before bringing an action into court grounded on the aforementioned liability, any interested party shall initiate a compulsory preliminary attempt of 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 alleged damage (the proceedings are governed by Article 696-bis of the Italian Code of Civil Procedure). In the alternative, it is also 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 2018 seem to confirm the positive trend.

31 Supreme Court, 5 July 2017, No. 16,601.

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 is usually a high unexpected cost. 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. Specific competences will therefore be required in order to deal with potential disputes in the future.

Chapter 13

KOREA

Jin-Hong Kwon, John JungKyum Kim, Jae-Hwan Kim and Yang-Ho Yoon[1]

I OVERVIEW

In the Republic of Korea, the economy has developed and grown, while the insurance industry has been 'soft', with sluggish growth at 0.1 per cent in gross written premiums from 2016 to 2017. Korea still remains active as the seventh-largest insurance market in the world and is 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 coverages that are known as the 'third insurance business' in Korea. Currently, there are 24 life insurers and 31 non-life insurers that are admitted to conduct the business of insurance in Korea – three of the licences were issued by the Korean regulatory authorities in 2016, which included Allianz Global Corporate & Specialty, Asia Capital Re and Pacific Life Re. Foreign insurers as non-admitted insurers also engage in insuring local risks in Korea through the non-admitted market and through 'fronting arrangements'.

Insurance market participants and consumers continue to be engaged in contentious matters in Korea, including typical insurance coverage and claims disputes, issues related to mis-selling of insurance products, reinsurance recoveries and compliance issues with the Korean regulators including data protection and privacy law breaches, and other claims involving third-party service providers. Of notable importance, there were four contentious matters that reached the Korean Supreme Court in the past year, involving policy interpretation and disputes on requisite causal links to a compensation claim, and also a case with a conflict-of-laws issue (see Section III).

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.

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The regulation of the insurance industry in Korea is overseen through a two-tier system for all insurance and insurance services companies including insurers, reinsurers, producers, brokers and agents through the Financial Services Commission (FSC) and the Financial Supervisory Service (FSS). The missions of the FSC and the FSS are to promote and ensure the three basic objectives, which are to (1) maintain the stability of the financial services markets, (2) provide mechanisms for the financial strength and solvency of insurers, and (3) protect consumers and their interests.

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 the Insurance Supervision Regulations.

The FSS, as the 'executive arm' of the FSC, records the current status of insurance contracts and the financial status of insurance companies, monitors business operations of insurers and sanctions insurers for non-compliance for 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 and supervises insurance companies and their employees, including solicitation activities of insurance producers, agents and brokers.

The relevant chapter of the Korean Commercial Code 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. The KCC provides provisions relating to the conclusion or execution of insurance contracts, and the validity of insurance contracts including renewals, amendments, cancellation and termination.

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. Since its promulgation on 15 January 1962, the IBA and its subordinate regulations and enforcement decrees were revised numerous times to reflect the changes in financial environment and international regulatory trends.

There are some minor changes to the IBA noted in this chapter that involve amendments to the Enforcement Decree of the IBA in June 2018 that are to take effect in December 2018. In particular, the amendment will extend 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.

Also, in recent years, the Enforcement Decree of the IBA clarified that an insurance company that has only received approval with respect to tertiary insurance business (e.g., injury in the course of employment, disease, care insurance), without the approval regarding the damage insurance business, can also deal special provisions that provide cover for death arising from disease.

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 an insurance contract, a risk has already occurred or cannot occur, resulting in no risk to be insured under the insurance contract. However, this rule shall not apply if both parties to the insurance contract including any insured are unaware of such 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 the violation 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 in violation of 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

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 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, then such person may be subject to criminal punishment.

iii Fora and dispute resolution mechanisms

In Korea, insurance disputes can be resolved by (1) civil litigation before a court of law (including mediation by the court), (2) arbitration and (3) the decision of the FSS Financial Disputes Mediation Committee (FDMC) under the Financial Consumer Protection Bureau.

Korea does not have courts exclusively designed to resolve insurance disputes, and there is no designated arbitral institution or procedures that exclusively deal with insurance disputes. Thus, insurance disputes must be resolved in the civil court 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 of Korea, along with the governing law.

The Korean judiciary is composed of three levels, which are the district courts, high courts and the Supreme Court. A district court is the court of first instance involving a trial on the facts and the law. The high courts are appellate courts that are empowered to hear

appeal by parties from the district court – interestingly, the high courts may review both the facts and law as applied at the district court on a *de novo* basis. The Supreme Court is the highest court in Korea hearing 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 instance and second instance, and the decision of the Supreme Court shall bring complete finality to a dispute.

Generally, disputes will be resolved by district courts in eight to 12 months, but 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 an appellate court. An appeal to the Supreme Court may run its course for two to three years until a judgment 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 as conducted by the court. Alternatively, a case may be referred to the mediation committee to reach an agreement. Mediation decisions, once finalised, have the same legal effect as court judgments. In cases where parties are unable to come to 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, 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.

III RECENT CASES

There were three significant claims dispute cases that were heard by the Supreme Court over the past year and half arising out of conflicting policy interpretations and disputes on causal links between accidents and losses. The cases demonstrate a theme that the Supreme Court will give regard to all circumstances of an insurance disputes case, in order to arrive at a definitive ruling and to ensure a conclusive outcome. The cases also demonstrated the willingness of the Supreme Court to acknowledge and consider all implied terms and circumstantial and indirect evidence to reach a ruling.

i Indirect evidence to prove the requisite causal link

The Supreme Court's judgment in the 2015Du3867 case warns Korean courts from disengaging from a full inquiry into an industrial accident or worker's compensation claim on grounds that there is no clear scientific consensus on the causes of the resulting illness or condition alleged.

The case involved an industrial accident compensation claim made by a former employee against Samsung Electronics alleging that he developed a 'demyelinating condition' from his time working at the liquid-crystal display factory of Samsung Electronics in Korea. Specifically, he claimed illnesses arising from a demyelinating condition, which is a rare condition causing damage to the protective sheath surrounding the nerve fibres, occurring at a rate of 3.5 per 100,000 people in Korea. In the absence of clear scientific understanding of the physiological causes behind his condition, the claimant could not directly establish that it was the working conditions at the Samsung Electronics factory that led to his development of the condition and his subsequent illness. The worker failed to establish the causal link at first instance at the Seoul High Court; the case was appealed.

The Supreme Court remanded the case to the lower court, stating it had failed to give sufficient regard to the indirect evidence that may have proven the requisite causal link. The opinion directed that in the absence of direct evidence, a court should nonetheless have considered indirect evidence such as the rate of occurrence in the worker's peer group against a control group. Further, the Court also suggested that where the employer has created challenges for the investigation and assessment of the causal link by way of its non-cooperation, that this would also be a factor weighing in favour of the claimant in itself.

ii Coverage by mutual agreement outside the general terms and conditions

Insurance policies often incorporate statutory policy wording pursuant to insurance laws and regulations, and standard terms and conditions for coverage. However, it is common that pre-execution discussions that indicate that there were mutual understandings between insurer and policyholder were contrary to or supplementary to the strict wording of the incorporated statutory provisions and standard terms stated to govern the insurance contract. The Supreme Court judgment in 2015Da245145 demonstrates the willingness of the Korean courts to give effect to the pre-execution discussions and imply terms of the contract, although the express wording of the statutory provisions or the standard terms may not provide for the implied term.

In this case, the claim arose under a third-party liability insurance policy with respect to the insured's forklift. The coverage was stated to be determined in accordance with the provisions of the Presidential Decree to the Guarantee of Automobile Accident Compensation Act of Korea. However, as the Decree did not provide coverage of forklifts, the insurer argued that the policy consequently did not provide coverage for claims related to forklifts.

The Supreme Court ruled that even though the incorporated Decree provisions strictly applied did not provide for coverage of liabilities arising from forklift accidents, the evidence of pre-execution circumstances and discussions made it undeniable that the insurer had sought to provide coverage for the forklift, applying the Decree as if it applied *mutatis mutandis* to forklifts as well. The Supreme Court also clarified that Article 4 of the Korean Act on the Regulation of Terms and Conditions applies to insurance contracts: 'if a business person and a customer agree on a matter in a manner that is different from the manner stipulated in the terms and conditions, the agreement shall prevail over such terms and conditions.'

iii Determining the beneficiaries of an insurance policy in spite of uncertain terms

Cases 2015Da236820 and 236837 of the Supreme Court involved a personal lines accident insurance policy that designated 'legally entitled inheritors' of the insured's assets as the beneficiaries of the insurance policy. The plaintiff was the spouse of the deceased insured and one of the three 'legally entitled inheritors' of the deceased insured's assets.

At the District Court in the first instance, the plaintiff made its insurance claim and was awarded the full sum of the claim without any prorating under the policy despite being only one of three 'legally entitled inheritors'.

The trial at the District Court and the subsequent appeal to the Supreme Court involved disputes on a number of issues; but notably, the Supreme Court remanded the case – ruling that the lower court had erred in ordering the payment of the full sum of the insurance proceeds to the plaintiff, which was total claim amount; rather, the lower court should have ordered only a portion of the insurance proceeds based on the plaintiff's share as stipulated in the insurance policy relating to the deceased's inheritance.

A major cause for confusion and dispute in insurance claims practice arises from the unclear wording in designating the beneficiaries and the entitlement of each beneficiary under an insurance contract. However, the Supreme Court decision directs the Korean courts to give regard to all surrounding circumstances and applicable laws, (e.g., inheritance laws) where they may be referred to in order for the court to discern the beneficiaries and the entitlement of each beneficiary.

iv The international arena

Conflict of laws: availability of third-party direct action

Under Korean law, an injured third party has a right to bring direct action against the insurer who has issued a liability insurance policy to its policyholder. A conflict of laws issue arises where an injured third party seeks to enforce its right to direct action against the insurer under Korean law, where the governing law of the insurance policy does not provide for such right to direct action and to bring insurance claims.

Case 2015Da42599 of the Supreme Court involved a marine cargo liability insurance contract and an injured third party seeking to bring a direct action claim against a Korean insurer. The insurance policy expressly provided that disputes under the insurance contract were governed by English law, which does not provide for a right of direct action by an injured third party.

The Supreme Court ruled that the right to direct action ultimately has its basis in the insurance contract and that the insurance contract and the governing law of the insurance contract are most closely connected with the question of whether a third party has a right to direct action. It accordingly ruled the governing law of the insurance contract shall govern the question of whether the third party that was injured has a right to direct action against the insured, over the statutory right to direct action under Korean laws.

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 litigation and regulatory implications regarding a dispute pertaining to the solicitation and sale of immediate annuity products as the FSS and their respective policyholders allege that policyholders were short-changed in their annuity payments. The FSS had begun its regulatory review and action in late 2017, resulting in a non-binding order to Samsung Life Insurance Co Ltd that it owes and must pay additional amounts to the policyholders of its immediate annuity product. Recently, the FSS made a further non-binding order to all insurers to pay their respective policyholders for the alleged shortfall. In a rare case of collective standoff against the financial regulator, no insurer has complied with the orders to date (September 2018).

The dispute on the immediate annuities is likely to be the headlining legal case for the life insurance industry of Korea in 2018 and the next four to five years. The potential claims facing the largest player add up to approximately US$430 million; other life insurers are also facing potential claims of significant amounts.

Recently, Samsung Life submitted a request for resolution to the Seoul Central District Court for confirmation that it does not have any liabilities as demanded by its annuity holders and argued by the FSS.

ii Cyber-insurance claims for hacking of cryptocurrency exchanges

Over the course of 2017 and 2018, Korea has been one of the leading jurisdictions for cryptocurrency exchanges and arbitrage, with the country being responsible for over one-third of Bitcoin trades last year. Korea does not have any explicitly applicable cryptocurrency

regulations, nor has the tax authority defined it for tax purposes, which has fostered the growth of the large volume of trading with higher prices leading to what is known as the 'kimchi premium'.

However, the cryptocurrency exchanges have vulnerabilities in their security systems and have been the target of a number of hackings in Korea including Bithumb and YouBit. Cryptocurrency exchanges have faced challenges in establishing their right to claims proceeds as they find difficulties in establishing that they have satisfied conditions precedent to the insurance that proper security measures have been implemented to protect again data breaches, security threats and hackings. In addition, claimants have had issues with confirming the dates of accident given the lack of evidence, which is 'wiped out' during hackings, resulting in insurance claims being denied. Recently, a cryptocurrency exchange operator submitted an insurance claim under a cybersecurity insurance policy for insurance proceeds for losses it suffered resulting from a hacking leading to the theft of cryptocurrency, only to have it denied based on the policyholder having failed to implement such security measures and systems. More importantly, the cybersecurity insurance policies that have been offered do not cover 'theft of cryptocurrency' but for loss or leakage of personal and financial information. As cryptocurrencies continue to be traded in Korea and cybersecurity threats remain, ongoing claims disputes may also arise for insurers and their policyholders. In response, other insurers from Lloyd's of London and Hanwha General Insurance have developed new and customised insurance policies designed to protect against hacking for cryptocurrency exchanges and the financial losses resulting from the theft of cryptocurrencies.

Chapter 14

PORTUGAL

Pedro Ferreira Malaquias and Hélder Frias[1]

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 2017. As was the case in 2016, 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 the insurance, reinsurance, pension funds (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), 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 the regulations issued by the ASF;

g the regulations issued by the Portuguese Securities Market Commission in respect of unit-linked life insurance contracts and operations;

h the special legislation dealing with compulsory insurance; and

i the special legislation dealing with consumer protection (including the Portuguese unfair contract terms act).

In turn, pension funds and their managing entities are governed by Decree-Law No. 12/2006 of 20 January, as amended.

The pursuit, on a professional basis, of insurance intermediation activity in the Portuguese territory is deemed as 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 (single licence principle).

The insurance and reinsurance intermediation activities are governed by Decree-Law No. 144/2006 of 31 July, as amended (which implemented into Portuguese law the Insurance Mediation Directive) (DL 144/2006) and its implementing ASF Regulation No. 17/2006-R of 29 December, as amended.

A draft proposal of the statute implementing into Portuguese law the Insurance Distribution Directive has already been made public but it is pending final approval.

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 no damages may necessarily arise (e.g., the survival of the insured person in a life assurance).

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, owing to its essentiality to the validity of the insurance, is also subject to negative constraints.

First of all, insurable risks shall fall within the classes and 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.

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 Law on Arbitration entered into force, replacing the former Portuguese Arbitration Act.

The new law is rather innovative, drawing inspiration from the 2006 version of the UNCITRAL Model Law, introducing 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 four years since its entry into force, it is reasonable to state that the law 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, the insurer has the legitimate right to invoke the nullity of the insurance contract so it can refuse the payment of the insured sum (Article 25 LCS).

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, the payment can no longer be demanded by the insurer. Therefore, this lack of payment leads to the automatic termination of the contract on the due date of payment, 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, which ones are excluded – all of the remaining risks that are 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 eyes of an 'average' policyholder put in the actual policyholder's position. In case of doubt, any given provision shall be construed in a favourable manner to the policyholder's interests. In this particular case, the risk exclusion clause, according to which a claim shall be excluded if it was caused by a person that is not legally qualified to drive, shall be disregarded if the relevant non-qualified driver acted against the will of the car owner. In such a case, 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. This freedom of choice does not allow, however, 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 (Article 62 of the Portuguese Code of Civil Procedure).

The international jurisdiction is governed at the Community level by the 27 October 1968 Convention on jurisdiction and the enforcement of judgment 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 case of an indemnity or real estate-related insurance, the insurer may be sued in the courts of the state where the harmful event occurred;

c in 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 if the jurisdiction in matters relating to the insurance section of the Brussels Convention applies only to direct insurance or if it is extensive to reinsurance.

In terms of the restriction to the 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 shall be noted that there is not a substantial difference in the parties' interests in case of reinsurance that warrants that restriction, which could be merely inferred from the Convention.

Within the EU, Council Regulation No. 1215/2012, 12 December 2012 sets out the conditions under which a judgment (concerning civil and commercial matters) issued in a 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 conformation 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.

At present, the Centre promotes the settlement of disputes arising from insurance agreements of the following classes:

a motor;

b civil liability (family, exploration, hunting, use and possession of firearms) relating to complaints of up to €50,000; and

c multi-risk home insurance (commercial and housing) relating to complaints of up to €50,000.

Additional insurance classes are expected to be included in this ADR in the future.

Besides the above, 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, this is still an unresolved issued, notwithstanding the slight improvement observed in recent times, that insurance undertakings have to deal with in their dealings in the Portuguese market.

Chapter 15

SPAIN

Julio Iglesias Rodríguez and Francisco Caamaño Rodríguez[1]

I OVERVIEW

In recent years, Spanish insurance law has entered into a process of renovation in order to implement the latest EU Directives enacted in the field. Thus, following the transposition of the Solvency II Directive, which clearly affected the framework applicable to insurance and reinsurance companies, the Spanish parliament is currently working on a law that will transpose the new European requirements related to the activity and performance of insurance brokers and dealers.

On the other hand, an increasing amount of litigation in fields such as damages and civil responsibility has led to the consolidation of relevant judicial interpretations in matters such as the interest on arrears applicable to insurance companies, the consequences of an incomplete risk declaration by the insured party, or the effects linked to the non-payment of one of the instalment payments of the premium.

II THE LEGAL FRAMEWORK

i Sources of insurance law and regulation

In the Spanish legal system, insurance law is dispersed among a great variety of laws and regulations, a profound analysis of which would far exceed the scope of this chapter. For this reason, only the most relevant ones will be addressed below.

Rules governing access conditions and insurance companies' activities

The access conditions and 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 it.

These regulations are the result of the transposition by the Spanish legislator of the provisions set out in 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 (the Solvency II Directive). Consequently, it can be said that in this area Spanish law is harmonised with the remaining European Union Member States.

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Rules governing the mediation and distribution of insurance

The Spanish regulation of insurance mediation and distribution activities can be found, at the time of writing, in Law 26/2006 of 17 July on private insurance and reinsurance mediation.

However, it must be pointed out that a new law, which will repeal it and incorporate the provisions set out in Directive (EU) 2016/97 of the European Parliament and of the Council of 20 January 2016 on insurance distribution, is currently in parliamentary process.

Furthermore, it should be noted that 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 recently entered into force. This regulation is directly enforceable in Spain, as it is in all other European Union Member States.

Rules governing insurance contracts, in their various forms

Finally, with regard to the regulation of the different types of insurance contract, the predominant role of Law 50/1980, of 8 October, on Insurance Contracts (LCS) should be highlighted. This law contains both the general principles that apply to all kinds of insurance contract and the specific provisions governing the main types of insurance contract that exist in Spain (e.g., damage insurance, civil liability, fire, life, sickness). In short, this is the main law in this area and most insurance litigation is based on its provisions.

Nevertheless, in Spain there are also other relevant laws and regulations that develop the legal regime applicable to some specific kinds of insurance contract. This is the case, for example, of 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 in the circulation of motor vehicles, and Royal Decree 1507/2008 of 12 September, which approves the Regulation of mandatory civil liability insurance regarding the circulation of motor vehicles. Likewise, there are 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

Spanish law does not have an express definition of 'insurable risk'. However, as a general rule, it can be held that a risk will be insurable as long as it:

a has an element of chance or uncertainty. This requirement will be met as long as it is not certain that the insured risk will materialise (e.g., the possibility of suffering an illness or a traffic accident) or it is certain that such event will occur, but the exact moment is unknown (e.g., the death of the insured person in life insurance);

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 does still exist. In this regard, it must be pointed out that under Spanish law, as per the general rule in civil liability for damages, the loss occurs at the moment that the action or incident that causes the damage takes place (even though the claim and, therefore, its externalisation can take place much later in time). Thus, the contract will only be valid if it refers to losses arising from actions subsequent to its signing. Nevertheless, Article 73 LCS allows for contracts with 'claims made' clauses that have retrospective effects. In these cases, the claim constitutes the 'incident' and not the actual damaging act that causes the claim.

In this way, the future event that must occur (and must be unknown at the time of formalising the contract in order for the contract to be valid) is the existence of the claim;

c is lawful;

d is possible, meaning that the covered risk may potentially materialise;

e is fortuitous, meaning independent of the will of the parties or beneficiaries of the insurance contract. Nevertheless, two clarifications must be made in relation to this criterion:

- first, Spanish law does consider the insured party's suicide as an insurable incident, even though it is an uncontroversial fact that it is the consequence of a conscious and voluntary action of the insured party. The only restriction in the LCS to avoid fraudulent conducts 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
- second, even though civil liability derived from the wilful misconduct of the insured party cannot be insured under Spanish law, the insurer must provide compensation for the damages caused by such misconduct to *bona fide* third parties (i.e., those who are not implicated in a fraudulent scheme with the insured party). In fact, as per article 76 LCS, these third parties may bring their claims for compensation directly against the insurer (direct action). The insurer cannot invoke the wilfulness of the insured party to exonerate its cover and obligation to pay. Only after having paid out the compensation at hand will the insurer have the right to direct a claim against the insured party who acted wilfully, seeking to recover the compensation paid out; and

f is tangible, has an economic value, and can be valued 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 self-interest or on behalf of and for the benefit of third parties (Article 7 LCS). Nevertheless, as is stated in Article 25 LCS (damage insurance) and Article 83 LCS (life insurance), the validity of the insurance contract is subject, in any case, to the existence of a legitimate interest of the insured party.

iii Fora and dispute resolution mechanisms

Spanish insurance law is characterised as being protective of the rights of the insured parties. For this reason, it does have special provisions that, in some cases, force the parties to initiate extrajudicial procedures before bringing a claim before the courts.

For example, where the disagreement between insurer and insured party is limited to the extent of the damages that must be compensated (but there is no dispute over the coverage of the incident or risk), the LCS (article 38) states that the insurer and the insured party must resolve their conflict through a mandatory[2] extrajudicial procedure in which:

a each party appoints an expert;

2 This was recognised as being mandatory in the Supreme Court Judgment No. 747/2009, of 11 November.

b the appointed experts try to reach common ground. In the case of an agreement, the procedure concludes with the issuing of a report that contains, among other matters, the amount of compensation due; and

c if no agreement is reached, a third expert is appointed by the parties so that in 30 days (or the term agreed upon) the three experts may issue a final report (unanimously or with a majority vote) that will be binding for the parties unless challenged in court.

It is only once the report has been issued that, in the case of any of the parties disagreeing with it, it may be challenged within the proper time frame in a judicial procedure (Supreme Court Judgment No. 536/2016 of 14 September).

Another example of these special provisions can be found in the area of civil liability regarding the circulation of motor vehicles. Concretely, Article 7 of Royal Decree 8/2004 states that the injured party must file an extrajudicial claim with the insurer requesting compensation and providing information about the incident. The insurer must respond within three months with a reasoned compensation offer or a duly motivated response explaining the reasons why it understands that compensation is not warranted.

Notwithstanding the above, apart from these specific examples, Spanish law grants freedom to the parties to use the conflict resolution mechanism they deem appropriate for their interests and needs. That is, even if the reality of the market shows that conflicts in the insurance field are usually brought before the court system, parties are free, once the extrajudicial proceedings described previously have taken place, to bring the disagreement before alternative conflict resolution mechanisms (e.g., conciliation, mediation or arbitration). It should be pointed out that for a dispute to be validly brought before arbitration, in Spanish law both parties must consent.

With regard to this last issue, the Spanish Constitutional Court, in its Judgment 1/2018 of 11 January, held Article 76 (e) of the LCS to be unconstitutional (and thus null and void). The article stated that, in the context of legal expenses insurance, 'The insured party shall have the right to submit to arbitration any difference that may arise between him and the insurer regarding the insurance contract. Arbitrators cannot be appointed before the disputed issue arises.'

III RECENT CASES

In this Section, the most relevant and recurring judicial decisions on insurance law will be addressed, paying special attention to those occurring in the past 18 months.

i Risk restriction and rights restriction clauses

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 the 'rights restriction' clauses, which are those that restrict or modify the rights of the insured party to seek compensation once the damaged has been caused.

Article 3 LCS establishes that, in order to be valid and enforceable, 'risk 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, as outlined in the Supreme Court judgment No. 234/2018 of 23 April establishes as requirements for their validity:

a that the risk restriction clauses are included among the specific conditions of the insurance contract, and not in the general conditions;

b that the wording of the clause at issue must meet the transparency, simplicity and clarity criteria and, additionally, it must be highlighted within the text of the contract; and

c that the policyholder must expressly accept these clauses in writing. However, this does not mean that each clause must be individually signed. As the Spanish Supreme Court has clarified, this requirement will be met if the policyholder signs the specific conditions of the policy.

ii Deficient risk declaration

Article 10 LCS, among others, establishes that the policyholder has the obligation to declare to the insurer all the known circumstances that could affect the risk assessment through the questions it may ask, before the signing of the contract. This is so that the insurer may properly assess such risk and calculate the premium insurance.

However, as the Supreme Court reiterated in its judgment No. 323/2018 of 30 May, the Spanish courts have repeatedly asserted that the insured party will not be negatively affected by the lack of a risk declaration in the following scenarios: (1) in those cases in which the insurer has not conducted any questionnaire about the insured risk; and (2) in those cases where the information supplied by the insured party is incomplete as a consequence of an ambiguous or generic questionnaire.

Additionally, in judgment No. 273/2018 of 10 May, the Supreme Court also determined that the filling in of the health questionnaire regarding risk assessment in life insurance contracts is a strictly personal act of the insured party. Consequently, even if Spanish law allows for an agent to take out a life insurance policy in favour of its principal, the manifestations that this agent may make regarding the health questionnaire would not be binding unless it is proved that it was part of a fraudulent endeavour to avoid a proper risk declaration by the insured party.

iii Inexistence of the insured risk at the time the policy was subscribed

For an insurance contract to be valid, Article 4 LCS requires the risk to exist or the damage not to have been caused at the time the contract was entered into. This circumstance has generated an increasing volume of health and life insurance litigation. These are conflicts in which it is not unusual to find the risk declaration contemplated in Article 10 LCS.

For instance, in judgment No. 426/2018 of 4 July, the Spanish Supreme Court nullified a health insurance policy in which, although the insurance company had not conducted a health questionnaire with the insured party, it was proven that the disability declaration issued after the signing of the policy had been caused by an illness diagnosed before the policy was entered into. In this regard, the court considered the lack of a questionnaire to be irrelevant since the problem was not related to a defective risk declaration but to the inexistence of the element of chance inherent to any insurance contract.

Similarly, in judgment No. 279/2018 of 18 April, the Supreme Court considered irrelevant that the risk restriction clause was not highlighted, since the insured party's injury had been caused by an accident that took place before the signing of the contract.

iv Regarding the 'claims made' coverage clause

Article 73 LCS paragraph 2 establishes that, in relation to civil responsibility insurance, the parties will have the possibility of including rights restriction clauses that circumscribe the

insurance coverage to situations where the injured party's claim: (1) has been submitted in a period of time, either not less than a year after the termination of the last extension of the contract or, failing this, from its duration period ('future coverage'); and (2) is submitted during the policy's validity period, as long as the coverage comprises the scenarios in which the obligation to compensate has arisen at least one year from the beginning of the contract's effects, even if the contract is subsequently extended ('retrospective coverage').

In judgment No. 252/2018 of 26 April, the Supreme Court (in full committee) set as jurisprudential doctrine that the above-mentioned Article 73 LCS regulates two different risk restriction clauses, each one with its own time-related coverage requirements. Consequently, to admit the validity of future coverage clauses, retrospective coverage is not an additional requirement, and vice versa.

Additionally, in judgment No. 134/2018 of 8 March, the Supreme Court established, in relation to the burden of proof, that it is the insurer who has to accredit the existence and content of the 'claims made' clause in which it denies coverage.

v Third-party direct action and exceptions under which the insurer may avoid payment

Article 76 LCS establishes, in the field of civil responsibility, that: (1) the damaged party (or its heirs) may bring a direct action against the insurance company to demand the fulfilment of the obligation to compensate; and (2) the insurer may not deny payment by citing the exceptions that may apply against the insured party.

This circumstance, which has been repeatedly recognised by the Spanish courts (e.g., Supreme Court's judgment No. 200/2015 of 17 April, or Supreme Court's judgement No. 484/2018 of 11 September), implies that when facing a claim from a third damaged party (under Article 76 LCS):

a the insurer may deny payment based on the fact that the claimed damages were caused by a risk objectively excluded from the contract (i.e., a risk that does not fit in the scope established by the risk restriction clauses); but

b the insurer will not be able to deny its obligation to pay based on exclusion clauses that rely on the severity of the harmful conduct of the insured party (e.g., driving under the influence of alcohol or drugs, the accreditation of wilful misconduct). These would be personal exceptions and would not be effective against the damaged party.

This being said, the Spanish courts have clearly established that the regime set out in Article 76 LCS cannot operate as a mechanism for the damaged party to obtain an unjust enrichment. This is why, as the Supreme Courts reiterated in judgment No. 87/2015 of 4 March, the insurance company may also rely on exceptions that could exist between the insured party and the damaged party (e.g., the existence of a previous payment from the insured party, a waiver from the damaged party against the latter).

In addition, as the Supreme Court judgment No. 52/2018 of 1 February 2018 highlights, Article 76 LCS also does not protect those cases in which the damage claimed has been caused by the misconduct of the injured party who now claims compensation.

vi Interest in arrears in Article 20 LCS

Article 20 LCS determines, in general terms, that the insurer in default[3] is obliged to pay the insured party compensation equivalent to the legal interest rate (at the moment such interest is accrued[4]) increased by 50 per cent over the base amount, or the compensation to be paid, from the date of the accident until the payment is made. Additionally, if two years elapse from the date of the accident, this interest in arrears may in no circumstances be under 20 per cent.

This compensation, according to the applicable legal framework, will only be unenforceable if the non-payment of the compensation or the minimum amount was based on a justified cause or if it was not attributable to the insurance company.

As may be gathered, Article 20 LCS establishes a notably burdensome compensation regime for insurance companies. Thus, it has not been unusual to see proceedings where these entities argue that their opposition to the payment was based on a justified cause and, therefore, interest in arrears were not applicable.

Over the course of numerous judgments (among the most recent ones, we must highlight: Supreme Court Decision No. 26/2018 of 18 January, No. 143/2018 of 14 March, No. 317/2018 of 30 May, No. 199/2018 of 10 April and No. 70/2018 of 7 February), the Spanish Supreme Court has established certain criteria regarding what can be considered as a 'justified cause' and the meaning of 'not attributable'. For example, it is now a consolidated criterion that, in order for the insurance company's opposition to be considered justified, its substantiation and the considerations made by the first instance court must be examined, without the mere fact of taking the case to the courts constituting proof that a justified reason for delay exists. Similarly, the fact that the insurer had made an offer to the insured party conditional on the waiving of any legal action (and which was not accepted by the insured party) will not be considered an exonerating cause.

On the other hand, in line with Article 20 LCS, the Supreme Court in full committee (although with one dissenting vote) established, in judgment No. 64/2018 of 6 February, that Article 20 LCS was applicable to a health insurance company declared civilly liable for medical malpractice.

vii Indivisibility of insurance premiums and the effects of default

Insurance premiums, under Spanish law, are considered to be single and indivisible because the insurer withstands the whole risk during the whole contract and not in fractions of time. This is notwithstanding the fact that the parties may agree for payment to be made in instalments.

Article 15.2 LCS determines that, in case of default of an insurance premium after the first annuity, 'the coverage is suspended a month after the due date'.

Taking into account these two circumstances, some judicial and doctrinal sectors defended the theory that, even though some of the insurance premium instalment payments were in default, such defaults were irrelevant to the effects of Article 15.2 LCS until the due date of the last instalment payment.

3 This will occur when the payment has not been fulfilled within three months from the date of the accident, nor has the payment for the minimum amount been fulfilled in the 40 days following the notification of loss.

4 The legal interest is currently 3 per cent.

Nonetheless, this theory has been rejected by the Supreme Court, which has established as jurisprudential doctrine that, in these cases, from the moment in which the first instalment is unpaid, the suspension of coverage under Article 15.2 LCS is automatic (judgment No. 684/2017 of 19 December 2017).

IV THE INTERNATIONAL ARENA

The jurisdiction of the Spanish courts to hear cases in which the dispute has arisen between different members 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 his state of residence and Spain, Article 22 quinquies of Organic Law 6/1985 of 1 July of 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 have agreed to submit the dispute to the Spanish courts after the dispute has arisen;

d both contracting parties have submitted the case to the Spanish court's jurisdiction before the dispute arising, and both parties were domiciled in Spain at the time the contract was signed; or

e both contracting parties have submitted to the Spanish court's jurisdiction before the dispute arising, 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 will be determined, generally, by Article 7 of Regulation (EC) No. 593/2008 of the European Parliament and of the Council of 17 June 2008 on the law applicable to contractual obligations (Rome I); or the private international law provisions contained in Articles 107 to 109 LCS.

Consequently, in general terms, LCS will be applicable to those casualty insurance contracts in which the risk is located in the Spanish territory and the policyholder has his or her habitual residence there (if it refers to a natural person) or its registered office or administrative management headquarters (if it refers to a legal person). Furthermore, the LCS will also be applied when the contract has been entered into in order to fulfil an insurance requirement imposed by a Spanish law.

Additionally, with regard to life insurance, LCS will be applicable: (1) when the policyholder has their address, habitual residence or effective administration or direction in Spanish territory; (2) when, with the policyholder having Spanish nationality but being resident in another state, it was agreed with the insurer party; 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 subjected to Spanish law.

Finally, in large risks insurance contracts,[5] it is established that the parties will be free to choose the applicable law.

V TRENDS AND OUTLOOK

In the immediate future, the quantitative and qualitative relevance of the disputes in the traditional sectors of the insurance market (motor vehicles, health, civil responsibility) will continue. Similarly, as a result of the financial crisis suffered in recent years, directors' and officers' liability insurance will continue to generate litigation.

In addition, the social reality demonstrates that there are new needs for which the insurance market is trying to provide coverage. In this sense, the damages caused by use of drones, the insurtech sector, cyber risks and the new means of transport found in big cities (e.g., electric scooters) could be a source of new judicial conflicts.

Finally, from a regulatory point of view, we should not lose sight of the impact and evolution that the new requirements resulting from the transposition of the latest European regulation on the activity of insurance brokers and dealers may have.

5 Defined by Article 11 of Law 20/2015 of 14 July, on the organisation, supervision and solvency of insurance and reinsurance companies.

Chapter 16

UNITED ARAB EMIRATES

Hassan Arab, Mohammad Muhtaseb and Jyothi Venugopal[1]

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 the contracts of insurance.

The insurance sector in the UAE is governed by the Federal Law No. 6 of 2007 (as amended by Federal Law No. 3 of 2018) (the Insurance Law) concerning the Establishment of the Insurance Authority and Organisation of Insurance Operations. 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, 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 draft 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, issue necessary licences, determine unified tariffs to certain types of insurances and proposing programmes to develop the insurance sector. Apart from the Insurance Authority, there are health insurance regulators in Dubai (Dubai Health Authority)

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and Abu Dhabi (Health Authority of Abu Dhabi). The Insurance Authority supervises the health sector in coordination with the Dubai Health Authority and the Health Authority of 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. 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.

The insurance and reinsurance companies operating in the onshore UAE must also follow the regulations issued by the Chairman of Insurance Authority Resolution No. 2 of 2009 (the Resolution No. 2 of 2009) and the Insurance Authority Board of Directors Resolution No. 3 of 2010 that sets out some professional code of conduct.

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 Resolution No. 42 of 2017, which amends certain provisions of the Insurance Authority Board of Directors Resolution No. 25 of 2016 on standardisation of motor vehicle insurance policies regulations;

b Insurance Authority Board of Directors Resolution No. 12 of 2018 concerning the licensing and registration of insurance consultants and regulation of their operations; and

c Insurance Authority Board of Directors Resolution No 14 of 2018 on the application of financial solvency requirements contained in Chapter 2 of the financial regulations for insurance companies (including takaful insurance companies) on the branches of foreign insurance companies operating in the UAE.

ii Insurable risk

Resolution No. 2 of 2009 provides for three categories of insurance; namely, life insurance and capital insurance, property insurance and liability insurance.

Life insurance and capital insurance includes insurance operations with the objective to pay certain amounts owing to death, disability or attaining a specific age. Further, it includes health insurances, personal accidents 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 insurances usually within accident insurance of various risks.

Mandatory insurance is applicable to medical and motor insurances. This is a compulsory requirement applicable for all the seven emirates in the UAE. Every owner of a motor vehicle has the duty of making a compulsory contract of insurance that will cover his or her civil liability arising out of death or injury from accidents occurring from the vehicle.

Professional liability insurance is mandatory with respect to certain categories of professionals in the field of accounting, and financial and legal professions. Federal Law No. 12 of 2014 regulating the profession of auditors provides for compulsory insurance for auditors against liability to professional mistakes.

Federal Decree 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 sharia law, such as risks against speculative gains similar to gambling, are considered as 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 involves a combination of a federal and local system. 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 cases on insurance litigation filed before onshore UAE courts are in connection with claims related to vehicle insurance, insurance covering accidents in the event of a fire, and insurance claims on errors or omissions with regard to 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 similar to any other contract, a contract of insurance 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 such cases, 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 a material damage to a person as a result of the death of another is that the deceased was supporting such person at the time of his or her death in a permanent manner. In that event, the court must assess the value of the loss of opportunity sustained by the aggrieved party by loss of the 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 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 owning 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 actual damages to the insurer was 55,000 dirhams, and accordingly the Appeal Court awarded the actual 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 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 case 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.

V TRENDS AND OUTLOOK

The UAE economy continues to grow by diversifying its resources. The UAE has been making huge investments in the tourism, financial and construction sectors.

The introduction of compulsory health insurance in 2017 for all the residents in the UAE resulted in contributing a rapid growth in the health insurance sector. However, in 2018 it is expected that the health sector will see a stabilised growth. Other sectors that are likely to witness growth in 2019 are real estate, manufacturing, construction, education and tourism. With the much-awaited Dubai Expo 2020 lined up, there has been an increase in construction projects.

The areas that are likely to evolve and become more important to insurance disputes in the UAE largely relate to real estate, construction and professional malpractice sectors. With the advancement of the Hyperloop system, transportation services are expected to progress and this is another area that could evolve further. Similarly, rapid advancement in the area of integrated smart digital systems in the UAE is likely to pay more importance to the field of the artificial intelligence.

A noteworthy development that is anticipated to be introduced soon is the establishment of the insurance disputes resolution committee, a committee under the supervision of the Insurance Authority, to hear insurance disputes.

This committee helps to fast-track the disposal of disputes in a cost-effective manner. There is no official announcement yet on this subject, however, it is expected that a committee will be established in due course.

Appendix 1

ABOUT THE AUTHORS

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Cassio Gama Amaral's practice focuses on insurance, reinsurance and pensions with an emphasis on claims handling and litigation, as well as mediation and arbitration. He is a professor of a postgraduate course on insurance law at Escola Nacional de Seguros and author of several publications on insurance law matters. He is a member of the International Insurance Law Association, Brazilian Section (AIDA). He is fluent in Portuguese, English and French.

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He has been recognised in *Chambers Global: Insurance* (2016–2019), *Chambers Latin America: Insurance* (2016–2019), *The Legal 500: Dispute Resolution* and *The Legal 500: Insurance* (both 2016).

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Shouzhi is an executive partner of Guantao Law Firm Xiamen Office. He specialises in shipping, international trade and insurance. He has for over 12 years been dedicated to legal professional services, offers numerous types of legal advice for clients in China and overseas, and makes presentations in China, Europe and the United States. Shouzhi is currently an arbitrator in both Hong Kong International Arbitration Centre and Xiamen Arbitration Commission. He is also the adjunct professor of Navigation College, Jimei University. Because of his excellent achievements, Shouzhi was awarded by Asia Law and Practice in 2012 and 2013 as the 'leading lawyer' in the Asian-Pacific region for shipping and maritime.

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Dr Hassan Arab is the deputy managing partner and co-head of litigation at Al Tamimi & Company.

He is a leading expert in all aspects of civil and commercial litigation, and dispute resolution. Hassan regularly sits as an arbitrator and advises on arbitration-related issues. He has extensive experience in providing expert opinions on the UAE laws before arbitration tribunals and foreign courts.

Hassan obtained his PhD in law from the University of Essex, United Kingdom, and has a law degree from Beirut University in Alexandria, Egypt. He also has a master's degree in international business from the University of Wollongong and practice diplomas in international arbitration law and international commercial law from the College of Law, United Kingdom. He is on the panel of arbitrators for ICSID, ICC, DIFC-LCIA, DIAC, SICAC, SIAC, AIAC and CRCICA.

Hassan is a vice chair of the steering committee of the ICC-UAE Commission on Arbitration and a member of the future Arbitration Court of CIMAC. He is also a member to the ICC Commission on Arbitration and ADR and a member of the DIFC Court User's Committee.

He is the author and co-author of a number of publications on arbitration and dispute resolution and has authored several books.

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'Very professional and knowledgeable', Andrea leads the Rome litigation and arbitration practice of Hogan Lovells in Italy and is responsible for insurance litigation. He was named an Acritas Star for 2017 and 2018, and is featured by the *Chambers* and *The Legal 500* guides for dispute resolution.

As reported by *Chambers*, 'Andrea is active in a variety of insurance, commercial and antitrust disputes, including arbitration. His clients value the fact that he "handles the case as though the company were his" and "wants to make sure that everything is crystal clear".'

With 17 years' experience and a strong academic background, Andrea 'impresses with brilliant advocacy' and mediation skills, advising on strategy to manage and reduce potential risk exposure in 'the client's best interests'.

An assistant professor at Luiss Guido Carli (Rome), secretary of the editorial committee of the *Italian Arbitration Law Review* and Italian representative of the Hogan Lovells' accountants' liability group, Andrea has authored various publications for the most important law reviews and publishing houses.

He is a very active member of the firm for diversity and inclusion, with a specific focus on sexual orientation. Andrea is the ambassador for Italy of Pride+ (an internal network for LGBT and allies), member of the firm's global diversity and inclusion advisory committee and of the Italian diversity team.

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Anne Buhl Bjelke specialises in insurance law and dispute resolution.

For several years, Anne has established corporate and regulatory insurance law as her separate field of expertise, and she is now an acknowledged expert within this field of law.

With professionalism, Anne advises general and life insurance companies in Denmark and abroad, focusing on the commercial challenges and opportunities for the industry as

such. Her advisory services include regulatory insurance law and insurance mediation. She also has special knowledge of financial sector regulation.

Anne is an experienced litigator and has argued many cases before the courts, and she has with great conviction conducted several cases on professional liability, D&O liability and product liability, as well as insurance cover.

Even at a young age, Anne was a recognised legal expert, which is illustrated by her being admitted to the list of young talents of corporate Denmark in Berlingske Nyhedsmagasin's 'Talent 100' at the age of 35. She is rated as a 'leading individual' within insurance law by *The Legal 500*, and she is general agent of Lloyd's Underwriters in Denmark.

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Russell Butland is a senior associate in Allen & Overy's litigation and investigations group and a member of Allen & Overy's insurance disputes group. Russell has particular experience working on policyholder insurance claims, including property damage and business interruption, professional indemnity, directors and officers, and political risk policies. Russell has Higher Rights of Audience (Civil) and sits as a legally qualified chair of medical practitioners' tribunals.

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Francisco Caamaño joined Uría Menendez in 2015. He is a member of the insurance litigation group.

Francisco's primary practice is focused in the fields of civil law and commercial law. In this regard, he advises multinational companies of several industries (financial institutions, real estate, energy, infrastructure and telecommunications) in proceedings before the Spanish courts and the main arbitration courts. He also participates actively advising clients at the pre-litigation stages and on out-of-court settlements.

Francisco has relevant experience in the insurance law field, where he has participated in different proceedings relating to both corporate and contractual matters. He is also adviser to restructuring proceedings of insolvency and pre-insolvency indebtedness and has participated on the approval process of some of the most recent refinancing agreements entered into in Spain.

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Sharon Daly heads the commercial litigation insurance team, which is described by *The Legal 500* as 'second to none', with Sharon being personally commended for her ability to respond creatively to complex issues.

Sharon and her team have been involved in some of the most significant commercial litigation before the Irish courts in the past 10 years, including defending a major financial institution in a multibillion, multi-jurisdictional dispute arising from investment in Bernard L Madoff's business. Sharon also acted for insurers in the largest property damage dispute to come before the Irish courts in relation to the liability of hydro-electrical dams and flood damage arising therefrom.

Sharon and her team advise a wide range of clients on insurance issues including policy wordings, coverage, policy disputes, defence of large complex claims and subrogated recovery actions.

Sharon is the co-chair of the International Bar Association Insurance Committee for 2018–2020 and has actively sought to use this committee to bring together leaders in the insurance industry to address the challenges in the industry globally.

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Delphine Dendievel is a senior associate in the litigation department at Allen & Overy Paris. She specialises in commercial and criminal litigation, particularly in the areas of banking and finance matters, as well as in conflicts of laws and jurisdictional issues. Delphine assists French and foreign companies in complex multi-jurisdictional disputes. Delphine's experience includes advising major financial institutions on large fraud litigations such as the *Madoff* case (civil and criminal proceedings). Furthermore, Delphine is highly qualified in economics (she holds an *agrégation* in economics).

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Thales Dominguez Barbosa da Costa's experience comprises insurance and reinsurance, focused on legal opinions, review of insurance policies, judicial litigation and claims handling. He is fluent in Portuguese, English and Spanish.

He has a bachelor of laws from Faculdade de Direito de São Bernardo do Campo and a postgraduate specialisation in contract law from Escola Paulista de Direito.

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Hélder Frias joined the Lisbon office of Uría Menéndez Proença de Carvalho in 2006 and became a senior associate in 2015. Hélder worked in the London office of the firm from September 2010 to August 2011.

His practice is focused on banking, finance and insurance. Notably, he advises on M&A transactions involving financial institutions, bancassurance joint ventures, the transfer of insurance portfolios, and on other regulatory matters related to these markets, including insurance and reinsurance intermediation.

Hélder frequently advises on regulatory and supervisory aspects of financial and insurance activities (including banking and financial intermediation services and payment services), such as lending, creation of security, factoring, sale and purchase of receivables, money laundering, venture capital and financial products and investment and retail banking and insurance instruments (capital redemption transactions and unit-linked life insurance agreements).

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Jessica holds an undergraduate degree in psychology (minor in philosophy) from St Francis Xavier University, Canada. She graduated from the University of Birmingham with an LLB (Hons) in 2012 and completed the Legal Practice Course at BPP, London in 2013. Jessica was called to the Bermuda Bar on 9 October 2015. Jessica speaks fluent Portuguese.

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Frank Fulong Huang is a dispute resolution partner of Guantao Law Firm. He concentrates his practice in all areas of dispute resolution, with particular focus on shipping, insurance, international trade, guarantee, investment and shareholders disputes. Mr Huang has been selected as one of the 'China Leading International Lawyers' and was sent to London by the All China Lawyers Association (ACLA) in 2016 for an international commercial arbitration training programme in the law school of BPP University. Mr Huang is currently vice director of the international and Hong Kong, Macao and Taiwan working committee, a commission member of the shipping and logistics law committee of Shenzhen Lawyers Association, and a commission member of the insurance law committee of Guangdong Lawyers Association.

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Julio Iglesias is a counsel in the Madrid office of Uría Menéndez. He is a member of the insurance litigation group. He joined the firm in 2004 and has developed his career in the litigation and arbitration practice area.

Julio regularly advises clients at the pre-litigation stages and on out-of-court settlements. He is also actively involved in proceedings before the Spanish courts and the main Spanish arbitration courts.

His practice on business law matters encompasses insurance litigation, corporate litigation, consumer law and class actions and contractual and tort liability. He also has relevant experience in complex claims (pre-litigation) regarding insurance matters.

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JAE-HWAN KIM

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Jae-Hwan Kim is a Korean attorney and partner of the insurance and reinsurance practice group at Lee & Ko. As a core member of the insurance and reinsurance group, he specialises in all aspects of international trade, shipping, aviation and insurance with a focus on regulation and litigation. He has handled many major cases, such as 'the MV Hebei Spirit Oil Spill case', 'MV Sewol Capsizing case', 'Air China Aircraft Crash at Gimhae' and 'insurance claim regarding Incheon Warehouse Fire'. He has also been involved in a variety of cases in relation to international trade law, such as 'letter of credit case' and 'the dispute regarding export or import contract'. In 2010, he completed a master of laws degree at the University of Southampton, where he studied international trade law, maritime law and insurance law.

JOHN JUNGKYUM KIM

Lee & Ko

John JungKyum Kim is a co-head of the insurance and reinsurance practice group at Lee & Ko focusing on the international clients of the firm. As a US licensed attorney, he advises leading global insurers, reinsurers, producers, policyholders, insured parties and other interested parties on matters such as the formation and licensing of insurers and reinsurers and related business entities, drafting and negotiating insurance- and reinsurance-related commercial contracts, outsourcing of information technology, data processing and business delegation, product development and policy wording, marketing and solicitation practices, coverage opinions and disputes, sales and purchase of businesses, transactions between affiliates and subsidiaries, international and cross-border sales of insurance and reinsurance, regulatory compliance, insolvency proceedings and government relations on behalf of clients in the insurance industry. Mr Kim has 20+ years specialising in the handling of insurance and reinsurance matters as an attorney in various roles at large multinational insurance companies and leading law firms in both in New York and Seoul, including AIG, Tokio Marine &

Nichido Fire, Samsung Fire & Marine, and Kim & Chang. He is highly regarded for his extensive experience and expertise in effectively handling and advising clients on a broad range of insurance and reinsurance concerns, and related corporate matters.

JIN-HONG KWON

Lee & Ko

Jin-Hong Kwon is a Korean attorney and the co-head of the insurance and reinsurance practice group at Lee & Ko since 2013. Over the past few years, Mr Kwon has counselled and continues to provide invaluable advice regarding compliance under the Insurance Business Act and its subordinate and related regulations, along with management and structuring asset management programmes and investments for insurers and other financial institutions. In particular, he works on matters involving licensing and registrations, policy wording review and drafting for life and non-life insurers and reinsurers, outsourcing and delegation, cross-border solicitation and transactions, data privacy-related issues both onshore and offshore, contract drafting and negotiations and other key issues involving insurance and reinsurance market participants in Korea. He enjoys a solid reputation in the Korean marketplace and is a trusted adviser for Samsung Life Insurance, Samsung Fire & Marine Insurance, DB Insurance, AXA Direct, AIG, Royal Sun Alliance and Pacific Life Re, MetLife and BNP Paribas Cardif Life.

DAN LIU

Guantao Law Firm

Dan's practice has been on marine and non-marine insurance matters. She has particular experience in cargo and hull recovery claims, subrogated claims and policy coverage issues regarding marine insurance, property insurance, and liability insurance, etc. She also deals with various claims arising from air transit, bankruptcy of shipping companies, container chartering and international trade, etc. Before joining Guantao, Dan obtained her licence in a leading Chinese maritime law firm and then worked in an international boutique law firm and provided legal services for the world's top insurance companies, and world-famous airlines, logistics companies and shipyards.

APRIL MCCLEMENTS

Matheson

April McClements is a partner in the insurance and dispute resolution team. April is a commercial litigator and specialises in insurance disputes.

April advises insurance companies on policy wording interpretation, complex coverage disputes (in particular relating to financial lines policies), D&O claims, professional indemnity claims, including any potential third-party liability, and subrogation claims. April manages a significant number of professional indemnity claims for professionals, including insurance brokers, architects and engineers, for a variety of insurers.

April has been involved in obtaining High Court approval for various insurance portfolio transfers and schemes of arrangement arising from reorganisations and mergers and acquisitions involving life, non-life and captive insurers. April also works in the area of general commercial litigation, with a particular focus on contractual disputes, most of which are litigated in the Commercial Court. She is also a strong advocate of ADR and has acted for clients in mediations and arbitration.

PEDRO FERREIRA MALAQUIAS

Uría Menéndez Proença de Carvalho

Pedro Ferreira Malaquias is a partner based in the Lisbon office of Uría Menéndez Proença de Carvalho.

He joined Vasconcelos, F Sá Carneiro, Fontes & Associados (which later integrated with Uría Menéndez Proença de Carvalho) as a partner in 2001. He heads the firm's finance department and is responsible for the areas of banking and insurance.

Before joining the firm, Pedro worked in the legal department of Banco Português do Atlântico, SA and in the Competition Directorate General of the European Commission, and headed up the legal department of BCP Investimento – Banco Comercial Português de Investimento, SA between 1995 and 2001. Since 1998, Pedro has worked as a legal consultant for the Portuguese Banking Association, and acts as their representative on the legal committee and on the retail committee of the European Banking Federation. He is also a member of the European Financial Markets Lawyers Group.

He specialises in banking and insurance law and is involved in banking, giving advice on all legal aspects related to retail and investment banking, including regulatory and supervisory matters; in securitisation and covered bonds transactions; and in insurance, negotiating insurance contracts on project finance and structured finance transactions, giving advice on insurance products such as unit link, and regulatory and supervision issues.

STEFANO MOTTA

Mattos Filho, Veiga Filho, Marrey Jr. e Quiroga Advogados

Stefano's experience comprises complex ligation in insurance, real estate and M&A matters, including debt recovery transactions, consumer litigation proceedings and consultancy. He is fluent in Portuguese and English.

He has a bachelor of laws from Universidade Presbiteriana Mackenzie and a postgraduate specialisation in civil procedure law from Pontifícia Universidade Católica de São Paulo (COGEAE).

MOHAMMAD MUHTASEB

Al Tamimi & Company

Mohammad Al Muhtaseb is a partner in the litigation department and joined the firm in 2010. Mohammad specialises in litigation and dispute resolution. He joined Al Tamimi as a litigation lawyer, however, his experience is in the field of dispute resolution, where he has advised some of the firm's major clients on various aspects of UAE law and court proceedings. He is further involved with cross-border litigation matters.

ANTHONY NOVAES

Mattos Filho, Veiga Filho, Marrey Jr. e Quiroga Advogados

Anthony Charles de Novaes da Silva has experience in insurance, reinsurance and pensions, including consultancy, administrative and judicial litigation, due diligence and claims handling. He is fluent in Portuguese, English and Spanish.

He has a bachelor of laws from Universidade Presbiteriana Mackenzie and a postgraduate specialisation in insurance and reinsurance from Escola Nacional de Seguros.

JOANNA PAGE

Allen & Overy LLP

Joanna Page is a partner in Allen & Overy's litigation and investigations group, and developed Allen & Overy's insurance disputes group, which is rated Tier 1 by both *Chambers* and *The Legal 500* for policyholder claims. Joanna speaks regularly in the United Kingdom, Europe and elsewhere on English law and for 10 years she taught company law at Cambridge University. She is a fellow of the Chartered Institute of Arbitrators and a CEDR-accredited mediator. She has Higher Rights of Audience (Civil).

LAURA PELLY

Matheson

Laura Pelly is a senior associate in Matheson's insurance disputes team in the commercial litigation and dispute resolution department. She joined the team in July 2017, moving from Duncan Cotterill in New Zealand. Laura has over 12 years' experience as a civil litigator in Ireland (solicitor) and New Zealand (barrister and solicitor) and 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 relating to financial lines and public liability policies), 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.

Laura specialises in coverage advice and disputes relating to Directors' and Officers' liability insurance policies, income and mortgage protection policies, and life insurance policies.

ANGÉLIQUE PFEIFFELMANN

Allen & Overy LLP

Angélique 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 insurances.

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 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, 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 heads the dispute resolution practice at the firm. 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, charterparties, 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, challenge 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 of 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 *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 and Partners 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 law school from the University of Leuven, 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 one was the Frits Kalshoven International Humanitarian Law Competition in 2015, in which Merel and her team reached the finals. The second moot court was the ELSA EMC² WTO Moot Court Competition. Her team won the regional round in the Czech Republic and received the awards 'Best written submission for the respondent' and 'Best overall written submission'. 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 Ghent and the public prosecutor of Antwerp) she decided to start her professional life at the law firm Schuermans advocaten. At the firm, Merel developed a special interest in insurance law. She is coached by Luc Schuermans, who has a profound expertise in the matter 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 pursues an academic career by publishing articles concerning insurance law and still participates in moot courts.

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.

JOHN WASTY

Appleby

John Wasty is the group head of dispute resolution in Bermuda and global head of the insurance disputes team.

John specialises in all areas of commercial litigation, restructuring, insolvency litigation, funds litigation and regulatory matters and has represented clients in a wide variety of commercial disputes in Bermuda, London, the United States, Europe and Asia. John advises extensively on schemes of arrangement and complex multiparty restructurings involving multiple jurisdictions. John is frequently involved in major arbitrations in Bermuda and internationally in both commercial and insurance/reinsurance matters.

In addition to being admitted in Bermuda, John has also been admitted in New York, England, Hong Kong, Canada and the British Virgin Islands. John obtained BA and JD degrees from the University of British Columbia (Canada) and an LLM from Osgoode Hall Law School, York University. John is also a Fellow of the Chartered Institute of Arbitrators.

YANG-HO YOON

Lee & Ko

Yang-Ho Yoon is a Korean attorney and partner of the insurance and reinsurance practice group at Lee & Ko. He primarily practises in 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 a master of laws degree at the University of Southampton.

MARC ZIMMERLING

Allen & Overy LLP

Marc 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 law degree from Johann Wolfgang Goethe-University, Frankfurt, Germany and has repeatedly been named by German legal directory JUVE as frequently recommended lawyer for insurance law as well as commercial, liability and corporate litigation, citing others in its 2018/2019 edition who describe him as an 'experienced litigator with good standing with the "Big Four"' and 'the man for the big cases'.

Appendix 2

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