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Global Practice Guides

Insurance Litigation

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Chambers Global Practice Guides

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INTRODUCTION

Contributed by: Barney Winckler, **Kennedys**

Kennedys is a global law firm specialising in dispute resolution and advisory services, with more than 2,300 people in 24 countries around the world. The firm handles contentious and non-contentious matters and provides a range of specialist legal services, including corporate and commercial advice, but with a particular focus on defending insurance and liability claims. Defendant claims work is at the heart of Kennedys' practice and accounts for more than half of the firm's business. This is a global practice with unsurpassed capabilities and expertise that can deal with any type of claim in any country – from high-volume or catastrophic personal injury claims to settling the largest multibillion-pound property, casualty, financial lines, marine or aviation claims.

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INTRODUCTION

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The Ongoing Impact of War, Disease and ESG on the Global Insurance Litigation Landscape

The 2025 edition of this global practice guide to insurance litigation enumerates the respective laws and rules governing insurance disputes in jurisdictions spanning each of the world's continents, bar Antarctica. Yet the guide also extends its lens of analysis to cover concomitant issues such as how litigation is funded, along with other pertinent aspects of dispute resolution in each jurisdiction that particularly impact insurers.

Legal practitioners from each of the featured countries report in detail on significant local trends in policy coverage disputes, as well as recent shifts in the litigation of claims whereby insurers fund the defence of insureds. Such claims in China, for example, arise most commonly in liability insurance lines and are clearly increasing in terms of both the cost and complexity of litigation.

Meanwhile, there has been a noticeable rise in large group actions against major Danish companies as litigation funding becomes more common – many of which trigger cover under D&O insurance policies. These cases often involve huge claims for damages and the volume of case material can be considerable, requiring extensive documentation and resulting in substantial legal costs for insurers in defending these claims.

How macroeconomic factors are impacting insurance-related litigation

The impact of macroeconomic factors – for example, the ongoing effects of the war in Ukraine and the COVID-19 pandemic – on the volume and type of litigation (notably, insurance-related litigation) is also examined.

The COVID-19 pandemic has given rise to specific coverage issues that have continued well into 2025, with a prominent example being the Danish Supreme Court decision of 2 May 2025 as to whether an injury sustained by an employee while working from home during lockdown constituted a compensable work accident under the Danish Workers' Act. In recognising the incident as a "work accident", the Danish Supreme Court set a precedent that injuries sustained during home-based work are generally covered, even if private domestic conditions contribute to the accident (in this case, tripping over a personal object while making a cup of coffee). The outcome of this case is expected to have far-reaching implications for insurers and policyholders alike, broadening the interpretation of what constitutes a work-related injury (particularly in the context of remote work, which has been normalised in many jurisdictions following the restrictions imposed owing to COVID-19).

Macroeconomic factors continue to affect both the scope of insurance coverage and insurers' risk appetites, with insurers tending to tighten coverage in response to events such as pandemics and wars – for example, by introducing exclusions related to infectious diseases or the risk of war. At the same time, insurers have become more cautious in underwriting risks in high-risk industries and regions, leading to higher premiums, increased deductibles, and more restrictive coverage terms and conditions.

The ongoing geopolitical instability, including the war in Ukraine, is likely to heighten the risk of cyber-incidents. The increasing frequency and sophistication of cyber-attacks is expected to cause more disputes in cyber-insurance coverage. Although it remains unclear whether a cyber-attack was the primary cause of the Iberian Peninsula blackout of 28 April 2025 (in which electric power was interrupted for up to 15 hours), the event triggered a surge in claims for business interruption, property damage, and loss of profits, as well as disputes over exclusions (power failure, force majeure, cyber-risk) and sub-limits. The Spanish Trends and Development chapter of this guide explains how public and industry reports have anticipated a significant volume of potential losses for insurers, prompting more sophisticated litigation strategies (expert evidence and concurrent causation analysis, among others).

Effect of ESG factors on insurance litigation

Environmental, social and governance (ESG) factors – from climate change and natural catastrophes to human rights – continue to play an increasingly important role in the insurance industry, progressively influencing both the underwriting of insurance risks and claims practices around the globe.

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The rise of ESG-related litigation in 2025, particularly in connection with D&O liability policies, means ESG compliance has become a decisive factor in underwriting and claims handling. Lawsuits increasingly target directors for alleged "greenwashing" and failure to adopt preventative environmental measures, as well as cybersecurity breaches, lack of diversity in governance, and insufficient transparency in executive remuneration. Court rulings in these claims in various European jurisdictions are expected to shape the interpretation of policy exclusions and the scope of coverage for ESG-related risks. This evolution is turning D&O insurance into a key risk management tool, not only for financial protection but also for driving good corporate governance and sustainable business practices.

In underwriting, insurers are now placing greater emphasis on identifying and managing environmental and social risks. Insurers in the renewable energy, green construction and ecological protection sectors have developed innovative products such as green insurance and carbon sink insurance. On the asset side, insurers have scaled up green investments, thereby aligning underwriting with sustainable finance.

ESG scores are also being adopted as reference criteria for underwriting and pricing decisions, thus encouraging insureds to improve their ESG performance. If the insured performs poorly in ESG areas, this can lead to reputational damage, regulatory scrutiny and legal challenges – all of which may result in insurance claims. Therefore, some insurance companies are beginning to incorporate ESG factors as a risk on a par with other traditional risks in the underwriting of new customers.

In claims handling and dispute resolution, ESG considerations are becoming relevant in determining the scope of coverage. In liability cases concerning environmental pollution or labour issues, courts and arbitration bodies may assess whether insureds fulfilled their environmental or social obligations, which in turn may impact insurers' indemnity obligations and settlement terms.

Climate change leads to extreme weather conditions and natural disasters

One of the most significant ESG factors impacting the litigation of insurance risks is the increased frequency of extreme weather events. Recent years have seen storm damage and extreme rainfall, resulting in floods, which have markedly influenced the underwriting of insurance risks.

On 16 April 2024, the heaviest rainfall recorded by the UAE in 75 years led to widespread floods, triggering an unprecedented volume of property and motor claims and thus raising complex issues around coverage, quantification and subrogation. There have been additional developments, including new broker regulations, clearer rules on policy language and form, and court decisions on arbitration and jurisdictional conflicts. The UAE Trends and Developments chapter of this guide explores how, together, these changes are reshaping the way claims are notified, adjusted and resolved.

In addition to extreme weather conditions, natural disasters are also affecting the underwriting of insurance risks – a pertinent example of which took place at the Nordic Waste site in Denmark and is discussed in the Danish Law and Practice chapter of this guide. The annual average number of severe natural catastrophic events experienced in the USA has increased from five to 28 since 2010, with many carriers no longer writing coverage in areas such as Florida and California. The US Trends and Development chapter of this guide describes how their departure leaves some risks uninsured and others covered by non-admitted carriers, resulting in higher premium costs.

The number of severe weather events is universally expected to continue on this upwards trend and the pressure on property, health and life insurers will increase accordingly. Investors and regulators alike are demanding that carriers gain a greater understanding of their climate risk exposures and develop business models to prepare for sudden and unanticipated changes in climate patterns.

Human rights considerations

Technical approaches to insurance law are gradually being balanced with – and, the Mexican Trends and

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Developments chapter of this guide argues, potentially eroded by – constitutional/human rights. Mexico's insurance litigation landscape has undergone a profound transformation, largely due to the constitutional reform of 2011 positioning human rights at the centre of the legal system. The incorporation of human rights has directly impacted the operation of insurers, imposing new burdens and responsibilities on them.

The denial of coverage – especially in health-related cases – is no longer a merely contractual matter but, rather, is viewed through the rubric of fundamental human rights. This is reflected in case law that allows conviction for moral damages and punitive damages, particularly when bad faith or failure to deliver the general conditions of insurance are demonstrated. The presumption of moral damages and the requirement to judge with a gendered perspective in certain cases are clear examples of this new judicial sensitivity.

Outlook for 2026

Overall, insurers are not only implementers of ESG principles but also key enablers of ESG adoption across the economy. As regulatory frameworks evolve, ESG considerations are expected to exert an enduring impact on risk assessment, product development and claims resolution within the insurance sector.

Against this backdrop, insurance litigation is becoming more strategic, technical and outcome-oriented. From a business perspective, insurers are reviewing policy wordings and claims protocols to anticipate disputes and reduce exposure, while law firms strengthen their pre-litigation capabilities and technical expert networks. From a jurisprudential standpoint, 2025's key rulings are likely to clarify coverage issues and set standards for quantifying damages.

All signs point towards a trend-setting year, with lasting effects on the practice of insurance litigation. As regulatory oversight intensifies and consumer awareness grows, disputes over policy interpretation, claims denial, and disclosure obligations are expected to grow in number. The escalating complexity of insurance products – particularly in areas such as health-, cyber- and ESG-related coverage – will likely give rise to novel legal questions.

BERMUDA

Law and Practice

Contributed by:
Oliver MacKay, Michael Frith, Kyle Masters and Sam Stevens
Carey Olsen

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Carey Olsen is a leading offshore law firm, advising on the laws of Bermuda, the British Virgin Islands, the Cayman Islands, Guernsey and Jersey from a network of nine international offices. The Bermuda office comprises nine partners and over 30 other lawyers and fee earners. Since it opened in 2017, it has established itself as a leading law firm on the island and internationally. Several of its lawyers previously worked in the insurance and reinsurance departments of other international law firms and are on the boards of insurance companies. This brings a practical, commercial dimension to the team's experience and advice. The firm is recognised by Chambers Global as a top-tier firm for many of its practice areas. It advises several businesses in Bermuda and leading international organisations from North America, Europe and Asia, including some of the largest global insurance and reinsurance companies.

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CAREY OLSEN

1. Rules Governing Insurer Disputes

1.1 Statutory and Procedural Regime

Bermuda is a British Overseas Territory. The modern legal system of Bermuda is established by the Bermuda Constitution Order 1968, an Order in Council of the United Kingdom that established the Supreme Court as the primary court of first instance and the Court of Appeal as the court with jurisdiction to hear appeals from judgments of the Supreme Court. The Appeals Act 1911 further establishes a right of appeal from any judgment of the Court of Appeal to the Judicial Committee of the Privy Council in London. This ultimate right of appeal to the Privy Council, along with the common law, is one factor that has made Bermuda an attractive jurisdiction for insurers.

Bermuda's legal system is largely based on English common law. The Supreme Court Act 1905 further establishes that (subject to the provisions of any acts of the Bermuda legislature) the common law, the doctrines of equity and the Acts of the Parliament of England of general application that were in force in England at the date when Bermuda was settled on 11 July 1612 have force within Bermuda.

Insurance disputes that are litigated in the Bermuda courts are generally heard by the Commercial Court, which is one of the five divisions of the Supreme Court. The same procedural regime that governs all commercial litigation governs insurance disputes in the courts, and is contained in the Rules of the Supreme Court 1985 (1985 Rules).

The primary statute governing insurance-related activities in Bermuda is the Insurance Act 1978 (Insurance Act); insurance and reinsurance companies are also subject to the provisions of the Companies Act 1981.

1.2 Litigation Process and Rules on Limitation

Litigation Process

The Supreme Court possesses and exercises the jurisdictions of the court of general assize, the court of chancery, the court of exchequer, the court of probate, the court of ordinary and the court of bankruptcy. There is also a Commercial Court, which deals exclusively with commercial (including insurance) and arbitration-related matters.

Appeals are common in Bermuda. The Court of Appeal has five Justices of Appeal, with the current President being Sir Christopher Clarke. Appeals are typically heard by three Justices. The Court of Appeal sits for three sessions of around a month per year.

Trials are conducted using the adversarial model between plaintiffs and defendants, with barristers making both oral and written submissions on their behalf. Bermuda has a fused legal profession and Bermuda litigators are both barristers and attorneys, although in special circumstances English King's Counsel are admitted to the Bermuda Bar.

Civil proceedings in the Supreme Court may be begun by writ, originating summons, originating motion or petition. The 1985 Rules prescribe which originating

process to use on the basis of the facts and circumstances of the case.

A typical civil action is commenced by filing a generally endorsed writ of summons, naming the parties to the action and providing very brief details of the relief sought. If the defendant defends the claim, then a generally endorsed writ must be supplemented by a statement of claim with the facts upon which the action is founded.

The party bringing the action is responsible for service. When a company is the defendant, a copy of the proceedings will be properly served if it is left at the registered office of the company in Bermuda. With respect to parties outside of the jurisdiction, the Supreme Court can be asked to make an order for service outside of the jurisdiction if the criteria in Order 11, Rules 1 and 2 of the 1985 Rules are met. A defendant who fails to respond as required under the 1985 Rules can have a default judgment entered against them.

Following the originating process to commence proceedings, the litigation process will move through the steps of interim applications, discovery and trial, closing with judgment.

Rules on Limitation

The Limitation Act 1984 sets out the applicable limitation periods. The majority of claims are subject to a limitation period of six years, which applies to claims for breach of a contract and in tort. A 20-year limitation period applies where the claim is based on a contract under seal or concerns the recovery of land and the proceeds of the sale of land or monies secured by a mortgage or a charge.

In contract law, the limitation period typically runs from the date on which the contract was breached. For a tort, the limitation period commences on the date the damage occurred. The Limitation Act 1984 makes provision for latent defects, as well as for cases where the cause of action could not, with reasonable investigation, have been discovered sooner.

Limitation is not an automatic bar to an action or recovery under it. A defendant must raise the Limitation Act 1984 as a defence and specifically plead the same.

1.3 Alternative Dispute Resolution (ADR)

Arbitration and mediation are the most common forms of ADR in Bermuda, which is a sophisticated hub for international arbitration of complex insurance and reinsurance disputes and has incorporated the UNCITRAL Model law into its domestic legislation via the Bermuda International Conciliation and Arbitration Act 1993. A branch of the Chartered Institute of Arbitrators was established in Bermuda in 1996, the primary function of which is to run arbitration training courses and to act as an appointing authority when asked to do so.

The court has repeatedly confirmed in judgments relating to the enforcement of arbitration agreements and awards that it will adopt a pro-enforcement stance on such matters, in keeping with Bermuda's obligations under the New York Convention (which has had the force of law in Bermuda since 1979).

The use of ADR is not mandated under the 1985 Rules, but that fact has not prevented the growth of its popularity and use, particularly mediation. The Supreme Court can impose costs consequences on a party where it has refused to engage in ADR and such refusal proves to be unreasonable. The Bermuda branch of the Chartered Institute of Arbitrators has localised procedural rules for mediation and arbitration, which are based on the UNCITRAL Rules.

Insurance and reinsurance contracts very often incorporate arbitration agreements, and confidential arbitration is the most common means of resolving insurance disputes in Bermuda.

2. Jurisdiction and Choice of Law

2.1 Rules Governing Insurance Disputes

Choice of Law

Bermuda's conflict of laws rules regarding determining the choice of law in a contract are the same as the "old" English common law rules. They were unaffected by the legislation binding the United Kingdom during its membership of the European Union, which

was not applicable in Bermuda (for example, the Rome I Regulation).

If the parties to a contract choose a particular law to govern the contract, effect will generally be given to that choice. In the absence of an express choice of law, the court will seek to identify either:

- an implied or inferred choice discerned from the surrounding circumstances; or
- the system of law with which the alleged contract has its closest connection.

It is common for parties to Bermuda insurance and reinsurance contracts to select Bermuda law to govern the contract.

The only statutory provision that limits the parties' freedom to select the governing law of a contract is Section 11 (2) of the Segregated Accounts Companies Act 2000, which provides that the governing instruments in relation to segregated accounts are deemed to be governed by Bermuda law.

For tort claims, the Bermuda court first considers where the tort was committed in substance. For torts committed outside of Bermuda, the court applies the double-actionability rule: the tort must be actionable under both the lex fori and lex loci delicti.

Jurisdiction

In general, when determining whether or not a proposed defendant is subject to its jurisdiction, the Bermuda court will consider whether the proposed defendant can be validly served within the Islands of Bermuda or whether a defendant has submitted, or has agreed to submit, to the jurisdiction of the Bermuda courts (for example, by contract or by taking steps in the litigation proceedings in Bermuda). If the proposed defendant has a foreign address, the plaintiff must obtain leave to serve the proposed defendant out of the jurisdiction, pursuant to Order 11 of the 1985 Rules.

However, the External Companies (Jurisdiction in Actions) Act 1885 permits a foreign company doing insurance business in Bermuda by an agent or branch to be sued in the name under which it carries on business in Bermuda. It further provides that service of process on the agent or manager of the company in Bermuda is good service, without the need for leave.

2.2 Enforcement of Foreign Judgments

Foreign money judgments can be enforced by or against insurers in Bermuda, either under the Judgments (Reciprocal Enforcement) Act 1958 (1958 Act) or under common law principles, provided that certain conditions are met. The method of enforcement is therefore dependent on the jurisdiction in which the judgment was given.

The 1958 Act allows money judgments (including arbitration awards that would be enforceable as judgments in the United Kingdom) from the superior courts of the United Kingdom (along with certain Commonwealth countries and overseas territories to which the Governor has declared the 1958 Act applies) to be enforced by registration of the judgment in the Supreme Court at any time within six years after the date of the judgment. The judgment must be final and conclusive, and the sum must not be in respect of taxes, fines or penalties.

A foreign judgment from a country not catered for by the 1958 Act can be enforced in Bermuda under common law principles. Fresh proceedings must be issued in Bermuda, with the debt obligation created by the foreign judgment as the cause of action in the Bermuda proceeding. The foreign court must have had jurisdiction over the judgment debtor in accordance with Bermuda's conflict of laws rules.

Non-money judgments are not enforceable under the 1958 Act or common law. For example, a judgment ordering specific performance of a contract will likely not be enforceable, although it may be capable of recognition. Injunctions will also not be enforced – they may be recognised by the Bermuda courts as a defence to a claim or as conclusive of an issue in a claim but would not be sufficient to found a cause of action.

Arbitration awards are enforceable through the New York Convention on the Recognition and Enforcement of Foreign Arbitral Awards and Part IV of the Bermuda International Conciliation and Arbitration Act 1993.

Judgments that consist of an award of multiple damages will not be enforced in Bermuda.

2.3 Unique Features of Litigation Procedure

The 1985 Rules are similar to the English civil procedure rules that applied in 1999; as a result, practitioners and the courts utilise the 1999 edition of the English "White Book" and its commentary to assist in the interpretation and application of the 1985 Rules.

Unlike the modern English rules, the 1985 Rules do not impose any specific pre-action protocols. However, parties will still typically engage in pre-action correspondence pursuant to the overriding objective set out in Order 1A of the 1985 Rules, which obliges parties to assist the court in order to identify issues at an early stage and save costs.

Whilst English case law is persuasive in Bermuda, judges and lawyers in Bermuda will also look to the case law of other common law and offshore jurisdictions, such as Australia, Canada, New Zealand, the Cayman Islands, the BVI, Hong Kong and Singapore, particularly when issues arise for which there is no precedent in the Bermuda courts.

3. Arbitration and Insurance Disputes

3.1 Enforcement of Arbitration Provisions in Commercial Contracts

Arbitration clauses are common in commercial contracts of insurance and reinsurance concluded in Bermuda or by Bermuda-based insurers and reinsurers.

The Bermuda courts will generally enforce arbitration agreements, and have confirmed that that should be the ordinary approach in a number of judgments. The court's pro-enforcement powers extend to issuing anti-suit injunctions to restrain parties from acting in violation of an arbitration agreement. The presumption is that an anti-suit injunction will be granted where the arbitration agreement in question is valid and binding, and the respondent party has not shown strong reasons that the injunction ought not to be granted. The Bermuda court can grant such injunctive relief notwithstanding the jurisdiction in which proceedings are commenced and regardless of whether the seat of the arbitration is Bermuda. A party in breach of an anti-suit order can be held in contempt of court, and any resulting foreign judgment could be held to be unenforceable in Bermuda.

3.2 The New York Convention

Bermuda is subject to the New York Convention on the Recognition and Enforcement of Foreign Arbitral Awards, which has had force of law in Bermuda since the United Kingdom extended it to Bermuda in 1979. Part IV of the Bermuda International Conciliation and Arbitration Act 1993 provides a statutory enforcement regime for New York Convention awards.

The award creditor must file an application seeking leave to enforce the award. An originating summons must be issued on an ex parte basis, along with a supporting affidavit setting out the basic facts of the arbitration, the fact of the agreement to arbitrate, the hearing and the award. The affidavit should exhibit the arbitration agreement and the original award. Once the award creditor obtains an order granting leave to enforce, it will be served on the award debtor. An application to set aside the order can be made – in lieu of any such application, the award can be enforced as if it were a judgment of the court.

As noted in **2.2 Enforcement of Foreign Judgments**, the 1958 Act also provides for the enforcement of awards from the United Kingdom (and other select countries) for the payment of money, so long as the award would be enforceable as a judgment in the United Kingdom.

3.3 The Use of Arbitration for Insurance Dispute Resolution

Arbitration is the prevalent form of insurance dispute resolution in Bermuda, making Bermuda a sophisticated hub for the arbitration of complex insurance and reinsurance disputes. The vast majority of business lines, with the property and casualty at the centre of the Bermuda market, as well as the captive industry, utilise arbitration agreements as the primary form of dispute resolution clause.

In Bermuda, there are two arbitration statutes:

- the Arbitration Act 1986 (the 1986 Act) governing arbitrations between purely domestic parties; and
- the Bermuda International Conciliation and Arbitration Act 1993 (the 1993 Act) governing international arbitrations seated in Bermuda.

The Acts themselves determine what arbitrations they apply to, and whether an arbitration is "domestic" or "international". The 1993 Act incorporates the UNCITRAL Model Law into Bermuda law.

If Bermuda law applies to the interpretation of the arbitration agreement, a Bermuda arbitration will generally be confidential.

The 1986 Act provides for a right of appeal of an arbitration award to the Court of Appeal on any question of law arising out of the award. In the absence of consent of all parties, leave must first be obtained from the Supreme Court. There is no right of appeal under the 1993 Act, although a party could seek to challenge an award in the Court of Appeal on the very limited grounds that are taken from the New York Convention – eg, public policy or the dispute being incapable of resolution by arbitration.

4. Coverage Disputes

4.1 Implied Terms

Insurance and reinsurance contracts are subject to the same rules of contractual construction as any other commercial contract, and terms can be implied as a matter of judicial construction.

There are two statutes that imply terms into insurance and reinsurance contracts.

First, for a contract written by a segregated accounts company, the Segregated Accounts Companies Act 2000 provides that the following are implied terms:

- that the parties select the law of Bermuda as the governing law and submit to the jurisdiction of the courts of Bermuda;
- that no party shall seek, whether in any proceedings or by any other means whatsoever or wheresoever, to establish any interest in or recourse against any asset linked to any segregated account to satisfy a claim or liability not linked to that segregated account;
- that if any party succeeds by any means whatsoever or wheresoever in establishing any interest in or recourse against any asset linked to that segregated account, that party shall be liable to the company to pay a sum equal to the value of the benefit thereby obtained by them; and
- that if any party succeeds in seizing or attaching by any means or otherwise levying execution against any assets linked to any segregated account of the company in respect of a liability not linked to that segregated account, that party shall hold those assets or their proceeds on trust for the company and shall keep those assets or proceeds separate and identifiable as such trust property.

Second, the Supply of Services (Implied Terms) Act 2003 implies that terms regarding the period of time for completion under a contract and the consideration to be paid are reasonable, if not otherwise set. There is also an implied term that the supplier will carry out the service with reasonable care and skill. This is generally understood to be directed to consumer contracts.

4.2 Rights of Insurers

Insurance and reinsurance law in Bermuda is based on the English common law. However, unlike in England, the issues of non-disclosure and misrepresentation are not governed by statute (except in the case of life insurance). A recent divergence in the laws of Bermuda and England on these issues has arisen from the introduction of the Insurance Act 2015 in England. This modified the previously applicable common law remedies for non-disclosure and misrepresentation (collectively considered to be breaches of the duty of utmost good faith), which were also codified in the Marine Insurance Act 1906 (whilst this statute does not apply in Bermuda, some of its provisions are declaratory of the common law and as such are likely to be considered in determining the Bermuda common law). There have been no such revisions to the remedies in Bermuda. The duty of utmost good faith as it was characterised by the common law before the

Insurance Act 2015 came into force in England (on 12 August 2016) continues to apply to all insurance contracts in Bermuda.

As a matter of principle, insurance contracts governed by Bermuda law are contracts of "utmost good faith" (also known as the principle of uberrima fides). This common law duty applies to insurance contracts in Bermuda and is imposed on both the insured and the insurer, as the parties to the contract. In placing and effecting the insurance contract, the intended insured party (and its broker) owe the following pre-contractual duties that comprise the duty of utmost good faith:

- a duty of disclosure, requiring the insured to disclose all material facts to the insurer; and
- a duty not to make misrepresentations.

Failure on the part of the insured to discharge these duties will give the insurer the remedy of avoidance ab initio. This has the same effects as rescission of a contract – it means that the parties are placed retroactively into the position they would have been in had the contract never existed. The insurer must be careful not to waive its right to avoid the contract or affirm the contract. The remedy of avoidance must be elected by the insurer. The parties can agree to limit the scope of pre-contractual duties and the requirement to make an accurate representation through their insurance contract(s).

A breach of a continuing warranty discharges the insurer from any further liability under the contract from the date of breach (but still allowing claims by the insured in respect of any loss occurring before the breach). This discharge is automatic, and the insurer need not make any election. In the case of a breach of an existing fact warranty, the fulfilment of the warranty is a condition precedent to the attachment of the risk and thus a breach would effectively void the contract ab initio.

4.3 Significant Trends in Policy Coverage Disputes

Given that the vast majority of coverage disputes in Bermuda are arbitrated confidentially, trends are difficult to identify.

Noteworthy coverage disputes in Bermuda often arise from areas of Bermuda-specific insurance innovation, such as the statutory segregated account regimes. Insurance companies utilise segregated accounts for rent-a-captive solutions, ILS transactions and the separation of reserves amongst business lines, and unique coverage issues and disputes rise from these structures, which cannot always be determined by reference to the usual common law principles of coverage.

The Supreme Court delivered a seminal judgment in August 2023 that reinforced the integrity of the segregated accounts company structure and the separation of assets and liabilities as between segregated accounts. The judgment will likely be cited in all future insurance disputes that involve a segregated accounts company.

4.4 Resolution of Insurance Coverage Disputes

The majority of coverage disputes subject to Bermuda law are resolved by way of confidential arbitration. Mediation is also common.

Many insurance contracts for excess liability insurance and reinsurance written in Bermuda are written on the Bermuda Form. Disputes arising therefrom are resolved in Bermuda Form arbitration – that is, an English procedural law-governed arbitration of a contract governed by New York law. Bermuda Form arbitration agreements invariably provide for a seat in London or Bermuda.

4.5 Position If Insured Party Is Viewed as a Consumer

Most insurance business written in Bermuda is international insurance and reinsurance; on that basis, there is little consideration of consumer protections in Bermuda insurance law and procedure. It is worth noting, however, that the Consumer Protection Act 1999 protects consumers from unfair business practices, and that the insurers carrying on "domestic business" in Bermuda are obliged by the Insurance Code of Conduct of the Bermuda Monetary Authority (BMA) to conduct their business with customers fairly and with integrity.

4.6 Third-Party Enforcement of Insurance Contracts

The Contracts (Rights of Third Parties) Act 2016 permits a third party to enforce a term of a contract where:

- the third party is identified in the contract by name, as a member of a class, or as answering a particular description; and
- the contract expressly provides in writing that the third party can enforce such term. This allows properly drafted cut-through provisions to provide a valid means of third-party enforcement rights in Bermuda.

The Third Parties (Rights Against Insurers) Act 1963 allows a third party to take direct action against an insurer in circumstances where its insured owes a liability but is insolvent. The Motor Car Insurance (Third-Party Risks) Act 1943 has similar provisions.

Finally, the Merchant Shipping Act 2002 also provides a statutory right to lodge proceedings to enforce a claim for oil discharge liability against a ship's insurer.

4.7 The Concept of Bad Faith

Bermuda law does not recognise any concept of "bad faith" as a basis for awarding damages against an insurer, for example due to its conduct during the administration or handling of a claim. There are no "damages on damages".

4.8 Penalties for Late Payment of Claims

There are no statutory remedies for the late payment of claims in Bermuda.

However, insurers and reinsurers are regulated by the BMA, which has wide-ranging enforcement powers, including the giving of directions (pursuant to the Insurance Act) to an insurer restricting the business it can write in circumstances where the BMA considers there to be a significant risk that the insurer will be unable to meet its obligations to policyholders.

Insurers are also bound by the BMA's Insurance Code of Conduct, which provides that insurers should implement policies that require them to address claims in a timely, fair and transparent manner and avoid any aggressive and coercive claims-handling tactics and discrimination during the claims-handling process. This is consistent with the principle – also contained within the Insurance Code of Conduct – that directors of a Bermuda insurer must act in the best interest of the company and its policyholders. In any event, insurers must conduct their business in a prudent manner in accordance with the Insurance Act, and compliance with the Insurance Code of Conduct is a determinative factor in the BMA's assessment of such prudent conduct of business.

4.9 Representations Made by Brokers

As a general principle, a broker acts as an agent of the insured or the reinsured, particularly when it is placing cover. However, brokers can have many roles and will often find themselves as dual agents, particularly in circumstances where they are placing both reinsurance and a retrocession. Section 29 of the Insurance Act, for example, makes a broker with authority to accept premium the agent of the insurer.

Therefore, whilst the insured certainly can (and often will) be bound by its broker's representations, this is unlikely ever to be straightforward. This is particularly the case in Bermuda, where brokers are involved in more than one capacity – eg, with respect to captives.

It is worth noting that the BMA's Insurance Brokers and Insurance Agents Code of Conduct provides that an insurance broker must not recommend a transaction to a client unless it has taken reasonable steps to make the client aware of the risks involved, including any conflicts of interest and that, when providing advice to or arranging contracts of insurance for the client, a broker shall make full and adequate disclosure of all facts necessary for its clients to make an informed decision. The BMA has specific powers to grant and revoke a broker's registration in Bermuda under the Insurance Act.

4.10 Delegated Underwriting or Claims Handling Authority Arrangements

Delegated underwriting and claims-handling authority arrangements are often used by Bermuda insurers and reinsurers. Such arrangements are necessarily subject to appropriate oversight by the insurers as part of their overall risk management and material out-

sourcing requirements, and as such do not generally result in particular litigated issues in Bermuda.

5. Claims Against Insureds

5.1 Main Areas of Claims Where Insurers Fund the Defence of Insureds

Coverage for defence costs is provided in many types of liability policy, including professional indemnity and director's and officer's insurance policies. Different policies can provide for defence costs, in addition to the policy limit or within it.

In the context of Bermuda Form policies, defence cost coverage is often provided by way of endorsement.

5.2 Likely Changes in the Future

There is no indication that there will be any change in defence costs coverage in the coming years.

5.3 Trends in the Cost or Complexity of Litigation

The COVID-19 pandemic made it necessary for court proceedings to take place remotely, and the courts have maintained the ability to hear matters in this way. This has permitted judges to sit remotely, which has allowed for more efficient use of the court's resources. It has also allowed for clients, overseas counsel and even witnesses to attend hearings remotely when they would ordinarily have flown to Bermuda to attend.

In 2024, both the Supreme Court and the Court of Appeal introduced significantly higher court fees for court filings.

5.4 Protection Against Costs Risks

Bermuda has no third-party funding legislation but these arrangements are permitted in Bermuda, having been accepted by the courts, which have rejected arguments that such arrangements are unlawful.

Third-party funding can be used by any party and in any amount.

Contingency fees are prohibited in Bermuda by the Barristers' Code of Professional Conduct 1981, Rule 96.

6. Insurers' Recovery Rights

6.1 Right of Action to Recover Sums From Third Parties

Insurance contracts are contracts of indemnity and, as a matter of Bermuda law, an insurer has equitable rights of subrogation – ie, an insurer can receive recoveries from third parties that would serve to reduce the insured loss and bring proceedings in the name of the insured against liable third parties, having provided contractual indemnification to the insured.

6.2 Legal Provisions Setting Out Insurers' Rights to Pursue Third Parties

There is no legislative codification of subrogation rights in Bermuda – a court will consider the terms of the contract and apply common law principles. Subrogation claims are made in the name of the insured.

7. Impact of Macroeconomic Factors

7.1 Type and Amount of Litigation

Insurers and reinsurers in Bermuda continue to monitor and navigate the effects of the COVID-19 pandemic, and the extent of reinsurance disputes that may reach Bermuda for resolution remains to be seen.

With respect to the war in Ukraine, issues arise in Bermuda from the registration of Russian aircraft in the jurisdiction. The sanctions levied against Russian and Belarusian entities have caused issues for Bermuda insurers and other financial institutions to address, including with the regulatory authorities.

Bermuda's reinsurance sector is also uniquely exposed to the rise in natural catastrophes, particularly hurricanes in North America.

Each of these unprecedented factors creates an environment for insurance-related disputes. However, it is difficult to measure the impact in light of the preponderance of arbitrations for the resolution of insurance and reinsurance disputes.

7.2 Forecast for the Next 12 Months

It is conceivable that the Bermuda insurance market could be exposed to unique and novel claims and

disputes in the coming year, in response to the evolving risks from industries such as digital assets and licensed cannabis cultivation, each of which can be insured in Bermuda. Cyber perils also continue to present new and developing challenges to insurers globally, particularly with the growth of AI technologies, and Bermuda is no different.

Bermuda's segregated accounts regime is another area that could create additional disputes. The BMA is expected to issue a Guidance Note outlining its expectations for companies using segregated accounts to conduct regulated insurance business, a draft of which has been in circulation amongst the industry during 2025. This is likely to become effective towards the end of 2025 or at the beginning of 2026.

Along with the Incorporated Segregated Accounts Companies Act, which was enacted in 2019, these innovative ways of conducting insurance business in Bermuda have the potential to create novel disputed issues amongst counterparties and with regulatory authorities.

7.3 Coverage Issues and Test Cases

The Bermuda court gave important judgments in 2022 and 2023 regarding the integrity of the segregation of accounts regime, in *Ivanishvili v Credit Suisse Life (Bermuda) Ltd* [2022] SC Bda 56 Civ and in *Re Northstar Financial Services (Bermuda) Ltd and Omnia Ltd* [2023] SC Bda 57 Civ.

7.4 Scope of Insurance Cover and Appetite for Risk

Individual insurers will have varying lines of coverage and portfolios of risk, and the management of these will inevitably be impacted by specific and general market developments from time to time, including litigation developments.

The Bermuda reinsurance market has generally reported that the impact of the COVID-19 pandemic on the (re)insurance industry in particular remains uncertain. The potential scale of the losses is such that substantial capital retention is generally required until there is greater certainty, locking up capital that could otherwise be used to back new underwriting and thus exacerbating the demands on capital.

8. Emerging Risks

8.1 Impact of ESG on Underwriting and Litigating Insurance Risks

Bermuda reinsurers are required specifically to consider and address ESG risk as part of their overall risk management framework. Climate change risk in particular has been identified by the BMA as a significant financial risk to insurers and, as a result, the underlying stability of the financial sector. As such, in addition to the general assessment of ESG risks in the context of each insurer's business and operations, Bermuda insurers are expected specifically to take a proactive (and proportionate) approach to manage and, where possible, mitigate risks associated with climate change. This expectation applies to insurers in respect of both their underwriting activities and their operations and investments, and therefore can have a material impact on underwriting and risk management.

8.2 Data Protection Laws

While certainly important in its own right, Bermuda's data privacy laws (in particular, the Personal Information Protection Act 2016) are not generally expected to have a material impact on the underwriting and litigation of insurance risks by Bermuda insurers.

9. Significant Legislative and Regulatory Developments

9.1 Developments Affecting Insurance Coverage and Insurance Litigation

There have been a number of detailed changes to both the general business and long-term business insurance regulations that have an impact on the calculation of the relevant capital and solvency ratios. These changes to the capital model will likely have a general effect on the nature and extent of risks to be underwritten as capital needs adjust, but no overall impact on insurance coverage, insurance litigation or claims for which insurers will fund the defence is expected.

CHINA

Law and Practice

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W&H Law Firm

Contents

W&H Law Firm is a partnership firm that was established in early 1995, is headquartered in Beijing, and has domestic and international branches all over the world. Through growth and development over a period of 30 years, W&H Law Firm has become one of China's leading law firms. Taking a foothold in China while maintaining a global vision, W&H Law Firm's legal service domain has been growing on a worldwide scale. The Shanghai office of W&H Law Firm was established in 2003 and is currently the firm's largest branch. Thanks to its rapid development during the past 22 years, including strenuous cultivation of the market in Yangtze River Delta, W&H Law Firm's Shanghai office has grown into a large and comprehensive law firm.

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1. Rules Governing Insurer Disputes

1.1 Statutory and Procedural Regime

The statutory regime that governs the resolution of insurance disputes in China comprises:

- the Civil Code of the People's Republic of China (the "Civil Code");
- the Insurance Law of the People's Republic of China (the "Insurance Law");
- the Interpretations of the Supreme People's Court on Several Issues Concerning the Application of the Insurance Law of the People's Republic of China;
- the Maritime Law of the People's Republic of China (the "Maritime Law"); and
- other administrative regulations promulgated by the State Council and rules issued by the National Financial Regulatory Administration (NFRA), as well as local regulations implemented by various regional authorities.

The procedural regime that governs the resolution of insurance disputes in China includes:

- the Civil Procedure Law of the People's Republic of China (the "Civil Procedure Law");
- the Special Maritime Procedure Law of the People's Republic of China (the "Maritime Procedure Law"); and
- the Arbitration Law of the People's Republic of China (the "Arbitration Law").

1.2 Litigation Process and Rules on Limitation

The litigation process in China consists of the following procedures.

- Case filing – when a party submits a statement of claim to a court with proper jurisdiction and meets the filing requirements, the court must decide whether to accept the case within the statutory time limit. Once accepted, the court will serve a copy of the complaint and a summons to the defendant.
- Trial – civil cases generally follow the ordinary procedure, which includes pre-trial preparation, court hearings, evidence examination, and arguments. For less complex cases, simplified procedures or small claims procedures may be applied.
- Enforcement – after a judgment becomes effective, if the losing party fails to fulfil their obligations, the winning party may apply to the court for enforcement. The enforcement court will then take measures such as investigating assets and sealing, seizing or auctioning property.

General Rules on Limitation

Article 188 of the Civil Code stipulates that the statute of limitations for filing a civil claim with the court is three years, unless otherwise provided by law. The the statute of limitations begins on the date when the right-holder knows or should have known that their right has been infringed and who the obligor is. However, if 20 years have passed since the infringement, the court will no longer protect the right unless excep-

tional circumstances exist. In such cases, the court may – upon the claimant's request – extend the the statute of limitations.

Statute of limitations under Insurance Law

According to Article 26 of the Insurance Law, for insurance types other than life insurance, the insured or beneficiary has a period of two years in which to claim compensation or payment from the insurer. This period starts from the date they knew or should have known that the insured event occurred. For life insurance, the insured or beneficiary has five years to file such claims, starting from the date they knew or should have known that the insured event occurred.

1.3 Alternative Dispute Resolution (ADR)

In China, ADR mechanisms are not only widely highlighted but also continuously promoted at the institutional level. For a long time, China has been committed to developing a diversified non-litigation dispute resolution system that operates in parallel with litigation. This includes various forms such as people's mediation, administrative mediation, arbitration, notarisation, administrative adjudication, and administrative reconsideration. These mechanisms play an active role in resolving different types of disputes and have formed a multi-level and broad-coverage dispute resolution system.

At the same time, Chinese traditional culture has long valued reconciliation, prizing the concepts of "harmony is precious" and "no litigation". As such, litigation is viewed as a disruption of social harmony. Mediation and settlement are considered more aligned with social stability and the proper handling of interpersonal relationships. This cultural foundation has provided fertile ground for the development of ADR in China.

Main Forms of ADR in China

To further improve the diversified dispute resolution system, on 28 June 2016, the Supreme People's Court of the People's Republic of China (the "Supreme People's Court") issued the Opinions on Further Deepening the Reform of the Diversified Dispute Resolution Mechanism in People's Courts. The document explicitly states the need to rationally allocate social resources for dispute resolution and promote the organic connection and co-ordinated development between settlement, mediation, arbitration, notarisation, administrative adjudication, administrative reconsideration, and litigation. It also emphasises the leading, driving and safeguarding role of the judiciary in building the ADR system.

Currently, the most common and widely used forms of ADR in China include people's mediation, judicial mediation, settlement, and arbitration. China's ADR system has received strong support at both the policy and institutional levels and is playing an increasingly important role in judicial practice – becoming an essential part of building an efficient, diversified and mutually beneficial dispute resolution framework.

2. Jurisdiction and Choice of Law

2.1 Rules Governing Insurance Disputes

Insurance disputes must adhere to the rules of exclusive, hierarchical and territorial jurisdiction stipulated in the Civil Procedure Law, as follows.

- Exclusive jurisdiction – disputes involving real estate fall under the jurisdiction of the people's court where the property is located. Similarly, lawsuits arising from port operations fall under the jurisdiction of the people's court where the port is located.
- Hierarchical jurisdiction – China's court system comprises four levels (namely, primary people's courts, intermediate people's courts, high people's courts, and the Supreme People's Court). The court level responsible for the first-instance trial of an insurance dispute is generally determined based on the dispute's significance and the amount involved.
- Territorial jurisdiction – generally, jurisdiction over insurance contract disputes lies with the people's court where the defendant's domicile is located or where the insured subject matter (property or person) is located.

Choice of Law

In China, disputes over marine insurance are governed by the Maritime Law, whereas other types of property insurance and life insurance disputes fall under the Insurance Law.

For foreign-related insurance disputes, Article 41 of the PRC Law on the Application of Laws to Foreign-Related Civil Relations applies – the parties may negotiate and choose the applicable law. If the parties make no choice, the law of the habitual residence of the party whose performance of obligations is most characteristic of the contract – or other laws most closely connected to the contract – shall apply.

2.2 Enforcement of Foreign Judgments

According to Articles 298 to 300 of the Civil Procedure Law, a final and effective judgment rendered by a foreign court may be recognised and enforced in China if the following conditions are met.

- There is an applicable international treaty between China and the foreign country (or a reciprocal relationship exists between the two jurisdictions).
- The judgment does not violate the fundamental principles of Chinese law and does not prejudice China's sovereignty, security, or public interest.
- The foreign court had proper jurisdiction.
- The respondent was lawfully summoned and given a reasonable opportunity to present arguments and defend their rights, and any party lacking legal capacity was properly represented.
- The judgment was not obtained by fraud and does not duplicate a Chinese judgment or one already recognised by China from a third country regarding the same dispute.

If the above-mentioned conditions are satisfied, an insurer – as a party to the judgment – may apply for recognition and enforcement of the foreign judgment before a Chinese court and likewise may be subject to enforcement based on such judgment.

2.3 Unique Features of Litigation Procedure

Unlike common law jurisdictions, Chinese courts do not adopt a discovery procedure. Parties are responsible for submitting evidence within the time limits prescribed by the court. In general, the plaintiff is required to submit preliminary evidence at the time of filing, whereas the defendant must complete their evidentiary submissions during the period for filing a statement of defence.

In cross-border insurance disputes, all non-Chinese documents must be accompanied by Chinese translations.

Statute of Limitations in Insurance Disputes

As discussed in **1.2 Litigation Process and Rules on Limitation** (General Rules on Limitation), according to the Insurance Law, for insurances other than life insurance, the statute of limitations for the insured or the beneficiary to claim indemnity from the insurer is two years – starting from the date on which the insured or the beneficiary knew or should have known that the insured event occurred. For life insurance, the statute of limitations is five years, starting from the same date.

However, according to the Civil Code, the statute of limitations is three years. Thus, whether the statute of limitations for insurance types other than life insurance is two or three years is currently a matter of dispute.

3. Arbitration and Insurance Disputes

3.1 Enforcement of Arbitration Provisions in Commercial Contracts

In general, Chinese courts will enforce arbitration provisions in insurance and reinsurance contracts, provided the arbitration agreement is valid. Under the Arbitration Law and the Civil Procedure Law, a valid arbitration agreement must include the following elements:

- an expression of intent to arbitrate;
- a clearly defined arbitration matter; and
- a designated arbitration commission or institution.

Where these conditions are satisfied, Chinese courts typically will respect the parties' autonomy and enforce such arbitration provisions.

3.2 The New York Convention

China acceded to the Convention on the Recognition and Enforcement of Foreign Arbitral Awards 1958 (the "New York Convention") in 1986. Upon accession, China made two reservations pursuant to Article I(3) of the New York Convention:

- principle of reciprocity – China will only recognise and enforce arbitral awards made in the territory of other contracting states; and
- commercial reservation – China will apply the New York Convention only to arbitral awards arising from legal relationships (whether contractual or not) that are considered commercial under Chinese law.

According to the Civil Procedure Law, a party seeking recognition and enforcement of a foreign arbitral award must file an application directly with the intermediate people's court at the place where the respondent is domiciled or where the respondent's property is located. The application for recognition and enforcement of a foreign arbitral award must be submitted within two years from the last date for performance as specified in the award.

3.3 The Use of Arbitration for Insurance Dispute Resolution

Arbitration is indeed a significant form of insurance dispute resolution in China. It is particularly common in the following lines of business:

- reinsurance contracts;
- large-scale property insurance, such as in the energy, marine and aviation sectors; and
- cross-border or international insurance contracts.

Disputes in these sectors typically involve high-value claims and complex legal or technical issues, leading parties to prefer arbitration for its efficiency, expertise, and procedural flexibility.

The legal framework governing arbitration in China includes:

- the Arbitration Law;
- the Civil Procedure Law; and
- the specific arbitration rules of various arbitration institutions (eg, the China International Economic and Trade Arbitration Commission (CIETAC) Arbitration Rules).

Arbitration proceedings in China are private and confidential. Moreover, arbitration in China is final and binding – that is, there is no right of appeal. An award may only be challenged through a limited set of grounds in a set-aside application (eg, invalidity of the arbitration agreement or serious procedural irregularities).

4. Coverage Disputes

4.1 Implied Terms

According to Chinese law, certain terms – although not expressly stipulated in the insurance contract – may nonetheless be implied into the contract by operation of law and are legally binding on both parties. These implied terms are primarily derived from the Insurance Law and relevant judicial interpretations and are deemed to be inherently applicable to insurance contracts.

Commonly implied terms include the following.

Duty to Highlight and Explain Standard Exemption Clauses

The insurer must draw the policyholder's attention to any standard exemption clauses and explain them clearly in a reasonable manner. Otherwise, such clauses shall not be effective (see Article 17 of the Insurance Law).

Insurable Interest Principle

Insurable interest refers to a legally recognised interest that the policyholder or the insured holds in the subject matter of the insurance. The principle of insurable interest requires that, in personal insurance, the policyholder must have an insurable interest in the insured at the time of contract formation – in property insurance, the insured must have an insurable interest in the insured subject matter at the time of the occurrence of the insured event. This principle is designed to prevent moral hazard and wagering on insurance.

Utmost Good Faith Principle

Also known as the principle of uberrimae fidei, this principle requires both parties to the insurance contract to act honestly and disclose all material facts in the process of contract formation and performance. Neither party shall misrepresent or conceal material information.

Indemnity Principle

This principle applies only to property insurance and not to life insurance. It means that, in the event of a covered loss, the insurer is obligated to indemnify the insured for the actual loss sustained – within the scope of the insured amount – and the insured is not entitled to profit from the insurance.

Proximate Cause Principle

The insurer is liable only when the proximate cause of the loss falls within the scope of insured risks. Proximate cause refers to the most direct, dominant and effective cause that leads to the occurrence of the insured loss, among a chain of contributing factors.

4.2 Rights of Insurers

In China, insurers have the following rights concerning the presentation of the risk prior to the inception of the insurance policy.

- The right to require disclosure of material facts – prior to the conclusion of the insurance contract, the insurer has the right to enquire about relevant information concerning the insured or the subject matter of insurance. The applicant (policyholder) is obligated to make truthful disclosures in response to such enquiries.
- The right to refuse coverage or rescind the contract – if the applicant intentionally or owing to gross negligence fails to fulfil the duty of disclosure, and such failure is sufficient to affect the insurer's decision to underwrite the risk or determine the premium rate, the insurer has the right to rescind the insurance contract.
- The right to assess risk and determine premiums – based on the risk-related information provided by the applicant, the insurer has the right to determine whether to accept the risk, under what terms to provide coverage, and how to set the premium rate, sum insured, and the scope of coverage.

4.3 Significant Trends in Policy Coverage Disputes

Surge in Liability Insurance Litigation

Courts are seeing a marked uptick in claims under professional liability, public liability and product liability policies. The growth tracks the rapid penetration of liability products as Chinese corporates become more risk-aware, but it has also produced a corresponding rise in coverage fights – especially over policy triggers, aggregate limits and the scope of "business activities" clauses.

Fire Insurance Disputes Climb Alongside e-Commerce Logistics

China's booming online retail and warehousing sector has driven more property insurance placements. A spate of warehouse fires has triggered a wave of fire insurance claims and ensuing litigation, centring on questions of under-insurance, adequacy of risk disclosures, and whether standard fire exclusions for certain stored goods apply.

Personal Accident Claims From the "New Employment" Workforce

Driven by government requirements to protect gig economy workers, platform companies have rolled out group personal accident and term life schemes for delivery riders, ride-hail drivers and other freelancers. The volume of bodily injury and death benefit claims under these programmes has jumped, leading to disputes over the definition of "work-related" accidents, territorial limits, and the interplay between statutory compensation and private insurance.

4.4 Resolution of Insurance Coverage Disputes

Insurance coverage disputes are generally resolved via the following methods in China.

- Negotiation – in the event of a dispute over insurance coverage between the insurer and the insured or beneficiary, the parties will typically first attempt to resolve the matter through negotiation. This is generally the most cost-effective and efficient method, and many disputes are resolved during the negotiation stage.
- Arbitration – where the insurance contract contains a valid arbitration clause, the parties are required to submit the dispute to the designated arbitral institution in accordance with the agreed terms. Arbitration is characterised by its finality and confidentiality and is well-suited to disputes involving technical or commercial complexity.
- Litigation – if the parties fail to reach an agreement through negotiation or mediation and no valid arbi-

tration clause exists, the dispute may be brought before a competent court. Litigation tends to be more time-consuming.

Resolution of Reinsurance Disputes

Reinsurance contracts often involve international reinsurers and high-value claims and, as such, their dispute resolution mechanisms tend to be more international in nature. In practice, reinsurance agreements frequently provide for the application of foreign laws (such as English or Singapore law) and resolution through international arbitration. Commonly selected arbitral institutions include the LCIA, the Singapore International Arbitration Centre (SIAC), and the Hong Kong International Arbitration Centre (HKIAC). Reinsurance disputes are generally more complex, both legally and procedurally, and require a higher degree of specialisation and cross-border legal expertise compared to direct insurance disputes.

4.5 Position If Insured Party Is Viewed as a Consumer

In China, although the law does not distinguish between consumer insurance contracts and commercial insurance contracts, when the insured party is regarded as a consumer, their legal position differs significantly from that of professional parties in insurance contracts. The key differences are as follows.

- Contract interpretation favours the consumer – any ambiguity in the standard terms of insurance contracts must be interpreted against the insurer and in favour of the consumer.
- Stricter disclosure obligations for exclusion clauses – Article 17 of the Insurance Law requires insurers to highlight exclusion clauses conspicuously and to explain them clearly to the consumer. Failure to do so renders the clause unenforceable.
- Dispute resolution mechanisms favour consumers – consumers may file complaints with financial regulators (eg, the NFRA), which often take proactive measures to protect consumer rights. Consumer protection rules may also apply in litigation.

Therefore, insured parties identified as consumers enjoy a higher level of legal protection under Chinese law.

4.6 Third-Party Enforcement of Insurance Contracts

Under Chinese law, a third party may – in certain circumstances – enforce an insurance contract or bring a claim against the insurer. The main scenarios include the following.

- Named beneficiaries in life insurance contracts – in life insurance contracts where a beneficiary is expressly designated, the beneficiary may claim the insurance proceeds directly from the insurer after the occurrence of the insured event.
- Direct action by third parties in liability insurance – according to Article 65 of the Insurance Law, in liability insurance, if the insured causes damage to a third party, the insurer may directly compensate the third party in accordance with the law or the contract. Once the insured's liability to the third party is established, the insurer must directly compensate the third party at the insured's request. If the insured fails to make such a request, the third party may directly claim compensation from the insurer for the amount they are entitled to.
- Assignment of insurance proceeds to third parties – in commercial transactions, if the right to claim insurance proceeds is lawfully assigned to a third party (such as a mortgagee or a financing party), that third party may enforce the assigned rights against the insurer and claim the insurance proceeds directly.

4.7 The Concept of Bad Faith

In Chinese judicial practice, "bad faith" refers to a situation where a party harms the legitimate interests of others intentionally or owing to gross negligence. This concept is reflected across various areas of law, including civil law and insurance law, as follows.

Bad Faith Under the Civil Code

The Civil Code contains multiple provisions that explicitly address and regulate acts conducted in bad faith, including but not limited to the following.

- Collusion between parties – where a party colludes with the counterparty in bad faith to infringe upon the lawful rights and interests of others, the resulting civil legal act will be deemed invalid.

- Bad faith agency – where an agent colludes with the counterparty in bad faith to harm the interests of the principal, both the agent and the counterparty will bear joint and several liability.
- Bad faith possession – where a possessor causes damage to immovable or movable property during possession, and the possession is in bad faith, the possessor will be liable for damages.

Bad Faith Under the Insurance Law

The Insurance Law addresses acts conducted in bad faith both by the policyholder and by the insurer, as follows.

Bad faith on the part of the policyholder

According to the Insurance Law, if a policyholder intentionally or owing to gross negligence fails to fulfil the duty of disclosure, and such omission is sufficient to affect the insurer's decision on whether to underwrite the risk or adjust the premium rate, the insurer is entitled to rescind the contract. If the policyholder intentionally breaches the duty of disclosure, the insurer will not be liable for any insurance accident occurring before the rescission of the contract, and the paid premium will not be refunded.

Bad faith on the part of the insurer

Although the Insurance Law does not explicitly use the term "bad faith" to regulate insurers' conduct, under the general principle of good faith and relevant judicial practice, an insurer that unreasonably delays or refuses to pay a claim may be deemed in breach of contract.

4.8 Penalties for Late Payment of Claims

If an insurer delays the payment of a claim, it may be subject to the following legal liabilities and regulatory penalties.

- Civil liability – if the insurer fails to conduct a timely assessment or fails to fulfil its obligation to pay compensation or insurance benefits after receiving a claim from the insured or beneficiary, it must not only pay the insurance proceeds but also compensate the insured or beneficiary for any actual losses suffered as a result.
- Regulatory penalties – if an insurer refuses to fulfil its contractual obligation to pay compensation or insurance benefits in accordance with the law, the NFRA has the power to order rectification and may impose a fine ranging from RMB50,000 to RMB300,000. In serious cases, the regulator may impose additional measures, such as restricting the insurer's business scope, ordering a suspension of new business, or even revoking the insurer's business licence.

4.9 Representations Made by Brokers

Under Chinese law, whether an insured is bound by the representations of its insurance broker depends primarily on whether the broker had valid authority and whether the act in question was carried out within the scope of such authority. In determining whether such legal effect arises, courts will take into account factors such as the source and scope of the broker's authority, the insured's fault or acquiescence, and the insurer's duty to verify the existence of the agency relationship.

4.10 Delegated Underwriting or Claims Handling Authority Arrangements

In China, delegated underwriting and claims handling arrangements are common in the insurance industry, particularly in collaborations between insurers and insurance agents, brokers, or third-party service providers. These arrangements are typically based on contractual agreements and aim to enhance operational efficiency and expand service coverage.

Despite their prevalence in practice, such arrangements may give rise to legal disputes in certain circumstances – for example, when the delegated party acts beyond its authorised scope, provides substandard services, fails to adequately disclose information, or lacks proper licensing qualifications. In judicial practice, courts usually assess these cases by examining factors such as the scope of delegated authority, the insured's reasonable reliance, and the insurer's duty of oversight and internal control.

In recent years, regulatory authorities have strengthened supervision over intermediary cooperation and third-party outsourcing. Insurers are encouraged to establish robust compliance systems and enhance transparency to mitigate the risk of disputes arising from delegated authority arrangements.

5. Claims Against Insureds

5.1 Main Areas of Claims Where Insurers Fund the Defence of Insureds

In China, claims where insurers fund the defence of insureds most commonly arise in liability insurance lines, particularly product liability insurance, professional indemnity insurance, etc. Article 66 of the Insurance Law sets out a clear principle in respect of liability insurance: unless otherwise agreed, the insurer shall bear the arbitration or litigation expenses and other necessary and reasonable expenses paid by the insured party.

However, whether the attorney's fees fall within the scope of necessary and reasonable expenses the insurer must bear – as stipulated in Article 66 of the Insurance Law – has long been a subject of contention between insurers and insureds, both in contractual drafting and judicial interpretation. Whether the insurer is obligated to fund the defence (and to what extent) depends on the policy wording, statutory interpretation under Article 66 of the Insurance Law, and the court's assessment of the enforceability of relevant exclusion clauses.

5.2 Likely Changes in the Future

In the coming years, the rules governing the insurer's obligation to fund defence costs are expected to become more standardised and increasingly favourable to insureds. The main reasons for this trend are as follows.

- Stricter regulatory oversight – regulatory authorities have been emphasising the insurer's duty to adequately disclose and explain exclusion clauses, thereby restricting the excessive use of defence cost exclusions.
- Judicial tendency to protect insureds – courts in China are increasingly inclined to support the reimbursement of reasonable defence-related expenses, such as legal and appraisal fees, even where policy exclusions exist.
- Market and client-driven demands – corporate insureds are placing greater emphasis on securing defence cost coverage, prompting insurers to revise and refine their product offerings accordingly.
- Influence of international practices and cross-border litigation – in cross-border product liability insurance or cases involving foreign insureds, policyholders often expect protection aligned with the "duty to defend" model commonly seen in common law jurisdictions. As China continues to engage in international legal co-operation, the domestic insurance market may gradually align its policy design with global standards.

5.3 Trends in the Cost or Complexity of Litigation

In recent years, litigation in China concerning whether insurers are liable for insureds' defence costs has shown a clear trend of increasing in both cost and complexity. This trend is driven by the following key factors.

- Refined judicial standards and fee categorisation – courts are increasingly inclined to classify legal fees, appraisal fees, and other costs into distinct categories for separate evaluation, making the litigation process more complex.
- Rising claim amounts by insureds – as liability insurance coverage expands, insureds (particularly corporate policyholders) are asserting higher amounts for defence-related expenses.
- Inconsistent judicial interpretations – courts in different jurisdictions continue to apply varying standards when assessing the validity of defence cost exclusions and the insurer's duty to disclose such clauses, leading to unpredictability in outcomes.

However, with regulators emphasising clause transparency and the insurer's duty to provide adequate notice, and with growing market demand for defence cost coverage, such disputes may gradually decrease. As a result, the upwards trend in cost and complexity may level off within the next five years.

5.4 Protection Against Costs Risks

In China, claimants generally cannot obtain commercial insurance coverage to specifically protect against the costs risks associated with litigation, as the Chinese legal system has not yet widely adopted litigation costs insurance schemes similar to those in the UK and other jurisdictions.

6. Insurers' Recovery Rights

6.1 Right of Action to Recover Sums From Third Parties

Under Chinese law, where a third party causes damage to the insured subject matter resulting in an insured loss, the insurer – upon payment of insurance proceeds to the insured – is subrogated to the insured's right to claim compensation from the third party, up to the amount of the indemnity paid.

6.2 Legal Provisions Setting Out Insurers' Rights to Pursue Third Parties

The insurer's right to pursue third parties is set out in Article 60 of the Insurance Law. The insurer is entitled to bring a subrogation claim in its own name.

7. Impact of Macroeconomic Factors

7.1 Type and Amount of Litigation

In recent years, major events such as the COVID-19 pandemic and the war between Russia and Ukraine have had a significant impact on the volume and type of litigation in China, particularly with regard to insurance-related disputes. The main developments in this respect are as follows.

Impact of COVID-19 Pandemic

Insurance-related litigation has been affected by the pandemic in the following ways.

- Increase in property insurance claims and business interruption insurance claims – many businesses filed claims due to shutdowns or interruptions during the pandemic, raising disputes over whether infectious disease constitutes an insured peril. Courts have been divided on the issue, with some holding it to fall within exclusion clauses, whereas others have favoured the interests of the insured.
- Disputes under health and accident insurance policies – a rise in claims has been seen where insureds died from or were severely affected by COVID-19, entailing debates over the scope of coverage and the definition of illness.
- Rise in contract interpretation disputes – issues such as whether the pandemic constitutes a "material change" or "force majeure", and whether insurers may deny coverage or terminate policies on that basis, have been increasingly litigated.

Impact of War in Ukraine

The consequences of Russia's invasion of Ukraine have affected insurance-related in the following ways.

- Increase in marine and cargo insurance claims – with rising geopolitical risks, especially in cross-border trade and transport, claimants have filed for losses arising from delays, damage, or detention of goods. These claims often involve the interpretation of war exclusions or force majeure clauses.
- Disputes in aviation insurance and reinsurance – some Chinese aircraft lessors leased aircraft to Russian lessees who have refused to return the aircraft owing to sanctions and the ongoing conflict, giving rise to significant claims under all-risks insurance policies and war-risk insurance policies.

7.2 Forecast for the Next 12 Months

Given that the COVID-19 pandemic is now over, the number of related insurance litigations is expected to decrease during the next 12 months. Meanwhile, disputes arising from the Russia–Ukraine conflict are likely to continue, particularly in the areas of marine insurance, aviation insurance, and reinsurance.

7.3 Coverage Issues and Test Cases

Factors such as the COVID-19 pandemic, the Russia–Ukraine conflict, and China–USA trade tensions have indeed given rise to a number of significant insurance coverage issues and judicial test cases in recent years. These developments have had a substantial impact on insurance practice and legal adjudication, particularly in the area of contractual liability and coverage interpretation.

Insurance Coverage Disputes Caused by COVID-19

Taking the COVID-19 pandemic as an example, a large number of contractual disputes emerged due to the pandemic itself or the associated containment measures. In response, the Supreme People's Court issued authoritative guidance, clarifying how such cases should be handled.

Unless otherwise agreed by the parties, courts should comprehensively consider the varying effects of the pandemic across different regions, industries, and case types. A key focus is determining the causal relationship and the degree of impact between the pandemic (or related control measures) and the failure to perform contractual obligations. The Supreme People's Court provides the following guidance in this regard.

Failure to perform contractual obligations

Where the pandemic or its control measures directly result in non-performance of contractual obligations, courts may apply the doctrine of force majeure to partially or fully exempt a party from liability, depending on the extent of the impact. However, if a party contributes to the non-performance or aggravates the loss, the party will remain liable to that extent. A party claiming force majeure must also bear the burden of proving that they fulfilled their duty to provide timely notice.

Difficulty in performing contractual obligations

Where the pandemic only makes it difficult to perform contractual obligations, the parties are encouraged to renegotiate. Courts should facilitate mediation and support continued performance where feasible. Claims for the termination of a contract merely due to hardship will generally not be upheld.

However, if the obligation to perform becomes manifestly unfair on one party, the court may support adjustments to performance terms (eg, deadline, method, or price). Once a contract has been legally modified, further claims for liability exemption will not be supported. If the pandemic renders the contract's purpose unachievable, a termination claim will be upheld.

7.4 Scope of Insurance Cover and Appetite for Risk

Factors such as the COVID-19 pandemic, China–USA trade tensions, and the Russia–Ukraine conflict have significantly affected both the scope of insurance coverage available and insurers' risk appetites. On the one hand, insurers have generally tightened coverage in response to events such as pandemics and wars – for example, by introducing exclusions related to infectious diseases or the risk of war.

On the other hand, insurers have become more cautious in underwriting risks in high-risk industries and regions. In many cases, premiums have increased, deductibles have been raised, and coverage is now subject to more stringent terms and claims conditions.

8. Emerging Risks

8.1 Impact of ESG on Underwriting and Litigating Insurance Risks

In recent years, ESG factors have played an increasingly important role in China's insurance industry, progressively influencing both underwriting and claims practices.

In underwriting, insurers have placed greater emphasis on identifying and managing environmental and social risks. By way of example, in the renewable energy, green construction, and ecological protection sectors, insurers have developed innovative products such as green insurance and carbon sink insurance. On the asset side, insurers have scaled up green investments, aligning underwriting with sustainable finance. ESG scores are also being adopted as reference criteria for underwriting and pricing decisions, thereby encouraging insureds to improve their ESG performance.

In claims handling and dispute resolution, ESG considerations are becoming relevant to determining the scope of coverage. In liability cases involving environmental pollution or labour issues, courts and arbitration bodies may assess whether the insured fulfilled their environmental or social obligations, which in turn may impact the insurer's indemnity obligations and settlement terms.

Overall, insurers are not only implementers of ESG principles but also key enablers of ESG adoption across the economy. As regulatory frameworks evolve, ESG considerations are expected to exert a lasting impact on risk assessment, product development, and claims resolution within the insurance sector.

8.2 Data Protection Laws

In providing insurance services, insurers must process a substantial amount of personal information relating to policyholders, insureds, and beneficiaries. This data is not only voluminous but also spans the entire operational process, including underwriting, claims handling, and policy administration.

In the underwriting phase, insurers are required under the Personal Information Protection Law (PIPL) to strictly fulfil their duty of notification prior to processing personal data. They must ensure that the collection, storage and use of personal information complies with the law. Given that offline channels remain the dominant distribution method in China's insurance sector, insurers must harmonise data-handling rules across both online and offline channels and clearly delineate the legal bases for data processing in scenarios where consent is not required (eg, compliance with statutory obligations).

In the context of litigation and dispute resolution, issues such as data breaches and misuse of personal information have increasingly emerged as central points of contention in insurance-related disputes. The PIPL significantly strengthens enforcement, including higher penalties for violations and the introduction of public interest litigation for mass infringements. As a result, insurers are required to enhance their internal data governance frameworks, improve authorisation protocols, and implement robust risk-control mechanisms.

Moreover, inconsistencies between the Insurance Law and the PIPL present ongoing compliance challenges. Key issues include the lack of clear upper limits on data retention periods, uncertainty regarding the scope of information to be shared in reinsurance transactions, and the absence of defined obligations for insurance agents to return or delete personal data after termination of engagement. As regulatory scrutiny intensifies, personal data protection will increasingly become a focal point in the compliance and legal risk-management strategies of insurance institutions.

9. Significant Legislative and Regulatory Developments

9.1 Developments Affecting Insurance Coverage and Insurance Litigation

According to the official website of the NFRA, a total of 28 insurance-related regulatory documents were issued in 2024. These include key rules such as the Regulatory Rating Measures for Life Insurance Companies, the Measures for the Exercise of Discretion in Administrative Penalties, the Guidelines on Promoting High-Quality Development of Green Insurance, the Anti-Insurance Fraud Measures, and the Implementation Opinions on Accelerating the Development of Shanghai as an International Reinsurance Centre. These developments are expected to significantly impact the scope of insurance coverage, the handling of insurance litigation, and the insurer's obligation to fund defence costs.

By way of further example, in July 2025, the NFRA promulgated the Administrative Measures for the Suitability of Financial Institution Products (the "Suitability Measures"). Effective from 1 February 2026, the Suitability Measures emphasise the fulfilment of insurers' obligations and the protection of the interests of the insured.

In addition, in May 2024, the General Office of the State Council issued its Annual Legislative Work Plan, which includes a proposal to submit the fifth amendment to the Insurance Law to the Standing Committee of the National People's Congress for review. The amendment is intended to address key operational, regulatory and risk-resolution challenges currently faced by the insurance sector. It aims to fill regulatory gaps and provide a stronger legal framework to support the high-quality development of the insurance industry. Once enacted, this amendment may have material implications for insurance contract interpretation, the allocation of coverage, the insurer's duty to defend, and the litigation landscape more broadly.

Trends and Developments

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AnJie Broad Law Firm has an insurance practice team that assists clients in a wide range of service areas, including insurance M&A, the establishment and compliance operations of insurance institutions, and finance work. The firm provides accurate policy advice and first-class dispute resolution services across numerous policy types and market sectors. Insurance dispute resolution is a core practice area and a team priority. Its team of more than 50 lawyers consistently acts on the toughest arbitration cases at the forefront of insurance dispute resolution, as well as property insurance claims disputes, life insurance claims disputes, insurer subrogation disputes, reinsurance contract disputes, insurance fund product disputes, and insurance institution investment disputes. AnJie Broad Law Firm can offer both local insights and global reach, and has established an extensive co-operative network with first-class law firms in the USA, the UK, Germany, France, Canada, Australia, Japan, South Korea, and other states and regions, which allows the firm to deliver top-tier global insurance-related legal services.

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The Changing Face of Chinese Insurance Disputes

The insurance industry is an important pillar of financial and social security systems, and China's insurance industry has undergone rapid development in recent years. As of 31 December 2024, there were 349 members of the Insurance Association of China (IAC) – of which, 13 were insurance group (holding) companies, 86 were property insurance companies, 93 were life insurance companies, 14 were reinsurance companies, 18 were insurance asset management companies, and 71 were insurance intermediaries.

In addition to the members of the IAC, there are other asset management companies and insurance intermediaries acting in the market. According to data released by the National Financial Regulatory Administration, the primary insurance premium income from January to May 2025 totalled RMB3,060.2 billion.

With the continuous development of the insurance industry, the number of insurance litigation cases is also growing. As of July 2025, there were more than one million litigation cases concerning insurance disputes in the China Judgments Online Database, mainly involving disputes over property insurance policies and life insurance policies, as well as some subrogation cases and a small number of insurance premium disputes cases. Litigation and arbitration are still the main ways to resolve insurance disputes; however, the surge in insurance disputes has created a demand for the development of various dispute settlement systems.

Emergence of new types of insurance litigation in China

Disputes may arise regarding all aspects of the formation and performance of insurance policies, such as:

- the determination of the validity and the application of the exclusion clause;
- whether the insurer meets its obligation to provide an explicit explanation of the meaning of the exclusion clause;
- whether the incident is covered by the insurance policy; and
- whether the calculation of the loss is accurate.

Insurance litigation cases regarding new types of insurance policies continue to emerge as well. In addition to disputes arising from traditional insurance policies (eg, motor vehicle liability insurance, work injury insurance, pension insurance and life insurance), cases related to cyber-insurance, D&O liability insurance and green agriculture insurance are also emerging. Insurance litigation regarding these new types of insurance policies may involve multiple legal relationships and complicated facts, thereby creating difficulties and challenges for law practitioners and adjudicators. Some new types of insurance litigation are set out in detail here.

Surge in securities class actions leads to rapid increase in claims and litigation cases relating to D&O liability insurance policies

With the official implementation of the new Securities Law of the People's Republic of China in March 2020, PRC supervisory departments have continued to make breakthroughs in clarifying the scope of directors' and officers' liability and the compensation for losses for which directors and officers are responsible, and have further strengthened the recourse against actual controllers of listed companies.

In 2024, a total of 475 A-share listed companies disclosed plans to purchase D&O liability insurance, representing a year-on-year increase of 34%. Among them, 234 companies disclosed such plans for the first time. In the first half of 2025, more than 280 A-share listed companies issued announcements about the purchase of D&O liability insurance. This is primarily due to the intensified administrative supervision of listed companies and their directors, supervisors, and senior management, as well as the rising number of investor claims. In addition, the new Company Law of the People's Republic of China – which came into effect on 1 July 2024 – further strengthens the duties and liabilities of directors, supervisors, and senior executives, thereby significantly increasing their motivation to purchase D&O insurance.

Under the influence of the stricter regulation, the risk of litigation involving listed companies that concerns misrepresentation and fraudulent statements has risen, the standards that directors and officers must meet in performing their fiduciary duties have height-

ened, and the corresponding disputes over D&O liability insurance policies have increased. Compared with other liability insurance litigation, D&O liability insurance litigation has fewer referable precedents but involves more complex legal relationships and more difficulties in applying the law.

Situations will be more complex when foreign litigation procedures are involved. As many Chinese companies choose to be listed in stock markets outside Mainland China (eg, the Hong Kong Stock Exchange, the NYSE, or Nasdaq), the class actions and investigations brought against insureds in those jurisdictions will make the claims under D&O liability insurance policies even more challenging with regard to matters such as:

- whether penalties imposed by foreign regulators are covered under the D&O policy;
- how to apply foreign law for loss allocation when covered and uncovered insureds are both sued; and
- how to determine the reasonableness of the settlement amount entered in the proceedings in another jurisdiction when the D&O policy dispute is heard by a PRC court or arbitration tribunal.

Insurance litigation in the Internet Plus era

With the rapid development of internet services and the social economy, online sales of insurance products are expanding rapidly, creating new opportunities for the development of the insurance industry. According to the Interim Measures for the Supervision of the Cyber Insurance Business issued by the China Banking and Insurance Regulatory Commission (CBIRC) (the former China Insurance Regulatory Commission), insurance companies can operate cyber-insurance business in several areas, such as personal accident injury insurance, term-life insurance and whole-life insurance, household property insurance, and liability insurance.

In 2016, nearly 80% of Chinese insurance companies had started their cyber-insurance business through different business models, such as constructing their own websites or co-operating with third-party platforms. In 2024, the proportion of consumers purchasing insurance online has reached parity with offline channels. The online insurance purchase rate rose from 73% in 2023 to 78% in 2024, whereas the offline rate declined from 85% to 79% over the same period. Meanwhile, data suggests that online purchases are likely to surpass offline ones within the next two years.

The development of cyber-insurance without a well-established regulation system has triggered chaos. In 2019, the CBIRC and its branches received 19,900 consumer complaints about cyber-insurance, which represented a year-on-year increase of 88.59% and seven times the volume of complaints in 2016. The rapid growth correspondingly resulted in a surge in litigation cases related to cyber-insurance policies. The formation of a cyber-insurance policy is different to that of a traditional policy, so the disputes are usually related to the formation process.

According to Article 3 of the Interpretation of the Supreme People's Court on Several Issues Concerning the Application of the Insurance Law of the People's Republic of China (II) (amended in 2020), if the policyholder or the policyholder's agent does not sign or seal the insurance policy in person but the insurer or the insurer's agent signs or seals it on behalf of the policyholder, the policy should not take effect for the policyholder. However, if the policyholder pays the insurance premium after the insurer has signed the insurance policy on the policyholder's behalf, the payment should be regarded as the policyholder's retroactive recognition of the insurer's act of signing or stamping on behalf of the policyholder. Therefore, whether the electronic signature is provided by the policyholder themselves and whether the electronic signature is valid are significant in the formation and inception of cyber-insurance policies. The effectiveness of the cyber-insurance policy also depends on whether the policyholder pays the premium in full and on time through electronic payment.

According to Article 17 of the Insurance Law of the People's Republic of China (the "PRC Insurance Law"), an insurer should highlight for the attention of the policyholder clauses in an insurance policy that exclude the liability of the insurer on the insurance application form, insurance policy document or any other insurance certificate and should explain the contents of such clauses to the policyholder – either in writing

or verbally. Where there is no highlighting or explicit explanation, such clauses should be invalid. Owing to the convenient and efficient characteristics of purchasing cyber-insurance, policyholders frequently assert that insurers fail to fulfil their obligation under Article 17 of the PRC Insurance Law. Therefore, in cyber-insurance litigation, it is up to insurers to prove that they have fulfilled their obligation to inform the policyholder of the contents of the insurance policy truthfully via the internet sales platform.

Insurance litigation in the green economy

The demand for green insurance in the green financial market is increasing and agricultural insurance plays an essential role in the growth of green insurance in China. China is currently one of the leading countries in terms of its agricultural insurance premium income, which totalled RMB152.1 billion in 2024. Faced with the direct or indirect risks posed by global environmental pollution, climate change and natural disasters, the corresponding disputes over agricultural insurance policies have increased. The main features are as follows.

- First, agricultural insurance policies litigation usually comes in the form of a series of cases – ie, different plaintiffs in the same area bring separate litigation cases against the same insurer for similar facts and reasons.
- Second, agricultural insurance products are generally policy-oriented, and subsidies from the local government are granted for public interest considerations. The PRC's Regulations on Agricultural Insurance clearly stipulate that the local financial department is the administrative agency for agricultural insurance and thus the subsidies are determined by the local financial department. Therefore, when they hear the relevant cases, in addition to applying the PRC Insurance Law, the Civil Code of the People's Republic of China (the "Civil Code") and other laws, PRC courts also need to take into account the regulations issued by the local financial departments.
- Third, parties to agricultural insurance policies are prone to disputing the validity of the terms of the insurance policy and the manner of determining the loss resulting from incidents. In practice, the two main disputed focal issues are whether the loss has really occurred and whether there is a fraudulent claim.
- Lastly, because the insureds in agriculture insurance policies generally have low incomes and are in a relatively vulnerable position, the PRC courts tend to protect the interests of the insureds by taking into account the principle of equity.

Litigation property preservation liability insurance

Litigation property preservation refers to the protection measures taken by the court to prevent the party (generally the defendant) from transferring, concealing or selling the property before the judgment is issued, so as to ensure the smooth execution of the judgment after it takes effect in the future.

In accordance with the Civil Procedure Law of the People's Republic of China, when receiving the application for taking preservation measures, the people's court may require the applicant/plaintiff to provide a guarantee. In recent years, a litigation property preservation liability (LPPL) insurance policy has been considered a qualified and legitimate method through which to provide a guarantee.

LPPL insurance generally covers the losses suffered by the defendant as a result of the wrongful or improper application for property preservation by an applicant in a civil lawsuit. When the applicant/plaintiff loses the case, the defendant will sue the applicant/plaintiff and the insurer to reimburse the losses caused by property preservation measures.

With the wide application of LPPL insurance in civil litigation cases, more and more disputes have arisen from such insurance policies. The following criterion will be considered in LPPL disputes:

- whether the applicant has subjective fault;
- whether the preservation measures are adopted in an improper manner;
- whether the defendant suffered any loss; and
- whether there was a direct causation between the improper preservation measures and the defendant's loss.

New laws and regulations impacting insurance litigation in China

Planned amendment of the PRC Insurance Law

On 6 May 2024, the General Office of the State Council issued the "State Council's 2024 Legislative Work Plan", which indicates plans to submit the draft amendment of the PRC Insurance Law to the Standing Committee of the National People's Congress for deliberation. This signifies an acceleration in the pace of the new round of amendments to the PRC Insurance Law.

Formation of the State Financial Regulatory Administration

On 18 May 2023, the National Financial Regulatory Administration was formed to replace the CBIRC. It is responsible for the supervision of the financial industry, including the insurance industry.

Prior to this, the CBIRC had been in operation for more than five years. Following the formation of the State Financial Regulatory Administration, the CBIRC no longer exists.

Changes in hierarchical jurisdiction

In China, the court system is divided into four levels:

- the primary courts;
- the intermediate courts;
- the high courts; and
- the Supreme People's Court.

In accordance with the judicial interpretations published by the Supreme People's Court on 17 September 2021, the following applies:

- if the amount in dispute in a civil case is less than RMB500 million (not inclusively), the primary court will have first-instance jurisdiction;
- if the amount in dispute in a civil case is between RMB500 million (inclusively) and RMB5 billion (not inclusively), an intermediate court will have first-instance jurisdiction; and
- if the amount in dispute in a civil case is more than RMB5 billion (inclusively), the high court will have first-instance jurisdiction.

It is rare for the Supreme People's Court to hear a case at first instance.

Changes in territorial jurisdiction

In accordance with PRC laws, a lawsuit brought in an insurance dispute will fall under the jurisdiction of the people's court where the domicile of the defendant or the insured object is located. However, the territorial jurisdiction is subject to some exceptions.

China has established a number of professional courts, such as financial courts, to handle litigation in specific sectors. By way of example, since 26 March 2021, the Beijing Financial Court hears insurance disputes over which the Beijing Intermediate People's Court has first-instance jurisdiction. The Beijing Financial Court will also try appeals against decisions in insurance disputes from the first-instance district courts.

Impact of the Civil Code

The Civil Code came into force on 1 January 2021. Its provisions have numerous, significant impacts on the PRC Insurance Law and its judicial interpretations.

In accordance with the Civil Code, insurers have a specific explanation obligation not only with regard to clauses that exempt the insurer from liability or reduce the insurer's liability as prescribed by the PRC Insurance Law, but also for those clauses in which the applicants, beneficiaries or insureds have major interests.

Another noteworthy point concerns the amendment of the statute of limitations. Article 188 of the Civil Code provides that the limitation period for a person to request the people's court to protect their civil rights is three years, unless otherwise provided by law. However, before the Civil Code officially stipulated this statute of limitations, a two-year statute of limitations had long been implemented in China in accordance with the PRC General Principles of Civil Law (promulgated in 1987).

The PRC courts have been divided as to whether a two-year or three-year statute of limitations should apply to disputes involving property insurance policies, as the current PRC Insurance Law still stipulates that the period of limitation for the insured or

beneficiary of non-life insurance to claim insurance benefits is two years. Up to now, most courts would hold that a three-year statute of limitations in accordance with the more recent Article 188 of the Civil Code should be applied in property insurance claims, as most courts believe that the two-year statute of limitations prescribed by the PRC Insurance Law was inherited from the abolished PRC General Principals of Civil Law rather than the special provisions of the PRC Insurance Law.

Diversified dispute resolution mechanisms

Against the background of increasingly complex insurance policy types and an upsurge in disputes, the establishment of diversified dispute resolution mechanisms has become a new trend, in addition to the traditional dispute resolution measures of litigation and arbitration.

In July 2024, National Financial Regulatory Administration, the People's Bank of China, and the China Securities Regulatory Commission jointly issued the Opinions on Promoting the High-Quality Development of Financial Dispute Mediation (the "Opinions"), a comprehensive policy document comprising 23 articles across seven sections. The Opinions apply across banking, securities, and insurance sectors, and aim to enhance the institutional framework, functionality, and overall efficiency of financial dispute mediation in China. The initiative seeks to establish a well-structured, efficient and widely trusted mediation system that delivers measurable improvements in public satisfaction and trust in the financial dispute resolution process.

A diversified dispute resolution mechanism involves the resolution of a dispute through mediation in the form of non-litigation by insurance industry associations, arbitration institutions, courts and other third parties when the insured and the insurer in a dispute cannot reach a settlement by themselves.

According to the different participants, there are three main forms of diversified dispute resolution mechanisms in the insurance industry, as follows.

- The first model involves the insurance industry association leading the parties in resolving the dispute, with guidance from the CBIRC.
- The second model involves the administrative organs as the main body leading the two parties in resolving the dispute.
- The third model involves the arbitration institution as the main body leading the parties in resolving the dispute through mediation or settlement, instead of via arbitration procedures.

In recent years, valuable experience has been accumulated in the establishment of diversified dispute resolution mechanisms. However, there are certain shortcomings, as follows.

- First, the legal and regulatory system has not been well established.
- Second, the publicity and popularisation of diversified dispute resolution mechanisms ought to be strengthened.
- Third, the multiple dispute resolution mechanisms require enhanced financial support.

Outlook

The landscape of insurance litigation in China is poised for significant evolution. As regulatory oversight intensifies and consumer awareness grows, disputes over policy interpretation, claims denial, and disclosure obligations are expected to increase. The increasing complexity of insurance products, particularly in areas such as health, cyber, and ESG-related coverage, will likely give rise to novel legal questions.

Courts are gradually developing more sophisticated approaches to insurance disputes, supported by judicial interpretations and pilot programmes aimed at standardising rulings. Moreover, the integration of technology in dispute resolution (including online litigation platforms) will enhance efficiency.

However, challenges remain, including inconsistencies in local judicial practice as well as the need for greater transparency. Overall, trends point towards a more litigious yet maturing insurance legal environment, whereby clarity in policy wording, compliance with regulatory requirements, and proactive risk management will be critical if insurers are to navigate future disputes effectively.

CYPRUS

Law and Practice

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Chryssafinis & Polyviou LLC

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Chryssafinis & Polyviou LLC was established in 1903 and is one of the oldest and most prestigious legal practices in Cyprus, capable of handling complex and challenging cases in both the advisory and litigation domains. The firm currently employs over 70 staff members, around 30 of whom are highly trained and qualified lawyers with various specialisations, such as administrative law, banking law, company and commercial law (including mergers and acquisitions), competition law, constitutional law, the law of defamation, employment law, insurance law and litigation. Local and international credit institutions, insurance undertakings, investment firms, energy companies and G7 member states, among others, trust the firm to legally advise and/or represent them in Cyprus. Chryssafinis & Polyviou has also developed an extensive and dynamic network of corresponding legal practices abroad, including some of the leaders in the field.

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CHRYSSAFINIS & POLYVIOU SINCE 1903

1. Rules Governing Insurer Disputes

1.1 Statutory and Procedural Regime

In Cyprus, insurance disputes are governed by a wide range of legislation and procedural rules, as well as common law principles.

Statutory Regime

Insurance contracts

As insurance contracts are essentially private contracts, the Contract Law (Cap 149) governs disputes relating to the interpretation of insurance contracts, breach of contract, etc. Common law rules are also applicable in insurance contract disputes, as insurance policies have been widely interpreted and regulated by practice. EU Directives and related laws on consumer contracts and protection may also apply to insurance contract disputes, such as Law 93 (I)/1996, which implements Directive 93/13/EEC on unfair contract terms in Cyprus.

Disputes relating to negligence

Cap 148 governs the regulation of general negligence disputes, including personal injury claims and medical negligence, while common law principles govern the resolution of tort law cases relating to insurance.

Specific legislation

The Cypriot Law on Motor Vehicles (Third Party Liability Insurance) (Law 96 (I)/2000) governs cases relating to motor accidents, and deals with insurance disputes at a contract level, as well as personal injuries. It generally regulates the enforcement of insurance contracts' terms by third parties.

In addition, EU Directive 2009/103/EC on motor insurance has been implemented by Law 96 (I)/2000, which also contains provisions regarding the Motor Insurers' Fund, a compensatory body for victims of uninsured and unknown drivers. It also deals with insolvent insurance companies that have been involved in car accidents and accidents that took place outside the jurisdiction.

The Law on Compulsory Insurance of Employers Liability (Law 174/1989) requires employers to conclude insurance contracts regarding liability concerning accidents and/or diseases caused in the professional environment.

Procedural Regime

Although parties to an insurance contract are free to choose the way in which their disputes are resolved, in Cyprus such disputes are usually resolved in civil courts, and general civil procedure rules are applicable.

Civil Procedure Rules

In the new Civil Procedures Rules (CPR) that were implemented on 1 September 2023 in Cyprus, specific provisions deal with the resolution and initiation of insurance claims in District Courts, including specific pre-action protocols that must be followed. The old Civil Procedure Rules continue to govern cases filed before 1 September 2023, but no specific procedural rules on insurance claims can be found in the old rules.

Insurance disputes are heard by District Courts and on a second level by the Appeal Court. A third level of review was established in Cyprus in 2023, whereby an appeal from the Appeal Court is heard by the Supreme Court.

Arbitration

The Arbitration Act (Cap 4) governs domestic arbitration proceedings that can take place in Cyprus. Parties to an insurance dispute may incorporate an arbitration clause in their contract or agree to such dispute resolution method after the dispute has arisen. Arbitration is not very popular as a dispute resolution method for insurance claims in Cyprus and is not widely employed to resolve insurance claims.

Financial Ombudsman

Any individual can submit a complaint to the Financial Ombudsman against financial businesses, regarding a dispute of up to EUR170,000 in value, provided that the following conditions are cumulatively met.

- The complaint must be submitted by a consumer.
- Before it is submitted to the Financial Ombudsman, the complaint is submitted to the insurer in writing within 15 months from the date the consumer became, or ought to have reasonably become,

aware of the harmful action/omission of the insurer. The insurer must acknowledge receipt of the complaint (whether it responds to it is only relevant in terms of timing).
- The insurer must have been operating on the basis of a lawfully issued licence (or by virtue of the freedom of establishment) at the time the complaint refers to.

The Financial Ombudsman does not undertake the examination of complaints in the following circumstances:

- if the complaint relates to a transaction that does not fall under the competences of the competent supervisory authorities;
- if, on the day of the complaints' submission, a court of the Republic has already issued a decision on the same complaint, or litigation procedures are in progress regarding those complaints;
- if the complaint is submitted to the Financial Ombudsman more than 22 months after the consumer became aware, or ought to have reasonably become aware, of the harmful action/omission; or
- if the transaction did not result in significant loss in the opinion of the Financial Ombudsman.

1.2 Litigation Process and Rules on Limitation

The CPR regulate, inter alia, the procedural stages of an insurance dispute in Cyprus, which is heard by Civil Courts of first instance. The new CPR have introduced the pre-action protocols that must be followed before the submission of a claim in court. Specific protocols apply to personal injury claims arising out of an accident. The purpose of this pre-action requirement is to ensure that only necessary and genuine claims follow the judicial route through the courts.

The importance of the pre-action procedure is that a party may have to pay costs imposed by the courts in the following litigation proceedings if it fails to comply with the established steps. As a result, parties are strongly encouraged to pursue settlement discussions before the commencement of an action.

Initiation of a Claim

If the pre-action proceedings are not successful, the claimant may proceed with the filing of a claim form exposing the particulars of the claim. After the claim form is served on the defendant, the defendant may proceed with the filing of a defence and/or a counterclaim against the claimant. The claim form must contain all the significant facts upon which the claimant relies, together with the relevant documentation. Rules on proper pleading drafting can be found in the CPR.

Stages of Litigation

The CPR govern and determine specifically all stages of litigation, as well as any interim procedure that parties may choose to follow, pending litigation. Steps such as the disclosure of documents, witnesses and a timetable of the trial process are mandatory steps that parties have to follow. A pre-trial hearing must also be held before a judge by the parties, before the actual trial.

The court remains the regulator of the proceedings and actively encourages parties to resolve their dispute through negotiation and settlement processes, before the commencement of the trial.

Rules on Limitation

In Cyprus, insurance disputes have a limitation period according to the type of claim that is pursued. In contract claims the limitation period is six years, while the limitation period for personal injury claims and general negligence disputes is three years. The relevant legislation for limitation periods is the Law on Limitation of Legal Rights of 2012 (Law 66 (I)/2012).

1.3 Alternative Dispute Resolution (ADR)

Although ADR is increasingly encouraged in Cyprus, it is not a popular method of resolving insurance disputes; courts continue to be the main resolving authority. However, parties are encouraged by the courts and now the CPR to conduct negotiations, which take place on a "without prejudice" basis.

Arbitration

Rules on arbitration are established in Cyprus through the specific legislation on domestic arbitration (Cap 4). However, parties do not often incorporate such clauses into insurance contracts and do not usually agree to such dispute resolution method after a dispute has arisen.

The new CPR also provide specific procedural rules on the conduct of both domestic and international arbitration, as well as rules regarding the support and supervision of Civil Courts.

Mediation

Directive 2008/52/EC of the European Parliament and of the Council of 21 May 2008 on Certain Aspects of Mediation in Civil and Commercial Matters has introduced mediation in Cyprus as a dispute resolution method that can provide a cost-effective and quick extrajudicial resolution of disputes in civil and commercial matters through processes tailored to the needs of the parties. The Directive has been implemented in Cyprus through the Law Regarding Mediation in Civil Disputes 2012 (Law 159 (I)/2012), but mediation is not widely used in insurance disputes.

2. Jurisdiction and Choice of Law

2.1 Rules Governing Insurance Disputes

Jurisdiction

Insurance contracts contain jurisdictional clauses that are widely upheld by Cypriot courts as a representation of parties' contractual autonomy in cases with foreign elements.

Applicable rules on jurisdiction

The applicable rules are:

- the Brussels Regulation Recast (1215/2012), which applies where both parties are domiciled in an EU member state;
- the Lugano Convention, which is applicable where only one party is domiciled in an EU member state and the other is domiciled in an EEA member state; and
- common law, which is applicable where the defendant is not domiciled in any EU member state or EEA member state (Part 6 of the CPR Rules contains provisions on the jurisdiction of Cypriot courts).

Both Brussels Recast and the Lugano Convention contain detailed rules on insurance contracts regarding jurisdiction, in an attempt to safeguard the insured as the weaker party.

Cyprus is also a contracting party to the Hague Convention on Choice of Court Agreements 2005, which applies in extraterritorial cases with an exclusive jurisdiction agreement between the parties. It should be noted that the EU (of which Cyprus is a member state) has imposed limitations on the applicability of the Hague Convention regarding insurance contracts.

Regarding the limitations imposed, the European Union declared on 11 June 2015 that it will not apply the Hague Convention to insurance contracts, except in the following cases:

- where the contract is a reinsurance contract;
- where the choice of court agreement is entered into after the dispute has arisen;
- where, without prejudice to Article 1 (2) of the Convention, the choice of court agreement is concluded between a policyholder and an insurer, both of whom are, at the time of the conclusion of the contract of insurance, domiciled or habitually resident in the same contracting state, and that agreement has the effect of conferring jurisdiction on the courts of that state, even if the harmful event were to occur abroad, provided that such an agreement is not contrary to the law of that state; and
- where the choice of court agreement relates to a contract of insurance that covers one or more of the following risks, which are considered to be high risks:
  - (a) any loss or damage arising from perils that relate to their use for commercial purposes, of or to:
    - (i) seagoing ships, installations situated offshore or on the high seas, or river, canal and lake vessels;
    - (ii) aircraft; or
    - (iii) railway rolling stock;
  - (b) any loss of or damage to goods in transit or baggage other than passengers' baggage, irrespective of the form of transport;
  - (c) any liability, other than for bodily injury to passengers or loss of or damage to their baggage, arising out of the use or operation of:
    - (i) ships, installations or vessels as referred to above;
    - (ii) aircraft, insofar as the law of the contracting state in which such aircraft are reg-

istered does not prohibit choice of court agreements regarding the insurance of such risks; or
(iii) railway rolling stock;
(d) any liability, other than for bodily injury to passengers or loss of or damage to their baggage, for loss or damage caused by goods in transit or baggage, as referred to above;
(e) any financial loss connected with the use or operation of ships, installations, vessels, aircraft or railway rolling stock as referred to in a), particularly loss of freight or charter-hire;
(f) any risk or interest connected with any of the risks referred to in points a) to e);
(g) any credit risk or suretyship risk where the policy holder is engaged professionally in an industrial or commercial activity or in one of the liberal professions and the risk relates to such activity; or
(h) any other risks where the policy holder carries on a business of a size that exceeds the limits of at least two of the following criteria:
(i) a balance sheet total of EUR6.2 million;
(ii) a net turnover of EUR12.8 million; or
(iii) an average of 250 employees during the financial year.

In particular, the declaration aims to exclude certain types of insurance contracts from the scope of the Convention in order to protect certain policyholders, insured parties and beneficiaries who, according to internal EU law, receive special protection.

Choice of Law

Cypriot courts typically uphold choice of law clauses once incorporated into parties' contracts.

Applicable rules on choice of law

The following rules apply:

- Regulation (EC) No 593/2008 on the law applicable to contractual obligations (Rome I), Article 7 of which provides specific rules on insurance contracts in an attempt to safeguard the insured as the weaker party; and
- Regulation (EC) No 864/2007 on the law applicable to non-contractual obligations (Rome II), which may also cover personal injury claims and motor claims.

2.2 Enforcement of Foreign Judgments

Foreign judgments by or against insurers may be enforced under the European and international rules or under common law rules.

Under European law, foreign judgments of other EU member states or EEA states are easily enforceable in Cyprus through Brussels Recast, the Lugano Convention and the European Enforcement Order Regulation (805/2004). Common law rules apply for the recognition and enforcement of judgments given in a state outside the EU or EEA, but the enforcement of such cases is not as easy as within the European regime.

In addition, the Convention of 2 July 2019 on the Recognition and Enforcement of Foreign Judgments in Civil or Commercial Matters entered into force on 1 September 2023, and accommodates the recognition and enforcement of judgments between contracting parties. The Convention creates a uniform set of core rules on the recognition and enforcement of foreign judgments in civil or commercial matters, facilitates the effective recognition and enforcement of such judgments and provides greater predictability and certainty in relation to the global circulation of foreign judgments.

2.3 Unique Features of Litigation Procedure

Insurance disputes in Cyprus are litigated in an adversarial manner, with the courts having an active role, both before and after the introduction of the CPR.

In particular, the new CPR oblige parties to follow pre-action procedures in an attempt to try and reach an out-of-court settlement before a claim is filed in court. Parties are also required to engage in out-of-court settlement discussions or even ADR at any stage of the proceedings. Failure to pursue either pre-action procedures or out-of-court settlement discussions may result in sanctions in the form of costs, which the defaulting party may have to pay instantly.

Another feature of Cypriot insurance litigation is the rule of Article 14 of Law 96 (1)/2000, which states that, after they have paid a claim initiated by a third

party, insurers can turn to their insured for reimbursement due to a breach of contractual obligations by the insured. However, according to a recent judgment by the Supreme Court of Cyprus, in order for the insurer to pursue a claim against its insured, a court judgment should have been issued against the insurer prior to the reimbursement proceedings.

3. Arbitration and Insurance Disputes

3.1 Enforcement of Arbitration Provisions in Commercial Contracts

In Cyprus, arbitration clauses found in commercial insurance and reinsurance contracts are enforceable. Having ratified the New York Convention, Cyprus is deemed a pro-enforcement jurisdiction, for both arbitration agreements and awards.

The relevant legislation in Cyprus regarding arbitration procedures and enforcement (of both agreements and awards) is as follows:

- the relevant law for domestic arbitrations is Cap 4 (the Arbitration Act), which governs arbitrations without a foreign element; and
- the relevant laws for international arbitrations are the International Arbitration Act (Law 101/1987) and the Law ratifying the New York Convention (Law 84/1979).

Both laws give Cypriot courts the power to stay court proceedings upon the application of one party if the other party is in breach of an arbitration clause or agreement, unless the arbitration agreement is null and void, inoperative or incapable of being performed.

Both laws also set the necessary requirements for the type and form of the arbitration agreements or clauses. Arbitration clauses in Cyprus are viewed as separate contracts, as the courts follow the separability presumption of an arbitration clause, so that such clauses can be autonomous from the whole contract and, as a result, can generally be enforced.

3.2 The New York Convention

Cyprus has ratified the New York Convention through Law 84/1979, so courts in Cyprus operate with a pro-enforcement bias, following the provisions of the Convention in the enforcement of foreign arbitral awards (and agreements).

Foreign arbitral awards are enforceable in Cyprus under the provisions of either Law 84/1979, which ratified the New York Convention, or the Law on International Arbitration in Commercial Matters (Law 101/1987), which is essentially based on the UNCITRAL Model Law on International Commercial Arbitration.

In cases where the country in which the foreign award was rendered (seat of the arbitration) has also ratified the New York Convention, the relevant application for the recognition and enforcement of the foreign arbitral award in Cyprus can be based on the New York Convention and/or Law 101/1987. In cases where the country/seat of arbitration had not ratified the New York Convention, the legal basis for the recognition and enforcement should be Law 101/1987.

Article 35 of Law 101/1987 governs arbitration disputes of an international and commercial nature, and provides that "a foreign arbitral award shall be recognised as binding" unless there are valid grounds for refusing its recognition and enforcement, establishing the same pro-enforcement bias as the New York Convention.

Basically, and in combination with the New York Convention (and Law 84/1979), an application filed before the Cyprus courts needs to be accompanied by:

- a duly authenticated original award or a duly certified copy thereof;
- the original arbitration agreement or a duly certified copy thereof; and
- a translation of the above documents into Greek by an official or sworn translator, or by a diplomatic or consular agent.

Moreover, Section 5 of Law 121 (I)/2000 sets out that, for recognition, the applicant (which may be either the relevant authority or the person in favour of which the judgment was issued) files an originating summons application on a by summons basis, which must be accompanied by an affidavit stating all relevant facts.

Under the new CPR, any application for the recognition and enforcement of arbitral awards is submitted in accordance with Form 92. Once the form is served, the respondent has to proceed with the filing of appearance.

Article V of the New York Convention and Article 36 of Law 101/1987 set out the following limited grounds on which an application for the recognition and enforcement of an arbitral award may be rejected:

- the contractual incapacity of the parties or the invalidity of the arbitration agreement;
- the lack of proper notice as to the appointment of the tribunal or of the arbitral proceedings;
- the fact that the award deals with a dispute that does not fall within the terms of the submission to arbitration or goes beyond the scope of the submission;
- the fact that the composition of the arbitral tribunal or the arbitral procedure was not in accordance with the agreement of the parties;
- the fact that the award has not yet become binding on the parties or has been set aside or suspended by the competent court of the country in which, or under the law of which, the arbitration took place;
- the fact that the subject matter of the dispute is not capable of settlement by arbitration under the laws of Cyprus; and
- the fact that the recognition and enforcement of the award would contradict the public policy of Cyprus.

Moreover, the respondent may object to the summons on the grounds that the Cyprus courts lack jurisdiction, or if the award or judgment has been satisfied.

3.3 The Use of Arbitration for Insurance Dispute Resolution

Arbitration is not a common form of resolving insurance disputes in Cyprus, although certain insurance disputes are resolved by arbitration, such as disputes relating to reinsurance matters and contractors' all risk policies.

As mentioned in **3.1 Enforcement of Arbitration Provisions in Commercial Contracts**, the relevant law for domestic arbitrations is the Arbitration Act (Cap 4), which governs arbitrations without a foreign element. For international arbitrations, the relevant laws are the International Arbitration Act (Law 101/1987) and the Law ratifying the New York Convention (Law 84/1979).

Arbitration is a private method of resolving disputes, as confidentiality is one of the privileges of this dispute resolution method. It should also be noted that neither of the above laws contains provisions addressing the possible appeal of awards regarding their substance. Awards cannot be appealed, and can only be set aside in the seat of arbitration or refused recognition and enforcement when such application is filed only for the exhaustive reasons stipulated in the above-mentioned laws.

4. Coverage Disputes

4.1 Implied Terms

Insurance contracts are private commercial contracts that are not individually negotiated. As such, implied terms regarding consumer protection and unfair contract terms apply regarding insurance contracts as well, by operation of the Law on Unfair Contract Terms (Law 93 (I)/1996).

Law 93 (I)/1996 implements Directive 93/13 on unfair terms in consumer contracts, which sets out the context in which a contract term can be deemed unfair and all the necessary steps that member states should take to ensure effective protection of consumers regarding the conclusion of, inter alia, insurance contracts.

The terms of insurance contracts must comply with the requirement of good faith. Article 3 of the Directive specifies that "*A contractual term which has not been individually negotiated shall be regarded as unfair if, contrary to the requirement of good faith, it causes a significant imbalance in the parties' rights and obligations arising under the contract, to the detriment of the consumer*".

4.2 Rights of Insurers

In order to safeguard the risks deriving from a certain insurance policy, insurers have the right to request the following non-exhaustive list of documentation and/or

proof from proposed insureds prior to the inception of an insurance policy.

- For property insurance, they may request a property inspection and a valuation of both the property and the equipment.
- For life insurance, they may request thorough medical documentation as well as medical history, examination results and possibly medical reports.
- Generally, insurers may request the completion of a specific questionnaire in which the insured should disclose all the correct and true facts and every material circumstance, in line with the principle of utmost good faith, without omitting any significant fact that is directly relevant to the insurance contract.
- In addition, insureds are required to disclaim that all the information provided in their application and/or proposal form are the true and correct facts, which will form the basis of the insurance contract/policy. If any of the information provided by the insured is not factually correct and/or true, the insurer reserves the right to dismiss any potential claim made by the insured even while the insurance contract is still in force, as well as the right to render the insurance contract void ab initio.

4.3 Significant Trends in Policy Coverage Disputes

In the past 12 months, the significant trend in policy coverage disputes in Cyprus has been the rise of inflation, due to the economic implications of the war in Ukraine and conflicts in the Middle East causing the underinsurance of insureds.

Furthermore, due to extreme weather conditions resulting from climate change, weather-related claims have increased, so policies are now covering such risks with an increased premium.

Another significant trend is the demand by businesses for the coverage of cyber-attacks in insurance policies, again with an increased premium. However, cyber-attack coverage is not a standard term and is only covered upon request.

4.4 Resolution of Insurance Coverage Disputes

In Cyprus, insurance coverage disputes are usually resolved through court processes and litigation. The vast majority of disputes are resolved in an out-of-court settlement, now following the assisting procedure of the new CPR and the pre-action protocols that must be followed by the parties.

Arbitration and ADR in general are not popular methods for resolving insurance disputes, although reinsurance contracts frequently include arbitration clauses, which are enforceable.

4.5 Position If Insured Party Is Viewed as a Consumer

The position for the resolution of a dispute involving consumers is no different from any other insurance coverage dispute, with litigation through court being the main method of resolving such disputes.

However, disputes involving consumers may be resolved by submitting a complaint to the Financial Ombudsman against financial businesses, regarding a dispute of up to EUR170,000 in value; see **1.1 Statutory and Procedural Regime** (*Financial Ombudsman*) for more detail.

4.6 Third-Party Enforcement of Insurance Contracts

The specific circumstances in which a third party can enforce an insurance contract or sue an insurer in connection with an insurance contract are as follows:

- in cases of motor accidents on the basis of Law 96 (I)/2000, a third party can initiate an action against the insurer;
- in cases of accidents caused on a construction site, the injured may sue the insurer of both the main contractor and the subcontractor; and
- in cases where the insured is insolvent, Law 174/1989 gives third parties the right to initiate proceedings against the insurer.

4.7 The Concept of Bad Faith

The concept of bad faith is not found in any legislation in Cyprus.

However, Law 93 (I)/1996 on unfair terms in consumer contracts implements Directive 93/13 on unfair terms in consumer contracts, which introduces the concept of good faith that has essentially been interpreted by the European and Cypriot courts.

4.8 Penalties for Late Payment of Claims

No penalties for late claims payment are imposed by legislation in Cyprus, although insurers must meet a reasonable timeframe in paying a justifiable claim.

4.9 Representations Made by Brokers

According to Contract Law, Cap 149, Article 186, an insured is bound by representations made by its broker, unless the broker has acted ultra vires. The relevant provisions of contract law regarding agency can be found in Section XIII of Cap 149.

4.10 Delegated Underwriting or Claims Handling Authority Arrangements

In Cyprus it is not common to delegate claims to an external company handling authority arrangements, nor is it common to outsource underwriting matters. Usually, insurance companies have internal departments dealing with underwriting issues. If an insurance company has to outsource matters, strict criteria are imposed by the Insurance Regulator and there are specific guidelines for such exercise.

In rare cases in which claims are handled externally, it is not common for such arrangements to give rise to litigation.

5. Claims Against Insureds

5.1 Main Areas of Claims Where Insurers Fund the Defence of Insureds

Insurers usually fund many areas of liability claims for the defence of insureds, including:

- motor accidents and personal injury claims;
- professional indemnity claims;
- public liability claims;
- claims brought by third parties; and
- employers' liability claims.

5.2 Likely Changes in the Future

Insurers' defence funding for their insureds regarding liability claims is unlikely to change in the future, since defence costs form part of insurance policies.

5.3 Trends in the Cost or Complexity of Litigation

The new CPR have introduced new, more comprehensive procedures regarding insurance claims in the form of specific pre-action protocols that must be followed. These procedures are accompanied by possible sanctions in the form of costs, which may be imposed if one of the parties to the litigation fails to comply with them once the action has been commenced. The reason for this new function of the CPR is to reduce litigation and encourage parties to reach an out-of-court settlement.

This new development has had a huge impact on the reduction of litigation costs. However, insurance companies tend to request the involvement of external lawyers in handling insurance claims at an earlier stage, before the commencement of an action.

5.4 Protection Against Costs Risks

Protection against costs risks is not a standard insurance policy in Cyprus. It is an independent field of insurance that usually applies to professionals, in order for them to be covered in case an action is commenced against them. Such product usually forms an extension in the policy cover, and a separate sum is used to cover such claims and actions.

Notably, this product is requested to be bought by claimants in professional indemnity policies (medical, legal, architectural, and directors' and officers' liability).

6. Insurers' Recovery Rights

6.1 Right of Action to Recover Sums From Third Parties

Insurers can recover sums from third parties in the form of subrogation. This principle has its foundation in common law and it constitutes a standard clause in insurance contracts.

On the basis of the right of subrogation, in case of a loss caused by a third party to their insured, insurers satisfy the claim of their insured and can subsequently pursue an action in the name of the insured to recover some or all of the sum of money they have already paid.

Subrogation applies to all insurance contracts that are contracts of indemnity, such as fire insurance, vehicle insurance, loss of profits insurance, property insurance and liability insurance. However, it does not apply to life insurance nor prima facie to personal accident insurance.

6.2 Legal Provisions Setting Out Insurers' Rights to Pursue Third Parties

Subrogation is a principle arising out of common law and forms part of the insurance contract as a standard clause. Such claims are pursued in the name of the insured and concern the recovery of the whole and/or part of the sums already paid to the insured as a result of the loss incurred.

However, in Cyprus the right of subrogation concerning the Motor Insurance Fund is set out in detail in the Law on Motor Vehicles (Third Party Liability Insurance) (Law 96 (I)/2000), Article 30 of which states that the Motor Insurers' Fund has the right to pursue an action in the name of the person who has provided compensation.

7. Impact of Macroeconomic Factors

7.1 Type and Amount of Litigation

The COVID-19 pandemic was an unprecedented experience, raising multiple challenges in the insurance sector. Insurance companies were faced with an unexpected number of claims relating to business interruption and the inability to cover employees' salaries as a result of the pandemic. Insurance-related claims and lawsuits are and will, therefore, increase due to the consequences of the pandemic.

The COVID-19 crisis also resulted in a significant increase in cyber-risks but also in an opportunity for the insurance sector, due to cyber underwriting policies with the appropriate risk management. In addition, due to war in Ukraine and conflicts in the Middle East, there has been increased interest from corporate clients (mostly hotel owners) demanding coverage for terrorism – a risk that is usually excluded from an insurance policy. If this demand increases, it will definitely have an impact on the amount and complexity of litigation.

7.2 Forecast for the Next 12 Months

As long as the armed conflicts continue, insurance disputes over the coverage of terrorist attacks will need to be tackled and addressed by insurance companies and their lawyers.

7.3 Coverage Issues and Test Cases

The factors mentioned in **7.1 Type and Amount of Litigation** have rendered necessary the inclusion of business interruption clauses in insurance contracts, which in turn will result in the need to interpret those clauses in line with the new realities and effects of the COVID-19 pandemic.

7.4 Scope of Insurance Cover and Appetite for Risk

The factors mentioned in **7.1 Type and Amount of Litigation** have affected the scope of insurance cover and influenced the appetite for risk, as it has become imperative for new clauses to be included in insurance contracts related to the effects of the pandemic, alongside evolving new factors such as cybersecurity, terrorism and ESG.

8. Emerging Risks

8.1 Impact of ESG on Underwriting and Litigating Insurance Risks

ESG factors affect insurance companies in their non-financial risks and opportunities.

In reference to the effects of insurance risks on underwriting, underwriters have had to implement ESG aspects into their risk assessment analysis, resulting in the creation of a more thorough risk assessment. These factors have impacted the underwriting sector regarding not only motor insurance but also property insurance, from an early stage of the conclusion of the insurance contract.

Regarding the effect of ESG factors in litigating insurance risks, it appears that the result of lower coverage and/or discounts on insurance policies will have an impact on the number of claims ending in court. In addition, due to climate change, insurance policies covering property damage for certain areas that are rendered to be more dangerous than others will result, most probably, in an increase in litigation, since premiums will need to differentiate to a higher level. In implementing ESG factors, directors' and officers' liability claims could also increase in cases of poor governance.

On the other hand, improvements in the health and safety of workplaces could reduce the number of accidents and related claims.

Currently, since ESG factors are incorporated into insurance policies, companies that implement ESG policies could benefit from reduced premiums, thereby eliminating insurance risks.

In Cyprus, the full implementation of ESG factors and strategies by insurance companies into their policies is expected to take place over the coming year.

8.2 Data Protection Laws

The Data Protection Law (Law 125 (I)/2018) was adopted for the effective implementation of certain provisions of 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 has impacted the underwriting and litigating of insurance risks.

Underwriting risks have been affected in the sense of thorough assessment procedures, as the implementation of the EU Directive has resulted in more restricted data processing within insurance companies and between them. In addition, many insurance companies need to employ external reinsurers and certain personnel for underwriting purposes. Investigations concerning insurance disputes have also been impacted, since data protection laws permit only strictly necessary data to be collected and requested. As a consequence, litigation on insurance claims has become more difficult and unpredictable regarding the evidence that parties can provide throughout the trial.

9. Significant Legislative and Regulatory Developments

9.1 Developments Affecting Insurance Coverage and Insurance Litigation

Insurance Coverage

One of the most significant legislative developments regarding insurance coverage has been the compulsory insurance of medical professionals and medical service providers who have entered the General Health System in Cyprus. As a consequence, the number of policies will increase in the coming years as will possible litigation claims.

Interestingly, this will also affect the claims that insurers will fund the defence of, as litigation claims will rise.

Insurance Litigation

The new CPR set out specific provisions that govern the resolution and initiation of insurance claims in District Courts, including specific pre-action procedures that must be followed.

If these pre-action protocols are not followed by parties, the court reserves the right – once an action has been commenced – to impose sanctions on the defaulting party, in the form of costs that will have to be paid as soon as they are imposed.

Another form of sanction that courts may impose is the reduction of interest in the awarded sum of damages or to order that no interest will be awarded at all. The court may also order the stay of the proceedings if it rules there is a "lack of compliance with both the letter and the spirit of the pre-action Protocol".

Another major development introduced by the new CPR is the parties' obligation to disclose all the relevant documentation to their claim at a very early stage, and to provide the other side with the proof upon which they will base their claim if an action is commenced later on.

New Legislative Development Regarding Road Accidents

In 2025, the Motor Vehicles and Traffic Law (Law 86/1972) was amended regarding road accidents with no obvious physical injuries to any of the involved parties.

In particular, in the event of a road collision between motor vehicles on any road (including an open space, square and/or public space), the vehicles involved are moved to the nearest point where they will not obstruct other traffic, provided:

- the drivers involved consent to the movement of the vehicles;
- there are no obvious physical injuries to any of the parties involved;
- the intervention and/or presence of the Cyprus Police at the scene of the road collision is not necessary;
- the motor vehicles involved in the road collision can be moved without towing and without causing further damage to them or the road surface; and
- moving the vehicles is reasonable under the circumstances prevailing at the time on the road surface and the road.

Before the movement of the motor vehicles involved in the road collision, the drivers involved shall:

- immediately inform their insurance companies of the occurrence of the road collision;
- exchange their names, the numbers of their insurance policy certificates, their driving licence numbers, the details of their vehicle and their telephone numbers;
- promptly take photographs of the scene of the road collision, which include the motor vehicles in their final position after the road collision, their registration numbers, the damage caused and the surrounding area, in compliance with the principle of data minimisation in accordance with the provisions of Article 5 paragraph 1 point c) of Regulation (EU) 2016/679; and
- exchange the photographs taken among themselves and send them to a person indicated to them by their insurance company and/or its representative.

Furthermore, it is noted that the movement of a motor vehicle from the scene of a road collision does not constitute an assumption of liability for said road collision. Also, in a case where any driver does not suffer any apparent bodily injury during the road collision, any movement of his or her vehicle shall not deprive him or her of the right to claim compensation for such injury from the at-fault party at a future time. The movement of motor vehicles shall not be considered as abandonment of the scene of a road collision, nor shall it be deemed to be a breach of any term of an insurance policy in force at the time of the road traffic collision.

In any case, this newly adopted reform of Law 86/1972 will eventually have a significant impact on insurance claims, and is likely to minimise the litigation of such claims and disputes.

DENMARK

Law and Practice

Contributed by:
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Contents

Bruun & Hjejle is a leading Danish law firm with approximately 350 employees based in Copenhagen, specialising in complex transactions and disputes. The firm's insurance team comprises highly qualified attorneys who advise a wide range of significant Danish and international clients in the insurance sector. The team works closely with insurance companies, brokers and agents, and have extensive experience of assisting all key players in the industry. Bruun & Hjejle's practice also includes representing policyholders – often in matters involving insurance-covered liability – on the instruction of insurance companies. The team provides advice on a broad spectrum of insurance-related matters, including the negotiation and drafting of insurance contracts, the preparation of terms and conditions, and the interpretation of policy terms, as well as claims handling, coverage disputes, and regulatory issues.

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BRUUN & HJEJLE

1. Rules Governing Insurer Disputes

1.1 Statutory and Procedural Regime

The Danish Insurance Contracts Act (*Forsikringsaftaleloven*) is the most important substantive law in the field of insurance. The Insurance Contracts Act regulates the relationship between insurers, policyholders and insured persons, including the rights and obligations of the parties to an insurance contract.

In Denmark, the resolution of insurance disputes is primarily governed by the general rules of civil procedure as set out in the Danish Administration of Justice Act (*Retsplejeloven*). This Act provides the statutory framework for how civil disputes, including those involving insurance matters, are brought before and handled by the Danish courts. It regulates all key aspects of the litigation process, such as the filing of claims, service of documents, conduct of hearings, evidence, and appeals.

1.2 Litigation Process and Rules on Limitation

Courts Structure

The Danish court system is comprised of the district courts, the High Courts, and the Danish Supreme Court. As a general rule, civil cases are heard by the district courts as the court of first instance. Exceptionally, cases involving fundamental legal questions may be referred directly from the district court to a High Court.

All court decisions can be appealed to a higher court, following the two-tier principle (*to-instans princippet*). Access to the Danish Supreme Court as a third instance requires approval from the Appeals Permission Board (*Procesbevillingsnævnet*), which is only granted for cases with potential significance for future rulings or those of particular public interest.

Pre-Trial Procedure

Proceedings are instituted by filing a writ of summons to the competent court. The content of a writ of summons must meet the requirements set out in Section 348 (2) of the Danish Administration of Justice Act – namely, the writ of summons must:

- state the name and address of the parties, including a postal address in the European Economic Area for the sending of procedural notices to the plaintiff and for service of documents;
- name the court in which the proceedings are instituted;
- state the plaintiff's claim, the amount claimed, the case type, the plaintiff's civil registration number or business registration (*Det Centrale Virksomhedsregister*, or CVR) number (if any), and a brief description of the case;
- include detailed submissions on points of fact and law made by the plaintiff in support of the plaintiff's claim;
- set out the documents and other evidence on which the plaintiff intends to rely; and
- include the plaintiff's proposal for the hearing of the case, including proposed subjects for discussion at the pre-trial hearing (see Section 353 of the Danish Administration of Justice Act).

The court serves the writ of summons on the defendant, who is then required to submit a statement of defence within a specified deadline.

The court will call the parties to a pre-trial hearing unless the court finds such hearing unnecessary. The purpose of the pre-trial hearing is to discuss questions, set deadlines, and encourage settlement.

There is no general discovery process as in common law jurisdictions, but parties must identify and submit the evidence they intend to rely on. The court may order the production of specific documents.

Trial Hearing

The trial hearing is, as a general rule, conducted orally and is open to the public. The counsel for the plaintiff opens and presents the case – after which, both the plaintiff and the defendant give their statements, followed by witness testimonies. Finally, both parties present their closing arguments.

Judgment

As soon as possible after the trial hearing, the court deliberates and issues a judgment, which includes the reasoning and the decision on costs in accordance with Section 219 of the Danish Administration of Justice Act. In cases with one judge, the judgment is issued no later than four weeks after the trial hearing. In cases with several judges, the judgment is issued no later than two months after the trial hearing (Section 219 (3) of the Danish Administration of Justice Act).

Appeal

Judgments from the district courts can be appealed to the High Courts within four weeks following the pronouncement of the judgment. Further appeal to the Danish Supreme Court is only possible with the permission of the Appeals Permission Board.

As described in "Courts Structure", the Danish judicial system is based on a two-tier system, meaning that cases may – as a rule – be freely appealed once to a higher court. As such, judgments of the High Courts in the first instance may be freely appealed to the Danish Supreme Court.

1.3 Alternative Dispute Resolution (ADR)

In Denmark, ADR is generally prevalent and encouraged, and there are several different forms of ADR. The most common forms of ADR are arbitration, judicial mediation (*Retsmægling*), and private mediation. Additionally, in the insurance sector, a special board – the Danish Insurance Complaints Board (*Ankenævnet for Forsikring*) – handles insurance complaints from private consumers regarding insurance and pension matters.

Arbitration

Arbitration is a widely used alternative to the courts, especially for commercial disputes. In recent years, the Danish Institute of Arbitration has seen an increase in the number of cases, indicating the growing popularity of arbitration – particularly in disputes between businesses and in international cases. In 2024, 107 new arbitration cases were initiated at the Danish Institute of Arbitration. This represents an increase of 30% from 2023.

Special rules apply to consumer agreements. An arbitration agreement entered into before a dispute has arisen is not binding on the consumer (Section 7 (2) of the Danish Arbitration Act (*Voldgiftsloven*). Therefore, arbitration is only used to a very limited extent in cases where a consumer is a party.

Judicial Mediation

Judicial mediation takes place within the courts and only after the case has been filed. Mediation conducted by the courts is governed by Chapter 27, Sections 271 to 279 of the Danish Administration of Justice Act and is exclusively applicable to civil matters.

Judicial mediation was introduced in the Danish Administration of Justice Act in 2008 as an initiative aimed at resolving disputes in a way that is cheaper, simpler and quicker than a full court case.

Private Mediation

Private mediation can be facilitated either ad hoc or through an institution such as the Danish Institute of Arbitration.

Traditionally, mediation has not been very prevalent in the insurance industry. However, in 2023, the Danish

Mediation Institute entered into a co-operation agreement with the industry association F&P (Insurance and Pension). This partnership is aimed at promoting the use of mediation to resolve disputes in insurance cases.

Danish Insurance Complaints Board

The Insurance Complaints Board is a private complaints board authorised by the Danish Minister for Business and Growth. The board can only handle complaints from private policyholders (consumers).

The board is the primary complaints body for policyholders seeking out-of-court dispute resolution. Statistics from the board's website show that, in 2024 alone, it handled 1,761 insurance cases.

2. Jurisdiction and Choice of Law

2.1 Rules Governing Insurance Disputes

Generally, the parties are free to agree both on jurisdiction and on choice of law. If the parties have not entered into a valid jurisdiction agreement or valid choice of law agreement, the dispute will be determined according to the following rules.

Jurisdictional Matters

Disputes over jurisdiction in international cases either within the EU or in connection with an EFTA (European Free Trade Association) country that is not a member of the EU are primarily determined according to the rules set out in the Regulation 1215/2012 (the "Brussels I Regulation") and the Convention on jurisdiction and the recognition and enforcement of judgments in civil and commercial matters (the "Lugano Convention").

In the absence of any international factor and where the matter falls outside of the scope of both the Brussels I Regulation and the Lugano Convention, disputes over jurisdictional matters are determined in accordance with the rules on jurisdiction in the Danish Administration of Justice Act. According to the main rule of the Danish Administration of Justice Act in Section 235 (1), legal proceedings must be instituted at the defendant's home court, unless specific legal exceptions apply. With regard to companies, associations and private institutions, the home court is the court of the judicial district in which the main office is located or – if such main office cannot be located – the court of the judicial district in which one of the members of the board of directors or the executive board is resident (Section 238 of the Danish Administration of Justice Act).

Legal proceedings involving a claim for non-contractual damages or penalty may be brought in the court of the judicial district in which the legal wrong was committed (Section 243 (1) of the Danish Administration of Justice Act). Exceptional jurisdiction may also apply in accordance with Section 246 of the Danish Administration of Justice Act, where the defendant in an insurance dispute is not domiciled in an EU member state.

Jurisdictional matters are governed by Sections 235 to 248 of the Danish Administration of Justice Act.

Governing Law in Contractual Obligations

In Denmark, the choice of law in contractual obligations is governed by the Convention on the Law Applicable to Contractual Obligations 1980 (the "Rome Convention"). It is important to note, however, that the Rome Convention applies only to certain insurance contracts. Specifically, it only covers insurance contracts that cover risks situated outside the EU, as well as contracts of reinsurance, pursuant to Article 1 (3) and (4) of the Rome Convention.

If a matter is not covered by the Rome Convention, its regulation is based on non-statutory principles of private international law.

If Danish law is applicable, there are specific mandatory provisions within the Danish Insurance Contracts Act. For instance, the provisions concerning the duty of disclosure and risk information – as set out in Sections 5, 7, 8 and 9 of the Danish Insurance Contracts Act – are mandatory. Also, Section 20 of the Act stipulates that it is not permissible to agree that the insurance company will be exempt from liability if the insured event is caused by negligence that does not qualify as gross negligence.

Insurance Contracts and Choice of Law

In addition, questions regarding the choice of law in insurance contracts are regulated by Directive 2009/138/EC (the "Solvency II Directive"). The Solvency II Directive is applicable insofar as its substantive provisions and its scope of application so dictate. Where an insurance contract does not fall within the ambit of the Solvency II Directive, as stated in Article 178 of the Solvency II Directive, the choice of law is instead governed by the provisions of Regulation No 593/2008 (the "Rome I Regulation") regarding insurance contracts falling within the scope of Article 7 of the Rome I Regulation. This applies even for those EU member states to which the Rome I Regulation does not apply.

The Rome I Regulation does not apply directly in Denmark, owing to the Danish opt-out from certain areas of EU justice and home affairs legislation.

2.2 Enforcement of Foreign Judgments

The ability to enforce foreign judgments in Denmark depends on several factors, including the country of origin of the judgment and the existence of relevant international agreements or conventions.

Judgments From EU Member States

Denmark recognises and enforces judgments from EU member states under the rules set out in the Brussels I Regulation and the Lugano Convention.

Judgments From Non-EU Countries

For judgments from countries outside the EU and the Lugano Convention, enforcement in Denmark is more restricted. In the absence of an agreement on the recognition and enforcement of judgments between Denmark and the country in question, foreign judgments are not automatically recognised or enforceable in Denmark. If a foreign judgment is not recognised, the decision has neither res judicata nor prejudicial effect in Denmark. A new lawsuit must be brought before a Danish court, whereby the foreign judgment may be presented as evidence.

The Minister of Justice may lay down provisions allowing decisions made by foreign courts and authorities on civil claims to have legal effect in Denmark (Section 223 (a) of the Danish Administration of Justice Act).

Foreign judgments are not recognised or enforced on a non-statutory basis in Denmark.

2.3 Unique Features of Litigation Procedure

International insurers should be aware of the following unique features of the Danish litigation procedure.

- Denmark lacks the discovery procedure found in many common law countries. Instead, during exchange of pleadings, parties have the opportunity to request information or documents from the opposing party. If the opposing party fails to comply with such a request, the court may choose to draw adverse procedural inferences against them. It is also possible to request that the court order the opposing party or a third party to produce specific documents. The relevant provisions can be found in Sections 298 to 300 of the Danish Administration of Justice Act.
- As a general rule, the losing party in a litigation is required to compensate the opposing party for the costs incurred in conducting the case. In practice, however, it is rare for the prevailing party to recover all of their expenses, as the rates used by the courts to calculate legal costs are typically much lower than the actual fees charged by attorneys. The rules governing the legal costs are set out in Sections 314 to 316 of the Danish Administration of Justice Act.
- The Danish courts always offer the parties the opportunity to participate in court-facilitated mediation (judicial mediation). Participation in mediation is entirely voluntary and both parties must agree to take part in order for the process to proceed.
- According to section 3 (4) of the Danish Interest Act (*Renteloven*), interest must be paid no later than from the date legal proceedings are initiated, which in practice is the date the claim is filed with the court. The applicable interest rate is the official reference rate set by the Danish National Bank as of January 1st or July 1st of the relevant year, plus an additional 8% per annum.
- In Danish litigation, there is a principle of orality, which means – among other things – that witnesses are generally required to appear in person and give their testimony in court, rather than providing written witness statements.

- When expert opinions are obtained, it is done by the court appointing an expert to conduct an assessment. An independent expert is selected and both parties have the opportunity to ask questions. This means that, as a general rule, unilateral expert opinions are not used to the same extent as in many other jurisdictions.

3. Arbitration and Insurance Disputes

3.1 Enforcement of Arbitration Provisions in Commercial Contracts

Danish courts recognise and enforce arbitration agreements, including those contained in commercial contracts of insurance and reinsurance. A lawsuit concerning disputes that – per agreement between the parties – are to be settled by arbitration will be dismissed upon request by the courts, unless the arbitration agreement is invalid or the arbitration proceedings cannot be conducted for other reasons (Article 8 (1) of the Danish Arbitration Act).

3.2 The New York Convention

Denmark is a party to the Convention on the Recognition and Enforcement of Foreign Arbitral Awards 1958 (the "New York Convention"), having ratified it in 1972.

Foreign arbitral awards are generally recognised and enforced in Denmark. The enforcement process is governed by Section 38 of the Danish Arbitration Act, which is substantively aligned with Article 35 of the UNCITRAL Model Law on International Commercial Arbitration 1985 (the "UNCITRAL Model Law"). As a rule, foreign arbitral awards can be enforced in Denmark under Article 478 of the Danish Administration of Justice Act.

3.3 The Use of Arbitration for Insurance Dispute Resolution

Arbitration in Insurance Disputes

According to Section 7 (2) of the Danish Arbitration Act, an arbitration agreement entered into before a dispute arises is not binding on the consumer. Instead, disputes regarding consumer insurance are typically resolved either though the Danish Insurance Complaints Board or through the ordinary courts.

When it comes to commercial insurance, it is also not customary to agree on arbitration clauses in many standard business insurance policies. Consequently, disputes originating from insurance contracts are generally adjudicated by the ordinary judicial courts. However, there is a greater tendency to include arbitration agreements in larger insurance programmes, particularly those involving significant liability insurance.

Applicable Rules

The main rules are set out in the Danish Arbitration Act, which is based on the UNICITRAL Model Law.

The Danish Institute of Arbitration operates under its own set of rules in terms of the arbitration procedure (the Rules of Arbitration Procedure of the Danish Institute of Arbitration, as adopted by its board) in addition to the Danish Arbitration Act.

Confidentiality in Arbitration

Arbitration proceedings are typically not open to the public. Although parties can agree to make them public, this is uncommon. Parties can also include confidentiality clauses in the arbitration agreement for future disputes.

The Danish Arbitration Act does not address confidentiality, but there is an assumed unwritten obligation for confidentiality in arbitration. If there is no agreement, the arbitral tribunal can decide on confidentiality after hearing the parties, according to Section 19 (2) of the Danish Arbitration Act.

Appeals Against Arbitration Awards

In Denmark, arbitration awards cannot be challenged through ordinary legal remedies. Awards of the arbitral tribunal are not subject to appeal or general review by the Danish courts. Upon request by a party or assessment by the court of the arbitral award, the court may set aside an arbitral award on grounds of invalidity in accordance with Section 37 of the Danish Arbitration Act. Any legal action to set aside an arbitral award must be brought within three months of the date on which the party requesting the setting aside received the award.

According to Section 37 (2) of the Danish Arbitration Act, an arbitral award may only be set aside if either:

- the party requesting the setting aside proves that:
  (a) one of the parties to the arbitration agreement lacked legal capacity under the law of the country in which that party was domiciled at the time the agreement was made, or that the arbitration agreement is invalid under the law chosen by the parties (or – in the absence of such a choice – under Danish law);
  (b) the party requesting the setting aside was not given proper notice of the arbitral proceedings or of the appointment of an arbitrator, or was otherwise unable to present their case;
  (c) the arbitral award deals with a dispute not contemplated by or not falling within the terms of the arbitration agreement, or decides on matters beyond the scope of the arbitration agreement; or
  (d) the composition of the arbitral tribunal or the arbitral procedure was not in accordance with the agreement of the parties or with the Danish Arbitration Act; or
- the court finds that:
  (a) the subject matter of the dispute is not capable of settlement by arbitration under Danish law; or
  (b) the arbitral award is manifestly incompatible with the public policy of Denmark.

4. Coverage Disputes

4.1 Implied Terms

The principle of freedom of contract applies to insurance contracts. This autonomy is both supplemented and constrained by the Danish Insurance Contracts Act, which provides the general legal framework for insurance contracts. Although most provisions of the Danish Insurance Contracts Act are non-mandatory and may be contractually derogated from, certain provisions are mandatory and binding on the parties unless any deviation is more favourable to the policyholder.

In the absence of specific provisions in the Danish Insurance Contracts Act, the general rules of Danish contract law – as set out in the Danish Contracts Act (*Aftaleloven*) – apply.

Interpretation and Ambiguity

As insurance contracts are generally concluded on standard-form terms, the contra proferentem principle applies. Consequently, ambiguities in the policy wording are typically construed against the drafter – most often, the insurer. This interpretative approach may also apply where deviations from the non-mandatory provisions of the Danish Insurance Contracts Act are not expressed with adequate clarity.

In addition, principles of good insurance practice (*God forsikringsskik*) – as well as established industry customs and general practice – may be taken into consideration when interpreting the terms and scope of an insurance contract.

4.2 Rights of Insurers

Under Danish insurance law, insurers may be entitled to limit or disclaim coverage where the policyholder has provided incorrect or incomplete information relating to the insured risk prior to the conclusion of the contract. These matters are governed by Sections 4 to 10 of the Danish Insurance Contracts Act. The central duties imposed on policyholders are the duty to answer and the duty to disclose.

Duty to Answer

If a policyholder provides false information or conceals circumstances that must be presumed to be material for the insurer's risk assessment, the insurer is not bound by the contract (Section 4 of the Danish Insurance Contracts Act). In cases where the incorrect information is due to negligence, and it is probable that the insurer would have refused to enter the contract on the same terms, the insurer cannot be held liable (Section 6 of the Danish Insurance Contracts Act).

However, if the policyholder acted in good faith – meaning without actual knowledge or constructive knowledge of the inaccuracy of the information – the insurer remains liable as if the information had been correct (Section 5 of the Danish Insurance Contracts Act).

Duty to Disclose

Separately from the duty to answer, the policyholder has a general obligation to disclose material facts

not specifically requested but that are relevant to the insurer's assessment of the risk. If the policyholder – through gross negligence – fails to disclose such material information, the insurer cannot be held liable (Section 7 of the Danish Insurance Contracts Act).

It should be noted that the insurer must invoke the incorrect or omitted information without undue delay after becoming aware of it.

4.3 Significant Trends in Policy Coverage Disputes

Local Versus Master Policy

In a recent case from 2024 (Case No BS-40247/2022-SHR), the Danish Maritime and Commercial High Court found that where a local policy (issued in the USA) provided broader coverage than the Danish master policy – due to local legal requirements – the insured was entitled to retain the higher local payout. The Danish Maritime and Commercial High Court emphasised that unless the master policy contains clear, explicit reimbursement or limitation clauses, the insurer cannot demand repayment of excess amounts paid under the local policy. The judgment has been appealed to the Danish Eastern High Court.

Coverage of Injuries related to Pregnancy and Childbirth

In January 2022, 14 Danish insurance companies were fined for violating gender equality regulations by including terms in their personal accident insurance policies that excluded coverage for injuries related to pregnancy or childbirth. As a result, injuries related to pregnancy and childbirth can no longer be directly excluded in insurance terms.

In recent years, there has therefore been significant focus on the scope of coverage for birth-related injuries. It is now recognised that injuries sustained during childbirth may be considered as accidents. However, in each individual case, it must generally be assessed whether the injury occurred as a result of a sudden event or impact, as required by the standard definition of an accident in personal accident insurance policies.

This area is expected to continue developing, with clearer guidelines regarding the extent of coverage likely to emerge.

Coverage of Injury During Work at Home

In the aftermath of the COVID-19 pandemic, an increasing number of people in Denmark have begun working from home, which has given rise to certain coverage issues concerning workers' compensation insurance.

On 2 May 2025, the Danish Supreme Court issued a landmark ruling addressing this matter (published in UfR 2025.2875 H). An employee who suffered an accident at home (tripping over a private box while working) was granted coverage under the Danish Workers' Compensation Act. The court confirmed that injuries sustained during the performance of work tasks at home – and in the employer's interest – are covered, even if the accident involves private household items. The judgment is described in more detail in **7.3 Coverage Issues and Test Cases**.

4.4 Resolution of Insurance Coverage Disputes

Insurance disputes in Denmark may be resolved through various forums, as follows.

- Judicial proceedings – policyholders generally retain the right to initiate legal action before ordinary courts regarding disputes related to coverage, including questions of the insurer's liability or the calculation of compensation.
- Arbitration – certain types of insurance contracts contain arbitration clauses requiring specific disputes to be resolved through arbitration. With regard to the use of arbitration for insurance dispute resolution, please see **3.3 The Use of Arbitration for Insurance Dispute Resolution**.
- Internal complaints procedure – in accordance with the Executive Order on Complaints Officers in Financial Undertakings, insurance companies must designate an internal complaints officer. Policyholders disputing the insurer's claims management or decision may refer their case to this officer for internal review.

Disputes arising under reinsurance agreements are generally resolved using the same procedural mechanisms applicable to primary insurance contracts.

4.5 Position If Insured Party Is Viewed as a Consumer

In addition to the dispute resolution forums described in **4.4 Resolution of Insurance Coverage Disputes**, consumers may file complaints with the Danish Insurance Complaints Board (see **1.3 Alternative Dispute Resolution (ADR)**). Although the Danish Insurance Complaints Board's decisions are non-binding for policyholders, they are binding for insurers unless the insurer – within 30 days of notification – submits a written notice declining to be bound by the decision.

4.6 Third-Party Enforcement of Insurance Contracts

In general, only the policyholder is entitled to invoke rights under the insurance contract. Thus, third parties who are not parties to the contract are – as a rule – precluded from bringing claims directly against the insurer.

However, there are exceptions to this rule. The most notable are as follows.

- Property insurance is not solely limited to the policyholder. The insurance also extends to third parties (eg, mortgagees) who would sustain losses because of damage to or destruction of the insured object (Section 54 of the Danish Insurance Contracts Act).
- An injured party is entitled to bring a direct claim against the tortfeasor's insurance company, provided that both the tortfeasor's liability and the amount of compensation have been established (Section 95 of the Danish Insurance Contracts Act).
- The injured party in a motor vehicle accident is entitled to bring a direct claim against the tortfeasor's insurance company (Section 108 of the Danish Road Traffic Act (*Færdselsloven*)).
- Third parties may be entitled to invoke certain right if they are expressly named or included as an "insured person" in the policy (Section 57 of the Danish Insurance Contracts Act).

4.7 The Concept of Bad Faith

The Danish Insurance Contracts Act contains a limited number of provisions concerning bad faith. Under Danish law, bad faith is defined as knowledge or constructive knowledge. In relation to insurance, a key provision is Section 4, which exempts the insurer from liability for incorrect information provided by the policyholder if the latter acted in bad faith.

Moreover, the Danish Contracts Act serves a supplementary legal framework for insurance contracts in cases where the Danish Insurance Contracts Act does not provide specific regulation. Within this scope, the concept of bad faith plays a significant role in several contexts, including the formation of contracts, their invalidity, and agency relationships.

4.8 Penalties for Late Payment of Claims

If the insurer is paying a claim late, the insurer must pay interest on the amount. According to Section 24 (1) and (2) of the Danish Insurance Contracts Act, the insurer must pay interest when 14 days have passed since the day the insurer was able to obtain the information necessary to assess the validity and amount of the claim. The interest is set at an annual rate corresponding to the rate set by the Danish National Bank plus an additional 8%.

4.9 Representations Made by Brokers

In Denmark, insurance brokerage is a distinct and regulated profession, subject to specific legal obligations. The profession is governed by the Danish Insurance Mediation Act (*Lov om forsikringsformidling*) and the Executive Order on Good Practice for Insurance Distributors (*Bekendtgørelse om god skik for forsikringsdistributører*). According to these regulations, insurance brokers are required to act in the best interests of their clients by consulting multiple insurance providers to obtain the most appropriate coverage at the most competitive price.

Under the Executive Order on Good Practice for Insurance Distributors, the power of attorney should specify the extent to which the intermediary is authorised to act on behalf of the client, as well as whether information provided by the broker is to be considered as if it had been given directly by the client. In the absence of such specifications, the policyholder may, in many cases, be held liable for statements made by the broker.

Furthermore, the question of whether the policyholder is bound by the broker's actions is determined by the general rules on agency under Danish law.

4.10 Delegated Underwriting or Claims Handling Authority Arrangements

In Denmark, both delegated underwriting agreements and claims handling authority arrangements are common.

A few years ago, several insurance companies in Denmark went bankrupt (including Gefion Insurance, Qudos Insurance, and Alpha Insurance), which has led to disputes regarding the calculation of insurance agents' commissions. Most of these cases have been settled out of court – although some are still pending.

5. Claims Against Insureds

5.1 Main Areas of Claims Where Insurers Fund the Defence of Insureds

The main areas of claims in which insurers fund the defence of the insured is under liability insurances, such as:

- professional indemnity insurance;
- commercial general liability insurance; and
- D&O insurance.

In such cases, the insurer provides funding for the defence when the insured faces a liability claim brought by a third party. This is usually stated directly in the policy; however, even if there is no clause to this effect, the default position is that the insurer covers defence costs under liability insurance, pursuant to Section 92 (1) of the Danish Insurance Contracts Act.

According to section 92 (3) of the Danish Insurance Contracts Act, the insurer must pay the legal costs and interest (at the rate set by the Danish National Bank plus an additional 8%), even if the sum insured is exceeded. It is possible to agree otherwise but, in the vast majority of Danish liability insurances (namely, professional indemnity insurance and commercial general liability insurance), this principle is generally not deviated from. As a result, the insurer will sometimes cover an amount exceeding the sum insured.

5.2 Likely Changes in the Future

Although the complexity of liability cases brought against insurers is expected to continue increasing, as outlined in **5.3 Trends in the Cost or Complexity of Litigation**, no significant changes are anticipated regarding the funding of the defence for insured parties.

5.3 Trends in the Cost or Complexity of Litigation

In recent years, there has been a clear trend towards more complex and high-value liability claims being brought against insured parties, particularly under professional indemnity insurances, warranty and indemnity (W&I) insurances, and D&O insurances. This development is evident in both the scale and the intricacy of the cases, which often involve substantial damages and extensive documentation.

Litigation Funding

In recent years, so-called litigation funding has become increasingly common. This refers to situations where a third party finances a lawsuit on behalf of one or more parties in exchange for a share of any amount recovered. As a result, there has been a rise in the number of compensation claims involving very large sums, and these claims are typically brought against parties who are covered by insurance (and therefore have the ability to pay a potential award). Most often, these are professional advisers, such as lawyers and accountants, as well as members of management.

D&O Disputes

As litigating funding has become more common, there has been a noticeable rise in large group actions against major Danish companies – many of which trigger coverage under D&O insurance policies. These cases frequently involve very large claims for damages, and the volume of case material can be considerable, resulting in substantial legal costs for insurers in defending these claims.

By way of example, a number of Danish and international investors filed class actions against Danske Bank and several individuals, seeking damages for share price declines and violation of disclosure requirements following the money laundering case

relating to Danske Bank's Estonian branch. In November 2022, the District Court of Lyngby considered one of the investors' claims for approximately DKK2.4 billion against the former CEO of Danske Bank. The district court dismissed the claim in its entirety – finding that the CEO had not received information that could result in the stock price decline – and ordered the plaintiffs to pay DKK10 million in legal costs. The case has been appealed by some of the investors to the Danish Eastern High Court.

Professional Indemnity Disputes

A similar pattern can be observed in liability cases against professional advisers, such as attorneys and auditors. There is a growing tendency to hold professional advisers liable. By way of example, the Danish tax authorities recently brought a claim exceeding DKK700 million against a law firm that had issued a legal opinion regarding the possibility of reclaiming withholding tax. This opinion was subsequently used by a foreign bank to unjustifiably request refunds from the Danish tax authorities, leading to a historic loss for the Danish state. In the autumn of 2023, the Danish Supreme Court found the law firm liable for DKK400 million in damages (judgment published in UfR 2024.764 H).

As a consequence of the increasing amount of claims against auditors, several insurers in Denmark have withdrawn from offering professional indemnity coverage for auditors and premiums have increased significantly.

W&I Disputes

W&I insurance is increasingly common in M&A transactions, reflecting a market trend towards managing risks related to warranty breaches. As a result, M&A disputes are often very large and complex, involving high-value claims.

In a recent case, a buyer brought a claim against the seller – and subsequently against the seller's former management – after uncovering accounting irregularities in the target company following completion of the transaction. The dispute was initially pursued as an arbitration against the seller, which resulted in a finding of liability for breach of warranties. A payout of EUR50 million was made under the W&I insurance policy; however, this amount did not fully cover the buyer's losses. The seller was unable to pay the remaining amount, even with the W&I coverage, and consequently went bankrupt.

The buyer has since initiated litigation before the Danish civil courts, seeking recovery from – among others – the former management of the seller. The case was first heard by the Danish Maritime and Commercial Court, which acquitted the defendants. The decision has been appealed and the case is currently pending before the Danish Western High Court.

Forecast

It is expected that the trend towards large and complex liability cases against both management and professional advisers will continue. This is particularly likely because these parties typically – and, in the case of attorneys and auditors, always – have insurance coverage in place. The availability of insurance makes such claims more attractive to claimants and litigations funders, which in turn is likely to sustain or even increase the current level of complexity and cost in this area of litigation.

5.4 Protection Against Costs Risks

Legal expenses insurance serves as a mechanism for reducing the financial exposure associated with litigation. Rather than functioning as an independent policy, legal expenses insurance is instead incorporated into primary insurance policies such as liability, home, building, or motor vehicle insurance.

The terms and conditions governing legal expenses insurance are standardised across the market, with the exception of the deductible and the coverage limit.

This type of insurance covers the policyholder's costs in connection with legal disputes, including court fees, legal representation, and witness fees. It also includes costs awarded to the counterparty for which the policyholder is liable.

In the past few years, it has also become more common for claimants to agree with a third party to provide funds to cover the costs of a legal dispute in exchange for a share of any proceeds recovered (litigation funding).

Similarly, a new trend has emerged whereby claimants can obtain cover for known risks (typically, prospective or ongoing legal or administrative proceedings), securing a financial investment on behalf of the insured (litigation risk insurance). Litigation risk insurance has commonly taken two forms – either as adverse judgment insurance or as judgment preservation insurance.

6. Insurers' Recovery Rights

6.1 Right of Action to Recover Sums From Third Parties

Under Danish law, insurers have a statutory right of recourse against third parties who are liable for losses covered by a non-life insurance (Section 22 of the Danish Liability and Compensation Act (*Erstatningsansvarsloven*)). This right, however, is subject to the following exceptions and limitations.

- The right of recourse does not apply in cases covered by property insurance or business interruption insurance, unless the damage is caused intentionally or through gross negligence or in the course of public or professional activities (Section 19 of the Danish Liability and Compensation Act).
- The right of recourse does not apply in cases where damage is caused by an employee and is covered either by property or business interruption insurance or by the employer's liability insurance (Section 19 of the Danish Liability and Compensation Act).
- The two above-mentioned exceptions do not apply if the liability is regulated in the Danish Road Traffic Act, the Danish Aviation Act, or the Danish Maritime Act (Section 21 of the Danish Liability and Compensation Act)

The right of recourse does not apply – with no exceptions – if the loss is covered by a life, accident, health or other personal insurance (Section 22 of the Danish Liability and Compensation Act).

6.2 Legal Provisions Setting Out Insurers' Rights to Pursue Third Parties

The general framework for insurers' recourse rights against third parties is set out in Sections 19 to 22 of the Danish Liability and Compensation Act. Supplementary provisions may also be found in specific statutes, such as the Danish Road Traffic Act.

7. Impact of Macroeconomic Factors

7.1 Type and Amount of Litigation

There are currently no official statistics indicating that the overall amount of litigation in Denmark has been directly affected by global events such as the war in Ukraine. However, it is clear that these events have given rise to specific legal challenges, particularly for companies with business operations in either Ukraine or Russia. These challenges often relate to contractual obligations and supply chain disruptions.

In addition, following the COVID-19 pandemic, several new legal issues have emerged. By way of example, there have been questions about whether contracting COVID-19 at the workplace constitutes an occupational injury, and it is generally accepted that it can be considered as such. The pandemic has also led to other litigations, such as whether an accident occurring at home during while working remotely can be classified as a work-related injury (see **4.3 Significant Trends in Policy Coverage Disputes** (Coverage of Injury During Work at Home) and **7.3 Coverage Issues and Test Cases** for further details). This issue has become particularly relevant as remote work has become more common since the pandemic.

7.2 Forecast for the Next 12 Months

It is expected that new issues will continue to arise in connection with the war in Ukraine during the next 12 months. As the situation develops, it is likely that these emerging challenges will lead to an increase in litigation.

The ongoing geopolitical instability, including the war in Ukraine, is likely to heighten the risk of cyber-incidents. It is anticipated that the frequency and sophistication of cyber-attacks will continue to rise, causing more disputes in cyber-insurance coverage.

In addition, it is anticipated that the new tariffs introduced by the USA will also result in the emergence of further issues for commercial policyholders. These

changes are expected to create additional challenges for businesses and may, in turn, lead to more disputes.

7.3 Coverage Issues and Test Cases

The COVID-19 pandemic has given rise to specific coverage issues. A notable example – as mentioned in **4.3 Significant Trends in Policy Coverage Disputes** (Coverage of Injury During Work at Home) – is the recent Danish Supreme Court decision of 2 May 2025 (published in UfR 2025.2875 H), which addressed whether an injury sustained by an employee working from home during the COVID-19 pandemic constituted a compensable work accident under the Danish Workers' Compensation Act.

The central issue in the case was whether an employee, who was required to work from home owing to COVID-19 restrictions, was covered by workers' compensation insurance when she suffered an injury after tripping over a private object (a box) in her home while performing a work-related activity (making coffee during working hours). The Supreme Court ultimately recognised the incident as a work accident, setting a precedent that injuries sustained during home-based-work – if connected to work activities – are generally covered, even if private home conditions contribute to the accident.

7.4 Scope of Insurance Cover and Appetite for Risk

The outcome of the Danish Supreme Court decision described in **7.3 Coverage Issues and Test Cases** is expected to have significant and far-reaching implications for insurers and policyholders alike. The ruling broadens the interpretation of what constitutes a work-related injury, particularly in the context of remote work.

War in Ukraine

With regard to the war in Ukraine, it is important to note that most Danish insurance policies include war exclusions. This means that losses arising directly or indirectly from acts of war are generally not covered by standard insurance policies. As a result, a number of businesses may find themselves without insurance coverage for losses related to the war in Ukraine.

Cyber-Risks

The focus on cyber-insurance has increased significantly in Denmark, with most insurance companies offering such solutions. In addition to covering financial losses, these products often include notification services, employee training, and similar services.

Increased Risk of D&O Liability

In addition, the volume of civil claims seeking damages from directors, officers, and other members of upper management has increased significantly throughout the past decade. This has prompted a corresponding escalation in D&O liability insurance premiums, as well as a decrease in the scope of cover, particularly with regard to allegations implicating money-laundering offences.

This has led companies listed on the OMX Copenhagen 25 to adopt indemnity clauses, designed to safeguard their directors and board members against residual liabilities that fall outside – or are insufficiently covered by – the relevant D&O policy. This practice was confirmed as compatible with Danish company law by the Danish Business Authority in an opinion published in 2023.

8. Emerging Risks

8.1 Impact of ESG on Underwriting and Litigating Insurance Risks

Weather Conditions

One of the most significant ESG factors affecting the underwriting and litigation of insurance risks is the increased frequency of extreme weather events. In Denmark, recent years have seen particularly storm damage and extreme rainfall, leading to floods, which have significantly influenced the underwriting risks. Specifically, storm damage and extreme rainfall have led to floods in Denmark in recent years, significantly influencing the underwriting of insurance risks.

Natural Disasters

In addition to extreme weather conditions, natural disasters are also affecting the underwriting of insurance risks.

A pertinent example of the impact of natural disasters in Denmark in this regard is the "Nordic Waste" case. In December 2023, a major landslide at Nordic Waste's site was caused by heavy rainfall. The landslide involved large amounts of contaminated soil (approximately six million tonnes), creating a risk of pollution to local streams. It has been estimated that the clean-up following the landslide could cost as much as DKK500 million. Despite having environmental insurance coverage, the company faced costs far exceeding the policy limits.

ESG as a Risk Factor

If the insured performs poorly in the ESG areas, it can lead to reputational damage, regulatory scrutiny, and legal challenges – all of which may result in insurance claims. Therefore, some Danish insurance companies have started to incorporate ESG factors as a risk on a par with other traditional risks in the underwriting of new customers.

8.2 Data Protection Laws

Data protection is primarily governed by the EU General Data Protection Regulation (GDPR), which is implemented and supplemented by the Danish Data Protection Act (*Databeskyttelsesloven*). Additionally, insurance companies are subject to specific confidentiality obligations under Section 82 of the Danish Insurance Business Act (*Lov om finansiel virksomhed*), which prohibits insurers and their employees from unlawfully disclosing or misusing confidential information. Violations of this obligation may result in fines or imprisonment.

9. Significant Legislative and Regulatory Developments

9.1 Developments Affecting Insurance Coverage and Insurance Litigation

There have not been any specific legislative or regulatory developments recently that would significantly affect insurance coverage and insurance litigation. However, there is a general trend towards increased specification and tightening of regulatory requirements, both for financial institutions such as banks and for product safety standards.

For financial institutions, this increased regulation may impact the exposure of management members to liability claims and potential fines, triggering payouts of D&O insurance.

Similarly, in the area of product safety, new regulations can expose manufacturers and distributors to potential liability claims. An example of this is the General Product Safety Regulation (EU 2023/988) (GPSR), which came into force on 13 December 2024. This regulation introduces stricter requirements regarding the safety of products sold to consumers, which could have an impact on product liability insurers.

INDIA

Law and Practice

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Tuli & Co

Contents

Tuli & Co was established in 2000 to service the Indian and international insurance and reinsurance industry. It is an insurance-driven commercial litigation and regulatory practice, which has working associations with firms in other Indian cities. While Tuli & Co's principal office is in Noida and it has another office in Mumbai, the firm has a pan-India presence with insurance/reinsurance and complex commercial disputes before the Supreme Court, High Courts and tribunals across the country. Currently, 54 lawyers work for the firm.

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1. Rules Governing Insurer Disputes

1.1 Statutory and Procedural Regime

The insurance sector in India is regulated by the Insurance Regulatory and Developmental Authority of India (IRDAI), and there are, in addition, several consumer-centric regulations setting out various practice directions and guidelines to be followed by insurers, reinsurers and insurance intermediaries.

The IRDAI can investigate, either on its own motion or following a complaint or any other information received from policyholders/third parties, any alleged breach by insurers, reinsurers or insurance intermediaries, and the punishment can include a monetary penalty of up to INR10 million (approximately USD113,990) for each breach, resulting directions and/or cancellation of the relevant registration.

Apart from supervisory proceedings before the IRDAI and proceedings before any other regulators, such as the Securities and Exchange Board of India (SEBI), the Competition Commission of India (CCI) or the Central Consumer Protection Authority (CCPA), insurance and reinsurance disputes are generally adjudicated in the following forums.

- Arbitral tribunal – Most commercial general insurance contracts typically used to have a standard arbitration clause where any dispute on quantum – liability already having been admitted – could be referred to arbitration. This position has now changed on account of IRDAI's circular dated 27 October 2023 by virtue of which the insured and insurer are at liberty to enter into a separate arbitration agreement. See **3.1 Enforcement of Arbitration Provisions in Commercial Contracts** for a detailed discussion on this circular.
- Civil courts – Retail general insurance contracts, life insurance and health insurance contracts usually contain a jurisdiction clause in favour of the courts. For commercial general insurance contracts with an arbitration clause, insureds can approach a civil court when the dispute falls outside the scope of the arbitration clause.
- Consumer forums – Insureds can approach consumer forums with the relevant monetary and territorial (if applicable) jurisdiction. The right to approach a consumer forum is an independent option/remedy which cannot be curtailed even by an existing arbitration clause.

1.2 Litigation Process and Rules on Limitation

Litigation Process

An insured may, depending on the underlying facts, raise a dispute before an arbitral tribunal, an appropriate civil/commercial court or a consumer forum. See **1.3 Alternative Dispute Resolution (ADR)** for a discussion on arbitration.

Disputes before a civil/commercial court

The Commercial Courts Act 2015 (the "CCA 2015") prescribed the constitution of commercial courts for adjudicating commercial disputes of a specified value. The commercial courts have been set up at the district level as well as at the High Court level with the objec-

tive of having a more streamlined process for speedier adjudication of commercial disputes. It is mandatory to undergo a pre-mediation exercise before filing a commercial suit unless urgent interim relief is sought.

These courts are, effectively, civil courts with a specific mandate to hear only commercial matters. Insurance and reinsurance have been classified as "commercial disputes" under the CCA 2015. The pecuniary threshold for a dispute to be classified as "commercial" is INR300,000 (approximately USD3,419).

The commercial courts are governed by the Code of Civil Procedure 1908 (CPC) and the CCA 2015. If there is a conflict between the two, the CCA 2015 will generally prevail.

Civil courts in India are divided into district courts, high courts and the Supreme Court, in ascending order of hierarchy. There are approximately 688 district courts, 25 high courts and the Supreme Court, which is the highest court of law in India.

Out of the 25 high courts in India, the high courts at Calcutta, Bombay, Madras, Delhi and Himachal Pradesh have original jurisdiction to decide matters, including commercial matters, where the quantum of dispute is higher than an ascertained pecuniary value and, in relation to Calcutta and Madras, within a designated territorial limit from the High Court. Disputes below the prescribed monetary value would go to the commercial court with appropriate territorial jurisdiction at the district level or an ordinary civil court where the value is lower than INR300,000 (approximately USD3,419).

In all other cases, commercial courts at the district level with the necessary territorial jurisdiction can hear insurance/reinsurance disputes which are valued at INR300,000 (approximately USD3,419) and above. The hierarchy and designations of commercial/civil courts at the district level may be different across states in India.

Disputes before a consumer forum

The consumer commissions have a three-tier hierarchy, with District Commissions at the lowest rung, followed by a State Commission (for every state) and a National Commission at the apex level. District Commissions have the jurisdiction to deal with complaints arising out of contracts for services or goods (which includes insurance and reinsurance disputes) involving allegations of "deficiency in service", where the consideration does not exceed INR5 million (approximately USD56,995). For the State Commission, the threshold is over INR5 million up to INR20 million (approximately USD227,981), whereas the National Commission can take up original complaints where the consideration is above INR20 million. The District Commission and the State Commission must also have the necessary territorial jurisdiction.

Rules on Limitation

Limitation periods are generally governed by the Limitation Act 1963 (the "Limitation Act"), save for the limitation period to approach a consumer forum which is prescribed under the Consumer Protection Act 2019 (the "Consumer Act 2019").

According to Schedule 55 of the Limitation Act, the limitation period of three years is calculated either from:

- the date of the occurrence causing the loss; or
- the date of denial of the claim under the policy.

Under the Consumer Act 2019, the limitation period is two years instead of three years.

Some insurance contracts specify timelines to report claims and others require the reporting to be "as soon as reasonably practicable", both forms of which are typically expressed as conditions precedent to the insurer's liability. Therefore, the court may refuse to impose liability on account of a delay in notification of a claim, even if some portion of the limitation period still remains available to the insured.

In situations where a loss has been notified to the insurer, and the claim has been rejected or the policy is avoided, the limitation period of three years will commence from the date of communication of such denial.

1.3 Alternative Dispute Resolution (ADR)

Mediation

Mediation, conciliation and arbitration are recognised as ADR mechanisms. High courts and district courts generally have mediation cells and mediation has particularly gained traction following the introduction of the CCA 2015, which makes mediation a prerequisite to bringing a suit.

The Mediation Act 2023 (the "Mediation Act") was enacted to encourage institutional mediation for dispute resolution in India. While the Mediation Act was given assent by the President of India on 14 September 2023, only a few provisions have been notified at the date of writing.

Arbitration

On the adjudicatory front, arbitration is preferred for commercial disputes and most commercial contracts have an arbitration clause. The Arbitration and Conciliation Act 1996 (the "Arbitration Act") has been amended over the years with the aim of making arbitration a more effective and attractive alternative to court proceedings.

There are set timelines for completing domestic arbitrations, while in international commercial arbitrations there are guidelines/best practices in relation to timelines.

There is also an option for "fast track" arbitration, where an award may be passed within six months if the requirements are met.

Settlement Outside Courts

Independently, where a court is of the view that there are elements of settlement that may be acceptable to parties before it, it may formulate the possible terms of settlement, take the view of the parties and refer the parties to either:

- arbitration;
- conciliation;
- judicial settlement, including settlement through *Lok Adalat* or
- mediation.

This power is derived from Section 89 of the CPC. Such reference will require the consent of the parties where such consent/agreement is otherwise required under law, for instance in the case of arbitration.

Insurance-Specific ADR

Specifically for insurance disputes, the government of India has created the Insurance Ombudsman Scheme, which enables individual policyholders to settle their complaints out of court in a cost-effective and efficacious manner. An aggrieved policyholder can approach the Insurance Ombudsman provided their claim value is under INR5 million (approximately USD56,995).

2. Jurisdiction and Choice of Law

2.1 Rules Governing Insurance Disputes

Retail general insurance, life insurance and health insurance contracts usually contain a jurisdiction clause in favour of the courts. Typically, standardised arbitration clauses were mostly found in commercial general insurance contracts where any dispute on quantum, liability having been admitted, could be referred to arbitration. This position has now changed on account of IRDAI's circular dated 27 October 2023, by virtue of which the insured and insurer are at liberty to enter into a separate arbitration agreement. See **3.1 Enforcement of Arbitration Provisions in Commercial Contracts** for a detailed discussion on this circular.

2.2 Enforcement of Foreign Judgments

The enforcement and recognition of foreign judgments and decrees in India are governed by, inter alia, Section 44-A and relevant orders of the CPC. Only a foreign judgment of a superior court of a reciprocating territory, as notified by the government of India, can be enforced before the appropriate court in India.

In this regard, the Indian government has notified several reciprocating jurisdictions, including Bangladesh, the Colony of Aden, the Colony of Fiji, Hong Kong SAR, the Republic of Singapore, the Federation of Malaysia, Myanmar, New Zealand and the Cook Islands, the Trust Territories of Western Samoa, Papua New Guinea, Trinidad and Tobago, the Sultanate of Oman, the UAE and the UK.

2.3 Unique Features of Litigation Procedure

Case Load

In India there are about 46,624,074 civil cases pending before various district and lower courts, about 6,329,222 before the high courts and 86,723 before the Supreme Court.

These statistics may not provide a completely accurate current position given that several of these matters may not even be in a position to be heard on account of the parties' non-compliance.

Nonetheless, it is generally accepted that the disposal rate of individual judges and courts is on the higher side.

Court proceedings in India can often be time-consuming and potentially expensive. The establishment of commercial divisions has somewhat reduced the length of time, but the process is still lengthy and potentially expensive.

Domestic arbitrations have specified timelines for completion. According to Section 29A of the Arbitration Act, arbitration proceedings are required to be completed within 12 months from the date of completion of pleadings (a maximum period of six months for completing pleadings). Parties may, by mutual agreement, extend the 12-month period by another six months. Any further extension can only be granted by a court upon an application by a party.

There are no specific mandatory timelines for concluding an international commercial arbitration (arbitration seated in India with one non-Indian party), but Section 29A of the Arbitration Act states that the tribunal will endeavour to conclude such proceedings within 12 months from the completion of pleadings.

Arbitration-related court proceedings are generally disposed of relatively expeditiously.

There are limited grounds to challenge a purely domestic arbitral award. The grounds available for challenging an award arising out of an international commercial arbitration are further limited, as the ground of "patent illegality" is not available.

Costs of Proceedings

Courts in India refrain from awarding actual costs, and if costs are awarded in court proceedings, they are nominal.

In arbitration proceedings, Section 31A of the Arbitration Act gives the discretion to the arbitral tribunal to award costs to a party. The Arbitration Act defines costs as fees and expenses of the arbitral tribunal and lawyers, administrative fees and any other expenses incurred in connection with the arbitration proceedings. The costs awarded are typically "reasonable costs" as opposed to actual costs.

3. Arbitration and Insurance Disputes

3.1 Enforcement of Arbitration Provisions in Commercial Contracts

Indian courts generally strictly enforce arbitration clauses. This position also holds true for insurance and reinsurance contracts.

The seven-judge bench of the Supreme Court in its landmark decision in the case of *In Re Interplay Between Arbitration Agreements under the Arbitration and Conciliation Act 1996 and the Indian Stamp Act 1899*, (2024) 6 SCC 1 overruled the earlier five-judge bench decision of *NN Global Mercantile Pvt Ltd v Indo Unique Flame Ltd* (2023) 7 SCC 1 and held that an unstamped instrument containing an arbitration clause is valid and enforceable in law. The Supreme Court has also held that an arbitration agreement is a separate contract, and the invalidity of the underlying instrument does not render the arbitration agreement void. On 27 October 2023, the IRDAI issued a circular directing that all policies issued under the commercial lines of business shall have a mandatory arbitration clause, which stipulates that "the parties to the contract may mutually agree and enter into a separate Arbitration Agreement to settle any and all disputes in relation to this policy". In case parties mutually agree on an arbitration agreement, then the arbitration proceedings will be conducted as per the provisions of the Arbitration Act. The circular has further deleted arbitration clauses from all polices under the retail lines of business prospectively. For the existing retail policies, the existing arbitration clause shall remain

valid until the term of the policy expires unless a policyholder specifically requests the insurer to replace it with the clause mandated by the IRDAI. This also applies to all existing policies issued under the commercial lines of business.

Notably, the Supreme Court in *BGM & M-RPL-JMCT (JV) v Eastern Coalfields Ltd*, 2025 SCC online SC 1471, has recently clarified that a contractual clause which merely provides that disputes "may be" resolved through arbitration does not, by itself, constitute a valid and binding arbitration agreement within the meaning of Section 7 of the Arbitration Act. The court made it clear that such language is merely enabling and does not bind the parties to arbitrate unless there is a subsequent, express agreement to that effect.

Further, a five-judge bench of the Supreme Court in the case of *Cox & Kings Ltd vs SAP India (P) Ltd* (2024) 4 SCC 1, held that non-signatories to an arbitration agreement may be joined as parties to an arbitration proceeding. However, before doing so, the court or tribunal must determine whether such persons or entities intended to be bound by the arbitration agreement or the underlying contract based on their conduct, rights, or involvement in the formulation, execution, or termination of the contract.

3.2 The New York Convention

India is subject to the New York Convention as well as the Geneva Convention. Enforcement of an arbitral award rendered in a recognised jurisdiction is governed by Part II of the Arbitration Act.

The party applying for enforcement of a foreign award is required to produce, as evidence, the following:

- the original award or a duly authenticated copy of the award;
- the original arbitration agreement or a duly certified copy of the same; and
- such other evidence as is necessary to prove that it is a foreign award.

Refusal to Enforce a Foreign Award

Enforcement of a foreign award may be refused on any of the following grounds (among others):

- a party to the arbitration is under some incapacity or the arbitration agreement is not valid under the law to which the parties have subjected it or under the law of the country where the award was made;
- no proper notice of the appointment of an arbitrator or of the arbitration proceedings was served, or a party was otherwise unable to present its case;
- the arbitral award is beyond the scope of the arbitration agreement;
- the composition of the arbitral tribunal was not in accordance with the parties' agreement or the law of the country where the arbitration took place;
- the award has not yet become binding on the parties, or has been set aside or suspended at the seat of the arbitration;
- the subject matter of the arbitration is not arbitrable under the law of India; and
- the enforcement of the award would be contrary to the public policy of India.

3.3 The Use of Arbitration for Insurance Dispute Resolution

Most commercial general insurance contracts typically have a standard arbitration clause where any dispute on quantum, liability having been admitted, can be referred to arbitration. Under such limited arbitration clauses, the insured would be precluded from arbitrating disputes where the claim has been rejected in its entirety as not being covered under the policy or the policy has been repudiated. However, the insured may also choose to approach the consumer forum (if applicable), which is a summary procedure, or the relevant civil/commercial court.

The Supreme Court has recently settled the question of whether corporate insureds can be considered as "consumers" under the Consumer Protection Act 1986 (the "Consumer Act 1986"). The Supreme Court in the case of *National Insurance Co Ltd v Harsolia Motors* (2023) 8 SCC 362 has held that since insurance contracts are contracts of indemnity there exists no element of profit generation and therefore insurance disputes come within the purview of the Consumer Act 1986.

Applicable Rules

The arbitration clauses must be standardised, and the arbitration is governed by the provisions of the

Arbitration Act, including in relation to the procedural rules for conducting the arbitration. That being said, an arbitrator/arbitral tribunal, with the consent of the parties, may adopt its own procedural rules for conducting the proceedings as long as such rules are not in contravention of any non-derogable provisions of the Arbitration Act. The Arbitration Act is based on the principles of party autonomy, and the power to determine procedural rules governing the arbitration proceedings is enshrined in Section 19 of the Arbitration Act.

Challenge to an Award

Section 34 of the Arbitration Act provides a party with a right to approach a court to set aside an arbitral award. A court hearing a challenge of an award does not sit as a first appellate court over the decisions of an arbitral tribunal, and therefore, it cannot re-examine the evidence/merits to arrive at a different possible conclusion or finding.

The court's scope of interference is limited to the grounds laid out in Section 34, which includes incapacity of a party to enter into arbitration, improper notice of arbitration, ultra vires jurisdiction, invalid composition of the arbitral tribunal, a conflict with the public policy of India, and patent illegality appearing on the face of the award. Also, by way of the amendment to the Arbitration Act in 2015, the scope of "public policy" has been narrowed down to include only those instances where:

- the making of the award is fraudulent or corrupt;
- the award is in contravention of the fundamental policy of Indian law; or
- the award is in conflict with the most basic notions of morality or justice.

The scope of interference is further restricted where an arbitral award has been passed in an international commercial arbitration, in which case the ground of "patent illegality", which includes perversity, is not available.

An application for setting aside an award must be made before the expiry of three months from the date on which the award was received by the party concerned. The courts can entertain the application beyond three months, but within 30 days, if the party concerned is able to demonstrate sufficient cause.

The order by the court under Section 34 of the Arbitration Act can be appealed, under Section 37, to the court with the necessary jurisdiction to hear appeals from the court in question. There is no statutory right to appeal from an order passed under Section 37. However, a party may prefer a special leave petition, under Article 136 of the Constitution of India to the Supreme Court. It is at the discretion of the Supreme Court to entertain such a petition, which it does sparingly.

4. Coverage Disputes

4.1 Implied Terms

Under Indian law, there are a number of terms that are implied into a contract of insurance. For instance, even though a policy may not expressly say so, all contracts of insurance are of utmost good faith and insurers are entitled to a fair presentation of the risk before its inception. The duty of utmost good faith places an obligation on the insured to voluntarily disclose all material facts relevant to the risk being insured. If there has been a misrepresentation or non-disclosure of a material fact, then an insurer can avoid the policy from its inception. Courts have held that the duty of utmost good faith applies not only at the inception of the contract of insurance but throughout its existence and even thereafter.

Another implied term is the right of subrogation, for which there is also statutory and judicial recognition. While there may not be a need for a separate contractual clause to trigger it, in practice, policies do contain subrogation clauses.

4.2 Rights of Insurers

Insurers are entitled to a fair presentation of the risk before a policy's inception, and this entitlement is derived from the fundamental principle of insurance law that utmost good faith must be observed by the contracting parties. This forbids the insured from concealing what they privately know, with a view to drawing the insurer into a bargain based on their ignorance of that fact. Insurers can avoid the policy if there

is fraud, misrepresentation or non-disclosure by the insured prior to the inception of the policy.

4.3 Significant Trends in Policy Coverage Disputes

In the past year, the courts have addressed a significant number of insurance-related issues, particularly in relation to interpretation of insurance policies, disclosure of material facts, and repudiation of claims by insurers on grounds of non-production of documents. There has been a trend towards stricter interpretation of terms and conditions of policies. Courts have reiterated that policy terms should be given paramount importance, and it is therefore not for courts to add, delete or substitute any wording. Courts have also held that the rule of contra proferentem will not apply unless there is a genuine ambiguity in the policy wording.

In terms of disclosure requirements, courts have recently held that non-disclosure and misrepresentation of material facts are sufficient grounds for an insurer to avoid a policy.

In relation to the burden of proof, courts have held that it is the insured's burden to establish that it suffered a loss, and that such a loss is covered under the policy.

4.4 Resolution of Insurance Coverage Disputes

Insureds in India can:

- resort to the dispute resolution mechanism set out in the policy document (usually arbitration in the context of commercial general insurance contracts);
- approach the internal grievance redressal mechanism of the insurer, the grievance cell of the IRDAI or the insurance ombudsman under the Redress of Public Grievance Rules 1998 (depending on the nature of the grievance); or
- initiate formal legal proceedings against the insurer before the consumer protection forums or the Indian civil courts.

Reinsurance contracts are also contracts of insurance and, therefore, the position on these is the same. In fact, the CCA 2015 defines a commercial dispute as including both insurance and reinsurance over the value of INR300,000 (approximately USD3,419).

4.5 Position If Insured Party Is Viewed as a Consumer

By operation of law, an insured can approach a consumer forum, inter alia, in relation to any claim against an insurer in India. This forum can be approached independently of any right that the insured may have under the policy terms, including its right to initiate arbitration proceedings.

The consumer courts follow a summary procedure, which does not usually involve detailed evidence or cross-examination of witnesses. The fee for filing a complaint before a consumer forum is also nominal, as opposed to before a civil court, where the fee is ordinarily determined based on the claim amount.

4.6 Third-Party Enforcement of Insurance Contracts

There is no equivalent law in India of the UK Third Parties (Rights Against Insurers) Act 2010. As a general rule, Indian law recognises the principle of privity of contract and consequently, a third party may not be able to bring a direct action or claim against an insurer.

That being said, it is common practice for third parties to name the defendant's insurer in motor accident-related proceedings. The Motor Vehicles Act 1988 (MVA) provides that the rights of an insured under a policy are transferred to a third party claiming against the insured in the event of the insured's insolvency. The MVA empowers the Motor Claims Tribunal to seek the insurers' involvement in a third-party action against the insured if the tribunal believes the claim is collusive or if the insured fails to contest the claim. However, Section 164 of the MVA limits the insurer's liability concerning third-party insurance with effect from 1 April 2022 in the following terms:

- in the case of death, INR500,000 (approximately USD5,699); and
- in the case of grievous hurt, INR250,000 (approximately USD2,849).

There are presently no limits on the insurer's liability in cases of permanent disability or minor injury.

4.7 The Concept of Bad Faith

Insurance bad faith does exist in India, but it is not expressly codified. Both the insurer and the insured are required to disclose material information to each other, and insurers cannot avoid reasonably clear liability by acting in bad faith or by resorting to unfair trade practices.

There is also a separate constitutional duty on government insurers to act in a fair and reasonable manner before and after inception of the insurance policy.

4.8 Penalties for Late Payment of Claims

The IRDAI (Protection of Policyholders' Interests, Operations and Allied Matters of Insurers) Regulations 2024 (the "PPHI Regulations 2024") require insurers to set their own timelines for making a claim payment, and while no specific penalty has been set out under the PPHI Regulations 2024, insurers will be expected to deal with this matter in their respective board-approved policy. In addition, there are other civil penalties which can also be imposed on insurers, including damages for breach of contract, compensation for deficiency in service, etc.

The Consumer Act 2019 has also introduced a centralised agency called the Central Consumer Protection Authority (CCPA). The CCPA has wide powers, including the power to initiate investigations and impose sanctions and penalties as may be required and allowed in the circumstances.

4.9 Representations Made by Brokers

The relationship between an insured and a broker is that of a principal and agent. An insurance broker is an agent of the insured and whether a representation made by a broker is binding or not would depend on whether the broker was authorised by the insured to make such a representation. In the absence of such authorisation, it is unlikely that representation made by the broker will be binding on the insured. It is pertinent to note that as the insured signs the proposal form, the insured must bear all the consequences arising out of the form.

4.10 Delegated Underwriting or Claims Handling Authority Arrangements

The PPHI Regulations permit Indian insurers to outsource activities that would usually be undertaken by the company internally, subject to the prescribed compliance requirements being fulfilled, and provided that the activities proposed to be outsourced do not fall within the ambit of the defined "core activities". Broadly, Indian insurers are prohibited from outsourcing product design, underwriting, claim handling or actuarial functions to a third-party service provider, as these activities form a part of the company's core functions.

In terms of delegating underwriting or claims handling to external parties, an Indian insurer is prohibited under Section 21 of the IRDAI's "Master Circular on Allied Matters of Insurers of 19 June 2024" from outsourcing "decision making in underwriting and claims".

5. Claims Against Insureds

5.1 Main Areas of Claims Where Insurers Fund the Defence of Insureds

Professional indemnity (PI), directors' and officers' liability (D&O), errors and omissions (E&O), employment practice liability (EPL) and cyber liability policies are examples of the types of policies that provide cover for defence costs incurred by insureds provided that the policy terms and conditions are satisfied.

5.2 Likely Changes in the Future

There is unlikely to be change in this area of the law in the next few years.

5.3 Trends in the Cost or Complexity of Litigation

There is familiarity and demand for liability insurance, and over the past five years there has been a steady upward trend in claims made under PI policies. 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 the authors have seen being made under liability policies.

Not only has there been an upsurge in the frequency of claims, but there has also been a sharp increase in the quantum being claimed by the insureds under liability policies, which means that claim severity is also on the rise.

PI and D&O claims are likely to continue to make up the largest share of claims. There is also likely to be a rise in EPL – while previously claims were usually made in other jurisdictions, a number of claims have recently been made in India, with high-value settlements demanded.

The cyber-insurance sector is also seeing increasing interest and development in terms of the wording and post-claim support being offered by insurers, reflecting the increase in claim notifications and related quantum. This is specifically because of the remote working environment introduced by the COVID-19 pandemic.

5.4 Protection Against Costs Risks

An insured can avail of protection against its costs risks for third-party claims under different types of insurance policies, including PI, public liability, D&O, EPL, E&O and product liability policies.

6. Insurers' Recovery Rights

6.1 Right of Action to Recover Sums From Third Parties

Under the principles of subrogation, the insurer has the same right as the insured to recover a loss from the third party responsible for the loss/the wrongdoer.

Subrogation applies in all types of insurance, except life insurance and personal accident insurance. The right of subrogation has been recognised by statute under Section 79 of the Marine Insurance Act 1963 (the "Marine Insurance Act") and case law, including *Economic Transport Organization v Charan Spinning Mills Ltd* ((2010) 4 SCC 114), where the Supreme Court classified subrogation into three broad categories.

Subrogation by Equitable Assignment

This is not evidenced by a document. It is based on the insurance policy and the insured receiving the claim amount. The insured cannot deny the equitable right of subrogation, even if there is no written evidence to support it.

Subrogation by Contract

This is evidenced by a document. The court recognises that insurers usually obtain a written letter of subrogation to avoid disputes about the right to claim reimbursement, or to settle the priority of claims between them or confirm the reimbursement amount under the subrogation, and to ensure the insured's co-operation. If the insured executes a letter of subrogation, the insurer's rights against the insured are governed by its terms.

Subrogation-cum-Assignment

The insured executes a letter of subrogation-cum-assignment. This enables the insurer to retain the entire amount recovered and sue in the name of the insured or in its own name if the letter so provides. The insured is then left with no right or interest and can no longer sue in its own name and for its own benefit.

A subrogation right cannot usually be waived. However, in some cases, the insurer and insured can agree to waive subrogation entirely, or in relation to specific individuals/entities.

6.2 Legal Provisions Setting Out Insurers' Rights to Pursue Third Parties

The right of subrogation has been recognised by statute under Section 79 of the Marine Insurance Act and the insurer can exercise this right in the name of the insured.

7. Impact of Macroeconomic Factors

7.1 Type and Amount of Litigation

Claims have been received by insurers in India where the insured has claimed for business interruption losses on account of the COVID-19 pandemic and the consequent lockdowns. However, since such policies require there to be a physical loss which, in turn, results in business interruption losses, the claims of insureds have often been rejected.

Currently, there are no authoritative rulings specific to claims of business interruption losses stemming from COVID-19-related disruptions.

7.2 Forecast for the Next 12 Months

As stated in **7.1 Type and Amount of Litigation**, there are presently no authoritative rulings on whether the COVID-19 pandemic and/or the lockdowns would amount to a physical loss, thereby enabling the consequent claim of business interruption. It is difficult to predict whether any such ruling will be available in the next 12 months.

7.3 Coverage Issues and Test Cases

Unlike the Financial Conduct Authority business interruption insurance test case in the UK, there has been no test case in India. However, the COVID-19 pandemic did give rise to business interruption claims under property insurance policies. In some cases, insurers have denied liability for COVID-19 notifications on the basis that material damage to property is a prerequisite for an indemnifiable claim for business interruption, and the COVID-19 pandemic did not cause any physical damage or loss to the insured property.

Due to the COVID-19 pandemic, several regulatory changes were also introduced by the insurance regulator with the aim of stabilising the insurance market and securing the protection of policyholders' interests. In this regard, with a view to furthering the business continuity of Indian insurers and other insurance entities, and ensuring proper service to policyholders, the IRDAI issued directions on, inter alia, the handling of COVID-19 claims, extension of grace periods for premium payments, relaxation of regulatory timelines and expeditious servicing of insurance policies.

7.4 Scope of Insurance Cover and Appetite for Risk

Factors such as the war in Ukraine and the pandemic have made insurers a lot more cautious about the risks they take. Premiums have been revised to take account of potential losses, and the coverage afforded has been under review.

8. Emerging Risks

8.1 Impact of ESG on Underwriting and Litigating Insurance Risks

The Indian insurance industry is a relatively new market compared to various global markets. As a result, the industry is still considered to be in a relatively nascent stage of development, particularly for various lines of insurance products which have recently been introduced in India. In relation to these products, the insurer's underwriting is derived, to some extent, from global claims experience, in the absence of specific Indian claims experience.

The IRDAI has introduced the IRDAI (Corporate Governance for Insurers) Regulations 2024 (the "CG Regulations"), which require all insurers (including FRBs and Lloyd's India) to have a board/executive committee-approved ESG framework and monitor ESG activities. However, these regulations do not provide any specific guidance in terms of any activities to be undertaken, the contents of the ESG framework or reporting/disclosure requirements.

Recently, the Indian market has witnessed an increase in the volume as well as the quantum of claims reported, due to various ESG factors. Additionally, there has been a significant increase in premiums, particularly for life and health insurance, attributed to adverse mortality and morbidity rates, experienced in large part as a result of the COVID-19 pandemic.

8.2 Data Protection Laws

Broadly, the norms on data security and confidentiality in India arise from statutory law, that is, the Digital Personal Data Protection Act 2023 and the Information Technology Act 2000. Further, the draft Digital Personal Data Protection Rules were issued by the Ministry of Electronics and Information Technology in January 2025 to supplement the Digital Personal Data Protection Act with additional guidance, but they are yet to be notified. In addition, certain similar norms under the Indian insurance regulatory framework are set out under the PPHI Regulations and the IRDAI Guidelines on Information and Cyber Security of 24 April 2023, which essentially place an obligation on insurers and insurance intermediaries to maintain the confidentiality of data. However, these norms also

permit disclosure of data, after obtaining consent from the data owner, and remain subject to requirements to maintain data security and other similar requirements.

Typically, in terms of market practices in India, it is understood that gaining the express consent of customers would allow insurers to disclose information to concerned entities, despite the existence of the confidentiality requirements under the statutory and regulatory framework. For this purpose, it is a common practice for insurers to request such consent in the initial proposal forms, which are signed by customers at the time of proposing/purchasing insurance. For capturing consent, insurers generally incorporate a broadly worded consent provision as part of the declaration under these forms. Thereafter, once the consent of the proposer/applicant is captured, this data is typically shared with reinsurers for their own underwriting and claim settlement purposes.

Furthermore, in terms of litigation, considering that the Indian data protection framework is in a nascent stage and the provisions set out under the current statutory framework are limited, there do not appear to have been any significant disputes of note concerning data protection in the insurance industry at the time of writing.

9. Significant Legislative and Regulatory Developments

9.1 Developments Affecting Insurance Coverage and Insurance Litigation

The Indian insurance sector is highly regulated and there have recently been many significant regulatory developments in the sector. Some of the developments affecting insurance coverage and insurance litigation are listed here.

- The IRDAI (Protection of Policyholders' Interests, Operations and Allied Matters of Insurers) Regulations 2024 along with "Master Circular on Operations and Allied Matters of Insurers" of 19 June 2024 and the "Master Circular on Protection of Policyholders' Interests 2024" of 5 September 2024, consolidate and repeal the earlier norms in relation to the protection of policyholders' interests, advertisements, outsourcing, receipt of premium, nomination, assignment, grievance redressal procedures, places of business, group insurance, and usage of trade logos by insurers.
- The IRDAI (Insurance Products) Regulations 2024 along with the corresponding master circulars on life, general and health insurance products respectively consolidate and repeal the IRDAI's norms related to life insurance products (unit linked and non-linked), health insurance products, and other insurance products. In addition, the IRDAI issued a gazette notification on 22 January 2024, which de-notified the tariff wordings under certain classes of insurance business (ie, fire, motor, engineering miscellaneous and marine).
- The IRDAI (Rural, Social Sector and Motor Third Party Obligations) Regulations 2024, along with the IRDAI's "Master Circular on Rural, Social Sector and Motor Third Party Obligations" of 17 May 2024, consolidate and repeal the IRDAI's 2015 norms related to an insurer's obligations towards the rural and social sector, and motor third-party insurance business. They specify the minimum thresholds to be achieved for life, general and health insurers to fulfil their statutory obligations under the Insurance Act.
- In addition, the IRDAI has issued the "Master Circular on Reinsurance 2024" of 31 May 2024, to specify norms on operational matters pertaining to FRBs and Lloyd's India, issuance/renewal of file reference number of Cross Border Reinsurers (CBRs), and the requirement of obtaining collaterals while placing reinsurance business with CBRs.
- The IRDAI (Actuarial, Finance and Investment Functions of Insurers) Regulations 2024 and the "Master Circular on Actuarial, Finance and Investment Functions of Insurers" of 17 May 2024, consolidate and repeal the IRDAI's erstwhile norms in relation to an Indian insurer's appointed actuary appointments, duties and responsibilities, valuation of assets, liabilities and maintenance of solvency margin, financial statements preparation, investments, and loans and advances.

JAPAN

Law and Practice

Contributed by:
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Contents

Hiratsuka & Co is a boutique law firm in Tokyo established in 1976, with four lawyers and one academic consultant, providing a full range of domestic and cross-border Japanese legal services. The firm handles various types of insurance, typical and non-typical, and has advised both insurers/reinsurers and insureds/reinsureds on matters such as fire insurance, earthquake insurance, liability insurance, marine insurance, satellite insurance and umbrella insurance. Another area of expertise is recovery actions in Japan based on subrogation. Hiratsuka & Co also advises on Japanese insurance regulations and assists non-Japanese clients in obtaining insurance licences in Japan. The firm has been instructed by insurance companies and law offices from all around the globe, including Japan, the UK, the USA, France, Germany, Switzerland, Italy, Spain, Norway, Russia, Singapore, Australia, Hong Kong, China and Taiwan.

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1. Rules Governing Insurer Disputes

1.1 Statutory and Procedural Regime

Overview

Litigation is the public system for insurance dispute resolution. If parties to an insurance policy have concluded an arbitration agreement, the courts will heed the agreement and the dispute will be resolved not by litigation but by arbitration (see **3.3 The Use of Arbitration for Insurance Dispute Resolution**). A dispute over an insurance contract may also be resolved by ADR, including court-assisted mediation and mediation by ADR institutions designated by the Insurance Business Act (see **1.3 Alternative Dispute Resolution (ADR)**). The purpose of ADR is to facilitate resolution by the agreement of both parties; accordingly, if no agreement is reached, the procedure ends and the dispute is resolved by litigation or arbitration.

Provisional Remedy and Compulsory Execution

Before or in the course of litigation or arbitration, a provisional remedy procedure is available. The claimant must submit prima facie evidence that demonstrates that their claim exists and that it is necessary to preserve it, and must deposit a counter-security with a Japanese court. After a judgment or an arbitral award becomes final and conclusive, a claimant may file a petition with the court to commence compulsory execution proceedings to collect its claim from a debtor's assets.

Litigation

The most important dispute resolution system is litigation. An insurance policy governed by Japanese law usually contains a jurisdiction clause whereby a specific District Court is agreed as the first instance court. In such case, the District Court is the first instance court, the Court of Appeal that has jurisdiction over the place of the District Court is the second instance court, and the Supreme Court is the final instance court. The number of judges is one or three in the District Court, three in the Court of Appeal, and three to five in the Supreme Court (nine to 15 when the Supreme Court decides to hear the case en banc).

Time Until Judgment

Japanese courts have a non-mandatory target to finish the first instance procedure as quickly as possible within a period of two years. About 75% of all cases appealed to the Court of Appeal (not limited to insurance disputes) are finished within six months by judgment, settlement, withdrawal, etc. About 90% of all cases in the Supreme Court (again not limited to insurance disputes) are finished within six months.

1.2 Litigation Process and Rules on Limitation

Litigation Process

Up to the first hearing date

The plaintiff files a complaint with the first instance court specifying the parties, their legal representatives (in the case of a company, this is a person who has legal authority to represent the company), the gist of the claim and cause of action. After the judge finds the complaint to be in order, the court effects service of the complaint and issues a summons for the first hearing date to the defendant. After the service, the defendant must submit their answer to the court. Both the complaint and the answer are treated as stated in the first hearing date for oral argument.

Up to witness examination

After the first hearing date, the plaintiff and defendant alternately submit legal briefs (a document describing its case), an evidence explanation and documentary evidence. The court may also designate the case for preparatory proceedings, where hearings are held in a meeting room without a public audience. The exchange of briefs and evidence usually continues until the issues are clarified and both parties' arguments are exhausted. If witness examinations are planned, the court confirms with the parties which facts will be proven by witness testimony.

Evidence

When submitting documentary evidence written in a foreign language, the party must submit a Japanese translation of the relevant parts, and the opposing party is entitled to object to the accuracy of the translation. If a party presents an expert's opinion to the court, the expert's report should be submitted first and the expert may then be examined in witness examination. An expert retained by a party is different from an expert designated by the court.

The Japanese judicial system does not adopt a discovery system such as those in place in England or

the US, so a party seeking disclosure of evidence in the hands of an opponent or a third party must file a petition with the court for a court order to produce documents.

Up to the first instance judgment

If a party applies for examination of a witness and the judge considers such examination necessary, the witness submits their statement to the court a few weeks before the witness examination. The witness is then examined and cross-examined in a courtroom, with an interpreter in the case of a non-Japanese-speaking witness. Both parties submit the final brief, taking account of the results of the examination. Prior to or after the examination, the court often asks both parties about the possibility of settling the case by amicable settlement. If no settlement is reached, the court renders judgment.

The second instance

A losing party in the first instance may file a petition for appeal within two weeks from the date of service of the original judgment, and must then submit detailed grounds for appeal within 50 days from the appeal. The opponent may file a written counterargument by the deadline designated by the second instance court (a Court of Appeal if the first instance court was a District Court). In practice, these submissions are of high importance as the judges examine them carefully in forming their initial impression of whether there are merits to the appeal. Ordinarily, the second instance judges are not willing to have additional hearing dates for further arguments. After the conclusion of oral arguments (which may take place on the first hearing date), the court may ask both parties about the possibility of settlement before deciding to render judgment.

The third instance

Judgments of the second instance courts may be appealed to the second appellate court, which is the Supreme Court if the second instance was presided over by a Court of Appeal. However, the grounds of appeal to the Supreme Court are very narrow and are limited to errors in the construction of the Constitution, among other barriers.

Rules on Limitation

General

Under Japanese conflict of laws rules, limitation is considered as a matter not of procedural law but of substantive law. Accordingly, the following applies if an insurance policy is governed by Japanese law:

- the right to claim an insurance payment, the right to claim a refund of insurance premiums and the right to claim a refund of a premium reserve are subject to a three-year limitation period from the time the right becomes exercisable;
- the right to claim insurance premiums is subject to a one-year limitation period from the time the right becomes exercisable; and
- limitation is effected when a party invokes the limitation after the expiry of the limitation period.

If an insurance policy is governed by a foreign law, the rights expire according to the limitation provisions set out in the foreign law.

Expiry of limitation period

It is possible to postpone the expiry of the limitation period, or to renew it, through certain events. For example:

- if a party commences litigation, the limitation period does not expire until the litigation is completed;
- if an agreement to hold negotiations on a claim is made in writing, the limitation period does not expire until one year (or an agreed time period of less than one year) has passed from the time of the agreement (or six months from the time of the notice of refusal of the negotiation); and
- if a demand is made, the limitation period does not expire for six months from the time of the demand.

Limitation is one of the most complicated areas of law and a Japanese lawyer's advice should be sought for specific cases.

1.3 Alternative Dispute Resolution (ADR)

ADR is widely used in the insurance field. Japan has three ADR institutions designated by the Prime Minister based upon the Insurance Business Act:

- the Sompo ADR Centre (for a dispute against a Japanese non-life insurance company);
- the Insurance Ombudsman (for a dispute against a foreign non-life insurance company); and
- the Life Insurance Counselling Office (for a dispute against a life insurance company).

All three institutions have complaint resolution procedures and dispute resolution procedures. Their systems are basically the same, as follows.

Complaint Resolution Procedure

An insured or a policyholder files a complaint with the ADR institution, which then provides necessary advice, notifies the relevant insurer of the complaint and requests them to respond swiftly. The insurer makes contact with the insured or the policyholder, and holds negotiations for the resolution of the dispute. If the dispute is not settled within a certain period, the institution may refer the insured or the policyholder to a dispute resolution procedure, and the complaint resolution procedure ends.

Dispute Resolution Procedure

An insured or a policyholder files a petition for dispute resolution with the ADR institution, which then appoints one or more committee members to handle the dispute resolution process. In the case of the Life Insurance Counselling Office, its internal permanent committee handles the dispute resolution process. The committee hears both parties' arguments and, if considered appropriate, proposes settlement terms. In principle, the insurers owe an obligation to accept certain settlement terms (special mediation terms in the case of the Sompo ADR Centre and the Insurance Ombudsman, and settlement terms in the case of the Life Insurance Counselling Office), while the insured or the policyholders do not.

Number of Cases

For the period from 1 April 2024 to 31 March 2025, the Sompo ADR Centre newly accepted about 4,530 complaint resolution cases and about 640 dispute resolution cases, the Insurance Ombudsman about 130 complaint resolution cases (the number of dispute resolution cases is not disclosed) and the Life Insurance Counselling Office about 3,980 complaint resolution cases and about 380 dispute resolution cases.

2. Jurisdiction and Choice of Law

2.1 Rules Governing Insurance Disputes

Jurisdiction

Agreement

Under the Japanese rules regarding international jurisdiction, parties to an insurance contract may agree on a country in which they are permitted to file an action with the courts. The agreement is not valid unless it is made regarding actions that are based on a specific legal relationship, and executed by means of a written document. An agreement that an action may be filed only with the courts of a foreign country may not be invoked if those courts are unable to exercise jurisdiction by law or in fact. A jurisdiction agreement in which the parties agree exclusive jurisdiction of the court that has the jurisdiction over the head office of the defendant is, in principle, valid, unless the agreement is extremely unreasonable and against public policy (the Supreme Court judgment of 28 November 1975 Minshu 29.10.1554).

Other grounds

The Code of Civil Procedure of Japan provides certain grounds for the jurisdiction of the Japanese courts where no jurisdiction agreement exists. Typical examples are as follows:

- an action that is brought against a corporation whose principal office or business office is located in Japan; and
- an action on a claim for performance of a contractual obligation, on a claim for damages due to non-performance of a contractual obligation or on any other claim involving a contractual obligation if the contractually specified place for performance of the obligation is within Japan.

However, even when the Japanese courts have jurisdiction over an action (except when an action is filed based on an exclusive jurisdiction agreement specifying the Japanese court), the court may dismiss the whole or part of an action without prejudice if it finds that there are special circumstances due to which, if the Japanese courts were to conduct a trial and reach a judicial decision in the action, it would be inequitable to either party or prevent a fair and speedy trial, in consideration of the nature of the case, the degree

of burden that the defendant would have to bear in responding to the action, the location of evidence, and other circumstances.

Choice of Law

General

Under the conflict of laws rules of Japan, the law that applies to an insurance policy is the law of the place chosen by the parties at the time of the conclusion of the insurance policy. In the absence of said choice of law, an insurance policy shall be governed by the law of the place with which the insurance policy is most closely connected at the time of the conclusion of the insurance policy. The law of the habitual residence of the insurer is presumed to be the law of the place with which the insurance policy is most closely connected. The parties may agree to change the governing law otherwise applicable to the insurance policy, but such change may not be asserted against a third party when it prejudices the rights of such third party.

Consumer protection

There are special provisions regarding the choice of law for consumer contracts. For example, even when the law applicable to the consumer contract as a result of a choice or a change of governing law is a law other than the law of the consumer's habitual residence, if the consumer has manifested their intention to the business operator that a specific mandatory provision from within the law of the consumer's habitual residence should be applied, such mandatory provision shall also apply to the matters stipulated by the mandatory provision with regard to the formation and effect of the consumer contract. Notwithstanding said general rule, in the absence of a choice of law with regard to the formation and effect of a consumer contract, the formation and effect of the consumer contract shall be governed by the law of the consumer's habitual residence.

2.2 Enforcement of Foreign Judgments

Validity of a Final and Conclusive Judgment Rendered by a Foreign Court

A final and conclusive judgment rendered by a foreign court must satisfy the following requirements in order to be enforceable in Japan:

- the jurisdiction of the foreign court is recognised pursuant to laws and regulations, conventions or treaties;
- the defeated defendant has been served (excluding service by publication or any other similar service) with the requisite summons or order for the commencement of litigation, or it has appeared without being so served;
- the content of the judgment and the litigation proceedings are not contrary to public policy in Japan; and
- a guarantee of reciprocity is in place.

This general rule is applicable to enforcement by or against insurers in Japan.

General Procedure

A party who seeks enforcement in Japan of a final and conclusive judgment rendered by a foreign court should firstly file a lawsuit against an obligor for an execution judgment. After the execution judgment becomes final and conclusive, the party may apply to the Japanese courts for compulsory execution against real property, vessels, movables, claims and other property rights.

2.3 Unique Features of Litigation Procedure

Litigation Costs

When filing a lawsuit, the plaintiff needs to purchase revenue stamps and attach them to the complaint. The amount of the revenue stamp is roughly proportional to the claim amount. The cost of revenue stamps is included in the litigation costs, which are borne entirely or partly by a losing party. However, in practice, such cost is not claimed.

Legal Costs

Legal costs (attorneys' fees) shall be borne by each party and are not recoverable from the losing party. In the case of a claim in tort, the Japanese courts often add 10% of the awarded amount as attorneys' fees. However, it is unrelated to the actual amount spent by the winning party.

3. Arbitration and Insurance Disputes

3.1 Enforcement of Arbitration Provisions in Commercial Contracts

If a party files a lawsuit with a Japanese court for a dispute (including insurance and reinsurance) that is subject to an arbitration agreement and the other party requests dismissal without prejudice, the Japanese court will, in principle, dismiss the lawsuit without prejudice. There are exceptions to this general rule where:

- the arbitration agreement is null and void;
- the arbitration procedure cannot be carried out based on the terms of the arbitration agreement; and
- the other party requests dismissal pursuant to the arbitration agreement after it presented oral arguments on the merits.

These rules are applied regardless of whether the place of arbitration is in or outside Japan, or has not been fixed.

3.2 The New York Convention

Japan is a contracting state of the New York Convention.

Enforcement of Arbitral Awards Handed Down in Other Jurisdictions

When the place of arbitration is outside Japan and a party seeks to enforce an award from that arbitration in Japan, the party must obtain an execution order of the arbitral award from the Japanese courts, and then apply to the Japanese courts for compulsory execution against the respondent's assets. In the application, various documents must be submitted to the Japanese courts, including an arbitral award for which an execution order has become final and conclusive.

Execution Order

A party who intends to enforce an arbitral award may apply for an execution order from the Japanese courts. The court may not make a decision on the application without holding oral arguments or a hearing that both the applicant and the obligor-respondent can attend. The court dismisses the application if it finds that any of the grounds set forth in Article 45 paragraph 2 of the Arbitration Act (which are substantially the same as Article 5 of the New York Convention) exists. Otherwise, an execution order is issued.

3.3 The Use of Arbitration for Insurance Dispute Resolution

Arbitration is not a significant form of insurance dispute resolution in Japan.

Rules of Arbitration

If the place of arbitration is in Japan, the general rules provided in the Arbitration Act are applied to arbitration, according to which:

- the parties must be treated equally in an arbitration procedure;
- the parties must be given full opportunity to argue their case in an arbitration procedure;
- the rules of arbitration provided by the parties' agreement must be observed by the arbitral tribunal, etc.

If the parties agree to resolve their dispute at an arbitration institution such as the Japan Commercial Arbitration Association, the arbitration rules provided by the institution are also applied.

Private Character

Arbitration is neither presided over by the national courts nor operated at the taxpayer's expense. In this sense, arbitration is private. On the other hand, Japanese law provides for general rules regarding the arbitration procedure; a claim by arbitration has the statutory effect of postponing the expiry of the limitation period, and an arbitral award is given the same effect as a final and conclusive court judgment. Considering these aspects, an authoritative academic has pointed out that arbitration has the character of a semi-public dispute resolution.

Appeal to Arbitral Award

If the place of arbitration is in Japan, a party may apply to the Japanese courts for a cancellation of the arbitral award. The court may not make a decision on the application without holding oral arguments or a hearing that both parties to the arbitration can attend. The court may cancel the arbitral award if certain grounds exist that are substantially the same as Article 5 para-

graph 1 (a)–(d) and paragraph 2 of the New York Convention.

4. Coverage Disputes

4.1 Implied Terms

Terms are not implied into a contract of insurance by operation of law. Japanese insurance contracts normally contain detailed terms and conditions. Disputes are resolved through the construction of specific terms in the contract.

4.2 Rights of Insurers

Principle – Insured's Obligation to Answer the Insurer's Questions

In concluding a non-life insurance policy, a life insurance policy or a fixed-amount accident and health insurance policy, an insurer-to-be has the right to request the disclosure of facts with regard to material matters concerning the likelihood of the occurrence of loss to be compensated for under the relevant insurance policy. The policyholder/insured-to-be owes an obligation to disclose the facts requested by an insurer-to-be. This is a mandatory rule under the Japanese Insurance Act that may not be contracted out of to the disadvantage of the policyholder or insured.

If the policyholder or insured fails to disclose such facts or discloses false facts intentionally or by gross negligence, an insurer, in principle, may cancel the insurance policy. This is also a mandatory rule that may not be contracted out of to the disadvantage of the policyholder or insured.

Exception – Insured's Obligation to Voluntarily Disclose Material Matters

These mandatory rules are not applicable to certain non-life insurance policies that compensate damage arising from business activities, including marine insurance policies, property insurance policies and liability insurance policies regarding aircraft or nuclear facilities. Freedom of contract is widely admitted. For example, standard hull and machinery insurance policies provide that a policyholder/insured-to-be must disclose facts with respect to important matters that may affect the acceptance of underwriting or the decision of the contents of an insurance policy by the insurer-to-be (ie, in these cases, the scope of disclosure is not limited to facts requested by an insurer-to-be). Such standard policies commonly provide for the insurer's right of cancellation where the policyholder or insured failed to disclose facts or disclosed false facts.

4.3 Significant Trends in Policy Coverage Disputes

Litigation Cases

There are many cases in which insurers allege that the insured caused the incidents intentionally or by gross negligence, and rely upon exemption clauses in the insurance policies. The Japanese courts carefully consider the circumstances and background of the incident, occurrences after the incident and economic motivation, among other factors, in their fact-finding and judgment on the issues.

ADR Cases

Wide varieties of cases and issues are raised with regard to various types of insurance; it is difficult to see any trends. Generally, an insurer may deny payment by relying upon the terms of the insurance contract and evidence submitted to the insurer. In some cases, the insurer or its agent may have given a misleading or unclear explanation of the contents of the insurance contract, giving rise to a dispute.

4.4 Resolution of Insurance Coverage Disputes

Generally, insurance coverage disputes are resolved through negotiation. If negotiation turns out to be difficult, they are resolved by litigation, arbitration or ADR.

The position is slightly different for reinsurance contracts. Most reinsurance coverage disputes are resolved by negotiation; it is rare for them to be settled though legal proceedings.

4.5 Position If Insured Party Is Viewed as a Consumer

Principle

The position is almost the same where the law views the insured party as a consumer. The differences are as follows.

The Consumer Contract Act

The Consumer Contract Act provides a consumer's right of rescission of a contract. A consumer may rescind a consumer contract, for example, in the case of a consumer's mistake caused by a trader's material misrepresentation or by a trader's provision of a conclusive assessment of uncertain matters. If a consumer rescinds an insurance policy based upon these rights, they receive a refund of the insurance premium; however, this would not be a sufficient remedy in many cases.

ADR

For a dispute between a consumer and a trader of national import, a consumer may utilise mediation or arbitration by the Dispute Resolution Committee of the National Consumer Affairs Centre of Japan. However, it is unclear how many insurance disputes are settled by these procedures.

4.6 Third-Party Enforcement of Insurance Contracts

Principle

A third party may neither enforce an insurance contract nor sue an insurer in connection with an insurance contract. If a third party's claim against an insured is established by final and conclusive judgment, the third party may apply to the Japanese courts for a seizure order of the insured's claim against an insurer for insurance payment. The third party is entitled to collect the claim for insurance payment directly from the insurer one week after service of the seizure order to the insured.

Execution of Statutory Lien in Liability Insurance

A third party who has a claim for compensation for damage against an insured under a liability insurance policy has a statutory lien over the insured's claim against the insurer for insurance payment (Article 22 paragraph 1 of the Insurance Act). Even if it does not have a final and conclusive judgment that establishes its claim against the insured, the third party may apply to the Japanese courts for a seizure order of the claim for insurance payment, based on the statutory lien.

Direct Claim Based on Insurance Policy

If an insurance policy contains a clause that allows a direct claim by a third party against the insurer, a third party may claim for payment against the insurer to the extent allowed by the clause. Such a clause is often contained in an automobile insurance policy.

Direct Claim Based on Japanese Law for Automobile Accidents

The Act on Securing Compensation for Automobile Accidents provides for compulsory automobile liability insurance, under which a person who puts an automobile into operational use for their own benefit is included as an insured. When the person is liable to compensate for damage to a third party, that third party may claim directly against the insurer for the payment of damage up to the amount of insurance coverage.

4.7 The Concept of Bad Faith

Japan does not have a concept of bad faith or bad faith breach of contract in the areas of insurance and reinsurance law.

4.8 Penalties for Late Payment of Claims

Late Payment Interest

If an insurance policy is governed by Japanese law, an insurer is obliged to pay late payment interest if it fails to pay the insurance claim by the due date. If the interest rate is agreed in the insurance policy, the agreed rate is applied. If there is no such agreement, the statutory rate is applied. The current statutory rate is 3% per annum but it may be changed by ministerial order in the future. If an insurer failed to make the payment by a due date that was on or prior to 31 March 2020, the old statutory interest rate of 6% per annum applies.

Due Date

Even if the due date of an insurance claim is provided in an insurance policy, if the due date falls after the expiry of a reasonable period of time to confirm matters that need to be confirmed under the insurance policy for the purpose of payment of an insurance claim, the day on which such period expires is treated as the due date for payment of the insurance claim.

If the due date of an insurance claim is not provided in an insurance policy, the insurer is not responsible for any delay until an insurance proceeds payment

is claimed and the period necessary to confirm the insured event, etc, pertaining to said claim expires.

An insurer is not liable to pay late payment interest for the period of delay in investigation that is attributable to a policyholder or an insured.

4.9 Representations Made by Brokers

Generally, an insured would not be bound by representations made by its broker. It is normally understood in Japan that when an insurance broker performs procedures such as application for insurance for its customers (ie, a person who is to be a policyholder or an insured), the insurance broker acts not as an agent but as a messenger of the customer. Under this interpretation, the insurance broker has no authority to represent the customer as agent and, accordingly, an insured is not bound by the broker's representations.

However, in a specific case, the question should be examined carefully, taking factual backgrounds into consideration.

4.10 Delegated Underwriting or Claims Handling Authority Arrangements

General

Delegated arrangements such as those adopted between a Lloyd's syndicate and managing agents are not common in Japan. With regard to a Lloyd's syndicate, there is a precedent in which the Japanese court allowed a leading underwriter who was one of the members of a Lloyd's syndicate to pursue legal proceedings relating to an insurance policy on behalf of themselves and other members.

Co-Insurance

Co-insurance is widely used in Japan. A leading underwriter and other underwriters usually conclude a business outsourcing contract, based on which the leading underwriter would issue the co-insurance policy papers, but the leading underwriter is not usually authorised to conclude the insurance contract on behalf of the other underwriters. In addition, the leading underwriter would deal with the administration of the insurance claim payment, but is usually not authorised to assess loss on behalf of other underwriters. Each insurer in a co-insurance contract owes separate liability to an insured in proportion to each underwriting ratio. In order to pursue 100% of the rights or obligations in a co-insurance policy, all co-insurers must be the plaintiffs or the defendants.

5. Claims Against Insureds

5.1 Main Areas of Claims Where Insurers Fund the Defence of Insureds

No statistics are published on the area of claims where insurers fund the defence of insureds or insurers make insurance payment for disputes costs.

Most liability insurance policies in Japan provide insurance cover for disputes costs. As long as the requirements for the cover are satisfied, insurers generally make insurance payments for the costs irrespective of the areas of claims. However, insurers of automobile insurance are specially allowed negotiation with the victims on behalf of the insureds. This allows insureds to save disputes costs, while insurers may negotiate for a smaller insurance payment.

5.2 Likely Changes in the Future

The situation is unlikely to change in the next few years.

5.3 Trends in the Cost or Complexity of Litigation

As Japanese society and the country's economy have become highly complex, litigation cases have inevitably come to contain complex elements, which has led to a general increase in litigation costs. More than half of the recently published court precedents in the area of liability insurance are automobile collision cases, which have traditionally been the most common type of case. However, there are also some cases concerning complex and high-value claims, such as those relating to a nuclear incident, asbestos damage, oil pollution, directors' and officers' liability and expert malpractice liability.

5.4 Protection Against Costs Risks

Claimants can buy rights protection insurance for insurance coverage of legal costs or litigation costs (see **2.3 Unique Features of Litigation Procedure**). In many cases, rights protection insurance takes the form of an additional endorsement to the automobile

insurance, fire insurance or other major insurance policy. A few insurance companies sell rights protection insurance for natural persons as well as legal persons in the form of independent insurance.

6. Insurers' Recovery Rights

6.1 Right of Action to Recover Sums From Third Parties

With respect to an insurance policy governed by Japanese law, the law gives an insurer a right of action to recover sums from third parties causing an insured loss to an insured.

6.2 Legal Provisions Setting Out Insurers' Rights to Pursue Third Parties

Article 25 of the Insurance Act of Japan provides the following effects.

- When it has paid an insurance claim, the insurer shall be subrogated with respect to any claim against a third party acquired by an insured due to the occurrence of damages arising from an insured event (the "Insured's Claim").
- The maximum amount of subrogation is the lesser of:
  (a) the amount of the insurance payment made by the insurer; or
  (b) the amount of the Insured's Claim (if the amount of the insurance payment made by the insurer falls short of the amount of damages to be compensated, the amount that remains after deducting the amount of the shortfall from the amount of the Insured's Claim).
- If the amount of the insurance payment falls short of the amount of damage to be compensated, the insured's right to receive payment of the unsubrogated portion of the Insured's Claim shall have priority over the subrogated claim.

Name

Under Article 25 of the Insurance Act, the Insured's Claim is transferred to the insurer by operation of law when the insurer has paid the insurance claim. Accordingly, the claim is exercised in the name of the insurer.

7. Impact of Macroeconomic Factors

7.1 Type and Amount of Litigation

Type of Litigation

There have been no drastic changes in the type of litigation in the year leading up to August 2025.

The war in Ukraine has not affected the types of litigation in Japan, and there have been no other developments that have affected the type of proceedings in Japanese courts.

Amount of Litigation

According to court statistics, about 620,000 ordinary civil and administrative litigation cases were newly filed in 2024, which is an increase of approximately 8% from 2023. In particular, there has been an increase of about 6,000 ordinary litigation cases before district court, and an increase of about 45,000 ordinary litigation cases before summary court.

7.2 Forecast for the Next 12 Months

While the majority of insurance litigation in Japan continues to arise from routine traffic accidents, several trends point to the future of complex, high-value disputes.

A primary trend is the focus on director and officer (D&O) liability. High-profile lawsuits and an emphasis on corporate governance have driven D&O policy adoption to approximately 80% among listed companies. This high level of adoption ensures a steady potential for claims stemming from shareholder actions concerning matters ranging from misstatements in financial reports to breaches of competition law. The potential for disputes over complex financial instruments also persists, as demonstrated by litigation concerning the write-down of AT1 bonds.

A second constant source of conflict stems from insurance claims following natural disasters. Events such as typhoons and earthquakes, including the January 2024 Noto earthquake, will continue to test policy wordings and drive disputes over causation and damage valuation, representing a fundamental risk in the Japanese market.

Looking ahead, the market is bracing for a new wave of disputes related to cyber risks. A 2023 survey by the General Insurance Association of Japan highlighted significant underinsurance in this area, but growing risk awareness is expected to drive the uptake of cyber policies. As this market matures, it will likely generate novel and complex litigation concerning business interruption losses and the application of policy exclusions to sophisticated cyber attacks.

Finally, the experience following the COVID-19 pandemic serves as a reminder that major social and economic disruptions can produce a long tail of litigation. While pandemic-specific claims are now less frequent, the principle remains that novel and complex disputes can continue to emerge years after an initial crisis has passed.

7.3 Coverage Issues and Test Cases

As far as is known, no specific coverage issues or test cases have arisen from COVID-19, the war in Ukraine or otherwise.

7.4 Scope of Insurance Cover and Appetite for Risk

Insurance Cover

In a broad sense, the COVID-19 pandemic and the war in Ukraine have affected the scope of insurance coverage available.

On 10 April 2020, the Japanese Financial Service Agency (FSA) requested insurance trade associations to take active measures to protect policyholders exposed to the risk of COVID-19. In response, some insurers introduced a retrospective revision of their insurance products to cover COVID-19-related losses and expenses, while others decided to apply accidental death clauses to COVID-related deaths. In addition, insurers have developed various new products covering COVID-19-specific losses, such as loss of earnings due to temporary closure or shortening of business hours and facility disinfection costs.

Meanwhile, the war in Ukraine has led to major Japanese insurers suspending war and strike coverage from cargoes carried near Ukraine in response to reinsurance trends.

Appetite for Risk

There is no evidence of published items that indicate that the pandemic or the war in Ukraine have changed appetites for risk within Japan.

8. Emerging Risks

8.1 Impact of ESG on Underwriting and Litigating Insurance Risks

The Effect of Climate Change on Underwriting

The General Insurance Association of Japan (a trade association representing non-life insurance companies licensed in Japan) established its Climate Change Response Plan in July 2021. The Plan states that its members shall:

- contribute to relieving and responding to climate change risks and assist in a smooth transition into a sustainable society; and
- aim for a decarbonised society by curbing their emission of greenhouse gases.

Various insurers have issued or amended their own climate change response papers to further the association's agenda. For example, a major insurer announced a policy to cease transactions with major customers in high greenhouse gas emission sectors that do not have decarbonisation plans in place by 2030.

The Effect of Climate Change on Insurance Litigation

Particular court precedents showing a connection between climate change and insurance litigation cannot be found.

8.2 Data Protection Laws

In Japan, the Act on the Protection of Personal Information has been in full force since 2005. With regard to underwriting, the following apply.

- Following recommendations by the Basic Policy on the Protection of Personal Information (Cabinet Decision of 2 April 2004, promulgated under delegation by the Act), non-life and life insurance companies have established and published personal information protection policies, which include the purpose of use of personal information,

the types of personal information to be obtained, methods of obtaining personal information, the provision of personal information, the protection and management of personal information, and requests for the disclosure, correction and deletion of personal data. Each insurance company carries out underwriting work in accordance with its respective personal information protection policy.
- Article 20 (2) of the Act prohibits the acquisition of sensitive personal data (race, creed, social status, medical history, criminal and victim records, etc), except with the prior consent of the subject individual or as provided by the Act. Thus, insurers must obtain prior consent when acquiring such information.
- Article 28 (1) of the Act prohibits the provision of personal data to third parties in foreign countries, except with the prior consent of the individual or as provided by the Act. In obtaining such consent, certain information must be provided to the individual, such as the data protection laws in that foreign country. Thus, insurers must provide such information and obtain prior consent when concluding reinsurance contracts with foreign reinsurers.

With regard to litigation, the following apply.

- Insurance companies must maintain a high level of information management because they handle highly sensitive information, such as an individual's physical characteristics. No court precedents regarding disputes over information management could be found.
- No court precedents regarding insurance claims over leaks of personal information could be found.
- A traffic accident victim is entitled to claim directly against the perpetrator's insurer under the Act on Securing Compensation for Automobile Accidents (see **4.6 Third-Party Enforcement of Insurance Contracts**). In such cases, the victim may dispute whether they gave consent to the insurance company's obtaining a medical certificate from the victim's hospital. This is considered to be mainly a question of fact-finding, and occasionally it has been found that the victim gave consent with regard to one hospital but not another. The courts pay due respect to the subject individual's right to privacy when considering such issues.

9. Significant Legislative and Regulatory Developments

9.1 Developments Affecting Insurance Coverage and Insurance Litigation

The Code of Civil Procedure of Japan was amended in May 2022, introducing:

- the digitalisation of court procedures; and
- "fast-track" proceedings allowing for a quicker resolution of court disputes.

As of August 2025, the date of enforcement of the revised Code has not been fixed.

Under the current regime, the parties must, in principle, file court submissions by paper, and formal hearings must be attended in person. The amendment will make it possible to commence suit, file submissions and inspect court files electronically without resorting to paper. It will also allow court hearings and witness examinations to take place electronically.

There are currently no mandatory limits on the time by which litigation must be concluded. There is a law requiring first instance courts to aim for the conclusion of proceedings within two years, but this is a best-effort provision that cannot be enforced. Furthermore, ordinary litigation is subject to two appeals. The amendment will make it possible for the parties to agree to apply for "fast-track" proceedings, whereby the proceedings must conclude within six months from the date of the first hearing, and a judgment must be issued within one month from the conclusion of the proceedings. A "fast-track" judgment cannot be appealed unless the claim was dismissed without prejudice to the merits. The draftsmen anticipated "fast-track" proceedings to be utilised in cases where the points of dispute are limited to the interpretation of contractual clauses or the application of law. As such, they may prove helpful in insurance coverage disputes.

However, the "fast track" has certain limitations. First, the proceedings are subject to a court determination that they would not prejudice fairness or proper procedure, and may not be utilised for consumer and individual labour disputes. Furthermore, any one of

the parties has the right to demand a switch to an ordinary procedure. In addition, a losing party may file an objection against a "fast-track" judgment within two weeks from service, upon which the proceedings will revert to the position before hearings were concluded and transition into ordinary litigation.

Other developments on the regulatory side include the revision of the Insurance Business Act and Comprehensive Guidelines for Supervision for Insurance Companies. The Act was revised in May 2025 and will be enforced by June 2026. The revised Guidelines have applied since 28 August 2025.

Both revisions are aimed at preventing the recurrence of recent high-profile scandals, including systemic fraudulent claims by a major auto-repairer acting as an insurance agent (the "Big Motor scandal"), and the pre-bidding co-ordination of premiums (a price-fixing cartel) by several insurers in the co-insurance market.

The revised Act introduces new obligations for certain large-scale insurance agents that deal with multiple insurers' products to monitor their business operations in order to avoid undue influence on claims payment, as well a new obligation for insurers to monitor said insurance agents in performing the obligation. It also expands the prohibition on the provision of excessive benefit to insurance policyholders, among other matters.

JORDAN

Law and Practice

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Hammouri & Partners

Contents

Hammouri & Partners is a prominent multi-practice Jordanian law firm that operates across large swathes of the Hashemite Kingdom of Jordan and beyond, with two new offices since 2023 in Iraq. The firm's history goes back to 1994, when it was established as a law office in Amman, Jordan by the late Professor Mohammad Hammouri. Since its establishment, the firm has been driven by the vision of serving clients through an exceptional team, best business practices and a commitment to highest ethical and professional standards. Over the past 28 years, the firm has grown both in relation to number of personnel as well as in relation to volume of work, and has developed strategic partnerships with many established law firms worldwide. The firm is managed by HE Dr Tariq Hammouri, the firm's managing partner, assisted by several dynamic teams of approximately 30 legal experts.

Hammouri & Partners would like to thank Ms Yotta Pantoula-Bulmer, of counsel and head of the firm's international department, and Ms Maryam Kailani, legal trainee, for their valuable contributions.

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1. Rules Governing Insurer Disputes

1.1 Statutory and Procedural Regime

The Jordanian Civil Law regulates insurance contracts; see Articles 920–949 in Chapter Three, Part Four of Jordan's Civil Law No 43 of 1976. The Jordanian legislature addresses the structure, conditions and effects of the contract, outlining the obligations of both the insured and the insurer, as well as specific provisions for certain types of insurance contracts (such as life insurance and fire insurance). These rules are regarded as a general framework governing insurance relationships.

For matters not expressly covered by these articles, the legislature has entrusted their regulation to specific laws, regulations and instructions – including the Insurance Business Regulation Law and the Compulsory Insurance System, which regulates the resolution of disputes related to insurance contracts. Accordingly, disputes are resolved through regular courts. However, the law initially requires consulting insurance companies to resolve the dispute amicably before resorting to court. Parties also have the right to exclude resorting to court and to instead resort to arbitration (an alternative means of dispute resolution) if the parties agree to this in accordance with the provisions of the law and procedures.

1.2 Litigation Process and Rules on Limitation

Litigation procedures in Jordan are governed by the Code of Civil Procedures and the Law of Magistrate Courts, and no special procedural provisions exist specifically for insurance disputes. However, for the purpose of resolving insurance-related judicial disputes, the law allows the judge to conduct technical expertise in insurance cases before compiling the evidence to facilitate dispute resolution in an amicable manner. In practice, when insurers are aware of the value of the disputed damages, they may seek amicable resolution of the dispute. This aims to reduce the consequences of litigation by avoiding awarding the plaintiff attorney's fees and reducing the value of the legal interest awarded.

The statute of limitations in cases arising from an insurance contract is governed by the provisions of Article 932 of the Civil Code, which sets a three-year period preventing the hearing of claims arising from the insurance contract, starting from the occurrence of the incident that gave rise to the dispute or from the date that the claimant becomes aware of it. However, if the insured conceals information related to the insured risk or provides incorrect information or false data related to the risk, the limitation period begins only when the insurer becomes aware of the concealment or inaccuracy.

1.3 Alternative Dispute Resolution (ADR)

In the event of a dispute arising between the insured and the insurer regarding compensation, the insured has the right to resort to the Dispute Resolution Committee, headquartered at the Central Bank of Jordan.

Alternative dispute settlement is also widely encouraged in Jordan, the most prominent form of which is "negotiations" as an initial step to limiting the dispute between the parties. "Conciliation" is then resorted to, through a conciliatory approach between the parties. If the dispute is resolved through consensus, the injured party is then compensated according to the concluded agreement.

If an agreement is not reached between the parties, "arbitration" is the most common method for resolving complex disputes, with the parties agreeing, through the contract concluded between them, to refer any dispute that arises between the parties to arbitration.

2. Jurisdiction and Choice of Law

2.1 Rules Governing Insurance Disputes

The legal rules governing disputes arising from insurance contracts in Jordan are derived from multiple sources. The most important is Jordanian Insurance Law No 20 of 2023, which is the primary law governing insurance activity in Jordan and which defines the rights and obligations of the parties to insurance contracts (the insurance company, the insured and the beneficiary). In addition, the Customer Dispute Settlement System issued by the Insurance Regulatory Commission (2021) is a mandatory framework requiring insurance companies to establish an internal mechanism to receive and resolve customer complaints. The general rules of the Jordanian Civil Code (No 43 of 1976), particularly those related to contracts, are also applicable.

2.2 Enforcement of Foreign Judgments

Foreign judgments may be enforced against or in favour of insurance companies in Jordan, provided that the legal requirements are met in accordance with the Jordanian Foreign Judgments Enforcement Law. These requirements include:

- the principle of reciprocity with the country issuing the judgment to be enforced;
- ensuring that the foreign judgment does not violate public order or public morals within Jordan; and
- ensuring the validity of the procedures for issuing the foreign judgment.

A request must be submitted to the Amman Court of First Instance, which is the competent court under Jordanian law. The foreign judgment must be certified by the issuing state's institutions. The request is then submitted to the court and reviewed, and an enforcement order is issued if it meets the legal requirements. The judgment becomes enforceable like any other judgment issued by Jordanian courts.

2.3 Unique Features of Litigation Procedure

Litigation in insurance contract disputes in Jordan has several unique features that distinguish it from other civil disputes – most notably, mandatory mediation as a condition for admissibility. The insured cannot file a lawsuit directly to the court unless they first exhaust amicable settlement avenues by filing a complaint with the insurance company and then resorting to the Financial Services Dispute Settlement Committee at the Central Bank of Jordan (as regular courts are not the only competent courts to resolve these disputes). In addition, the Financial Services Dispute Settlement Committee serves as a specialised semi-judicial body that provides free and mandatory mediation, which reduces the burden on the judiciary and provides faster resolution for the parties.

3. Arbitration and Insurance Disputes

3.1 Enforcement of Arbitration Provisions in Commercial Contracts

Jordanian courts enforce arbitration clauses contained in commercial insurance and reinsurance contracts, but within a specific and precise legal framework that achieves a balance between the parties. A key feature of enforcing arbitration clauses is the legal recognition of the arbitration clause. Jordanian Arbitration Law No 31 of 2023 regulates arbitration procedures and explicitly recognises any arbitration clause agreed upon in writing, whether pursuant to a separate contract or to a clause contained in the

original contract. If a valid arbitration clause is found in the contract, the court before which the case is filed will refrain from considering the subject of the dispute and will refer the parties to arbitration.

3.2 The New York Convention

The Hashemite Kingdom of Jordan is a member in the 1958 Convention on the Recognition and Enforcement of Foreign Arbitral Awards (the "New York Convention"), to which Jordan became a party in 1979. Foreign arbitration awards are enforced in Jordan by submitting a request for enforcement to the Amman Court of First Instance (the competent court), accompanied by a certified copy of the original arbitration award and a certified copy of the arbitration agreement. The court verifies that the formal documents stipulated in the convention have been met and that there are no grounds for rejection (such as the award being contrary to public order in Jordan). If the documents meet the legal requirements, the court issues an order for enforcement of the award, giving it the force of an executive order that can be executed through the relevant enforcement departments.

3.3 The Use of Arbitration for Insurance Dispute Resolution

Arbitration is considered a primary method for settling insurance and reinsurance disputes in Jordan, given their technical and complex nature, which often requires specialised expertise. This method of resolution is particularly common in reinsurance disputes, disputes between insurance companies and brokers, and large-scale commercial disputes related to mega-projects.

Arbitration in Jordan is regulated by Arbitration Law No 31 of 2001, which is in line with international standards, ensuring the flexibility and full confidentiality of proceedings. Arbitration awards are final and are not subject to substantive appeal; appeals are limited to procedural defects and specific exclusive grounds, such as violations of public order or the invalidity of the arbitration agreement. It is important to note that Jordanian courts actively support the enforcement of these awards locally and internationally, in accordance with the New York Convention. This enhances the reliability of arbitration as an effective and distinct mechanism for settling disputes in the insurance sector.

4. Coverage Disputes

4.1 Implied Terms

Some conditions are included in the insurance contract by operation of law. In Jordan, these mandatory conditions aim to achieve a balance between the two parties of the contract (the insurance company and the insured) and to protect the public interest, even if not explicitly stated in the written document. One of the key conditions is the insurable interest condition, under which the law requires that the insured have a financial interest in the insured item or person. Both parties are obligated to disclose all the information that may affect the acceptance of the insurance or its terms. If the insured conceals or provides false information about a material fact, the insurer has the right to terminate the contract or to refuse payment of compensation.

4.2 Rights of Insurers

Under Jordanian law – including the Jordanian Insurance Law – insurance companies have fundamental rights regarding the presentation of risks before the contract signing comes into effect. This is to ensure correct information and accurate risk assessment. The company has the right to interview the insured to obtain all essential data and facts that may affect the risk assessment, such as health status in life insurance or accident history in vehicle insurance. The company has the right to assess the risk and to reject it if it is found to be abnormal or exceed acceptable limits.

The company also has the right to refuse to insure the risk entirely, and the right to modify the coverage terms if there are factors that increase the risk. It has the right to submit the offer with exceptional conditions, such as specific exclusions or imposing a higher insurance value, as well as the right to void the contract in the event of dishonest disclosure. All of this is designed to ensure contractual fairness.

4.3 Significant Trends in Policy Coverage Disputes

The insurance sector has witnessed a significant shift towards mediation and arbitration, with reliance on such alternative dispute resolution mechanisms increasing significantly. These mechanisms aim to resolve disputes more quickly than traditional litigation, while preserving the relationship between the contracting parties and tightening the regulatory framework for dispute resolution. Committees specialising in resolving medical disputes (such as medical committees) have witnessed significant developments in their working procedures, focusing their role on interpreting disputed clauses in contracts, where ambiguity in the clauses is often interpreted in favour of the insured.

4.4 Resolution of Insurance Coverage Disputes

Insurance coverage disputes are typically settled through gradual mechanisms, while the handling of reinsurance disputes differs fundamentally due to the nature of the contracting parties. Direct insurance disputes (between the company and the client) are settled through direct negotiation as a first step in attempting to fully resolve the dispute, or by resorting to dispute resolution if initial negotiation fails. Arbitration may also be resorted to if the contract contains an arbitration clause.

Concerning reinsurance contracts, disputes arising between companies (as companies) are referred to the judiciary like any other lawsuit if negotiation or amicable settlement fails. Arbitration may also be resorted to as a forum for resolving disputes if the contracts contain an arbitration clause in accordance with the law.

4.5 Position If Insured Party Is Viewed as a Consumer

The position differs where the law views the insured party as a consumer. Since the Jordanian legislature considers the insured a consumer, the legal balance is largely in their favour. It requires that the conditions that lead to the loss or reduction of the insured's rights be clearly and conspicuously presented, and it restricts the insurance company's right to amend or terminate the insurance contract by unilateral will. It also requires certain mechanisms to protect the insured, such as interpreting the conditions in the event of ambiguity or conflict in the contract's clauses in favour of the insured. The law places the consumer in a protected position and reduces the contractual power of the company.

4.6 Third-Party Enforcement of Insurance Contracts

According to established judicial practice, the third party who is harmed or the beneficiary of the insurance contract has the right to file a direct lawsuit against the insurance company – such as a third party obtaining a court ruling against the insured (the person who caused the harm) proving their responsibility and entitlement to compensation. The harmed party is allowed to sue the insurance company directly to recover compensation. The law explicitly stipulates this right in certain types of mandatory insurance (such as motor vehicle insurance), where the harmed party is given the right to directly refer to the insurance company to ensure that they receive compensation.

4.7 The Concept of Bad Faith

Jordanian civil law addresses the principle of bad faith regarding the concealment of incorrect information by the insured. Insurance law addresses the principle of utmost good faith as a fundamental principle in insurance contracts. Under insurance law, bad faith is defined as:

- a deliberate breach of contractual obligations;
- the provision of false information; or
- the concealment of essential information with the intent to defraud or circumvent the insurance contract.

Under the law, the insured's bad faith results in the termination of the contract and the insurer's right to retain paid premiums as compensation. Meanwhile, the insurer's (insurance company's) bad faith is considered a reason for its liability for damages and incurred losses.

4.8 Penalties for Late Payment of Claims

Insurance companies are subject to penalties for late payment of compensation. These penalties are financial fines imposed by regulatory authorities, requiring

them to pay additional compensation to the insured for damages resulting from the delay. The system requires companies to adhere to specific time periods for settling claims. In the event of delay, the customer must be notified, explaining the reasons for the delay. In the event of repetition, penalties may escalate to the withdrawal of licences or partial suspension of activity. In certain types of insurance such as vehicle insurance, those affected have the right to file a formal complaint with the competent authority or committee to follow up on the violation. The company may also be required to provide a replacement vehicle to the insured during the repair period of the damaged vehicle.

4.9 Representations Made by Brokers

Under the laws regulating the insurance sector, the broker is considered the insured's agent in contracting procedures. Therefore, the representations and statements made by this broker to the insurance company are legally attributed to the insured and fully bind the insured, as long as they fall within the scope of the delegated authority. This responsibility is based on the principle of legal agency, whereby the agent's actions are considered to be attributable to the insured. However, this obligation may be waived in cases where the broker exceeds the limits of their agency, commits fraud or deception with the knowledge or complicity of the insurance company, or makes representations that the insured knows are false. Therefore, the insured's primary responsibility lies with selecting a credible broker and reviewing all statements made on their behalf to ensure that they are consistent with the facts and avoid any disputes.

4.10 Delegated Underwriting or Claims Handling Authority Arrangements

Under Jordanian law, these arrangements can lead to legal issues, due to the legislation related to delegation. The Jordanian Civil Code regulates delegation, and legal arrangements are binding on the parties involved. In terms of legal liability, if problems arise during the implementation of the delegation – such as failure to comply with the terms or errors in processing claims – lawsuits may be filed against the delegate. Conflicts of interest may also arise if there is a conflict of interest between the parties, leading to non-compliance with the mandate. Furthermore, cases may arise regarding compensation for damages resulting from improper implementation of the delegation. One party may seek to recover funds or compensation in the event of a breach of the agreed terms.

5. Claims Against Insureds

5.1 Main Areas of Claims Where Insurers Fund the Defence of Insureds

Insurance companies (the insurers) may raise several legal defences to limit their liability or reject a claim for compensation entirely. The most prominent of those defences against the insured is the non-occurrence of the insured risk. The insurer argues that the incident/accident did not fall within the scope of the agreed-upon insurance coverage, or that it is excluded under the policy's exclusions clause.

It is also possible to argue that there was a breach of the duty of disclosure (utmost good faith), where the insurer argues that the policyholder concealed information or provided false or incomplete information when concluding the contract, affecting the risk assessment. This may give the insurer the right to terminate the contract and refuse compensation.

In addition, the insurer may add that there was a breach of safety conditions – ie, the company may claim that the insured failed to take reasonable measures to prevent or mitigate the loss after the incident occurred, or that they acted with excessive or deliberate negligence contributing to the loss. In such cases, the insurer's obligation to pay compensation is terminated.

5.2 Likely Changes in the Future

The cost and complexity of this type of litigation is expected to continue rising in the coming years, due to evolving technological risks and tightening global regulations. However, as clearer case law and standards emerge – particularly around AI and environmental issues – some of the uncertainty may be mitigated. Insurance companies will likely continue to develop more specific exclusions in their policies, while insured parties will push for broader coverage. The result will be a litigation landscape that keeps pace with the environmental and technological develop-

ments, characterised by higher costs but with greater transparency and precision for all parties.

5.3 Trends in the Cost or Complexity of Litigation

Litigation in Jordan is inexpensive compared to other countries, especially Western countries. Litigation is open to all, and the costs of an insurance case are 3% of the claim value. These fees, expenses and costs are borne by the losing party. To ensure fair litigation, Jordanian law provides for a request for deferment of fees. If the applicant who wishes to file a lawsuit proves that they do not have the funds, they can submit a request for deferment of fees. After a decision is issued to defer the fees, the plaintiff registers the lawsuit and proceeds with it without losing their legal right to file a lawsuit.

5.4 Protection Against Costs Risks

Plaintiffs can purchase insurance against the risk of legal costs through specialised insurance policies known as legal defence or litigation costs insurance. These types of insurance provide pre-emptive coverage within personal or commercial insurance policies for potential lawsuit costs, while the second type is specifically provided after the dispute arises to cover litigation costs and the risk of paying costs to the opponent in the event of a loss. Coverage typically includes legal fees, attorneys' fees, witness and expert fees, and even potential court costs that may be awarded in favour of the opposing party. This type of insurance is a vital tool for reducing the financial risks for plaintiffs, enabling them to pursue their rights without fear of additional costs.

6. Insurers' Recovery Rights

6.1 Right of Action to Recover Sums From Third Parties

Jordanian law grants the insurer the right to recover their loss from a third party in certain circumstances. The law allows the insurer to replace the insured and to recover the compensation paid by the insurance company to the insured by substituting the insured's rights against the person who caused the damage (the person responsible for the accident). This is also granted by law to an insurance company after it has paid compensation to the insured. The insurer can then replace the insured in claiming damages from the third party responsible for the damage, and can recover the compensation paid by the insurance company from a person who committed a serious violation or who was responsible for the accident.

6.2 Legal Provisions Setting Out Insurers' Rights to Pursue Third Parties

The insurer's right to pursue third parties (causative parties) is regulated by Article 926 of the Jordanian Civil Code, which provides that the insurer replaces the insured in exercising their rights against the party responsible for the damage after payment of compensation. The lawsuit is filed in the name of the insurer (insurance company), who exercises these rights by replacing the insured. This mechanism ensures that the insured does not receive double compensation.

7. Impact of Macroeconomic Factors

7.1 Type and Amount of Litigation

The COVID-19 pandemic and the wars in Ukraine and Gaza have radically impacted the insurance litigation environment, exacerbating disputes. The pandemic has generated a number of claims related to business losses resulting from lockdowns. Insured companies have challenged their insurers to cover their losses resulting from business interruptions due to health lockdowns. However, insurers have adhered to their narrow interpretation of insurance policies, which excludes such losses.

Furthermore, the Ukraine war has disrupted supply chains and sparked disputes over maritime cargo claims related to war risks, as well as vessel and crop losses. The war in Gaza has also introduced complications in the insurance business, particularly in regions with trade, business or geopolitical links to the Middle East.

7.2 Forecast for the Next 12 Months

Insurance litigation is expected to evolve over the next 12 months as a result of new court rulings clarifying business loss coverage obligations related to the COVID-19 pandemic. Wars and geopolitical turmoil will continue to generate disputes over the extent of

insurance companies' risk coverage, prompting legislators to issue new regulations that address the challenges facing the insurance litigation environment and to clarify the obligations and limits of parties to insurance contracts.

7.3 Coverage Issues and Test Cases

These factors have led to the emergence of very important legal and experiential issues, as insurance companies seek to keep pace with the developments surrounding insurance transactions and litigation related to disputes arising from them – especially in areas such as property insurance in conflict zones, marine and aviation insurance during war, insurance against acts of terrorism or sabotage, and insurance for global supply chains affected by conflicts. Those cases are expected to set a legal precedent in interpreting the limits of "acts of war" coverage in commercial insurance contracts.

7.4 Scope of Insurance Cover and Appetite for Risk

Previously discussed factors – such as the continuation of wars and geopolitical unrest – have directly and tangibly impacted the scope of available insurance coverage. Exclusions related to acts of war, hostilities, terrorism, government confiscation or occupation, civil unrest and revolutions have increased.

Many marine and aviation insurance policies now clearly state that damages resulting from the conflict in Ukraine or threats in the Red Sea are not covered unless additional coverage is purchased. Some companies now offer coverage for hazardous areas, but with strict conditions, and have become more conservative in accepting risks associated with conflict zones or geopolitical tensions. As a result, wars and geopolitical unrest have narrowed the scope of coverage and reduced insurers' willingness to cover many risks, especially in areas affected by conflict or terrorist threats. Coverage has also become conditional, expensive and restricted by severe legal and geographical restrictions.

8. Emerging Risks

8.1 Impact of ESG on Underwriting and Litigating Insurance Risks

ESG measures are radically impacting the insurance industry by introducing new perspectives to risk assessment. Companies have become a decisive criterion for determining insurance premiums and terms. Companies that adhere to ESG criteria are granted preferential terms, while underperforming companies that do not comply with the criteria face higher premiums or are denied coverage, due to their failure to fully understand the full range of risks and to technically assess long-term performance. This has led to the evolution of insurance policies to address these new risks, while regulatory pressures have increased potential legal costs and fines in contracts.

8.2 Data Protection Laws

Data protection laws further complicate underwriting, as insurance companies must now assess an organisation's compliance with the law and the strength of its security programmes before granting coverage, which directly impacts insurance terms and premiums. These laws also significantly increase the risk of litigation, leading to numerous lawsuits and hefty fines for data breaches in violation of the law.

As a result, a specialised insurance area has evolved to address these new risks. This shift has led to the development of cyber insurance policies that offer tailored protection for data breaches, regulatory fines and business interruptions caused by cyber incidents. Insurers now employ advanced risk assessment tools and require organisations to demonstrate robust cybersecurity practices before offering coverage. The complexity of these policies reflects the growing importance of data security in the modern business environment, where a single breach can cause not only financial loss but also irreparable reputational damage. In addition, the rapid pace of regulatory change, with new laws and amendments continuously being introduced, requires insurers and insureds to stay vigilant and adjust coverage regularly to ensure full compliance and protection.

9. Significant Legislative and Regulatory Developments

9.1 Developments Affecting Insurance Coverage and Insurance Litigation

There are many developments that have affected insurance coverage and litigation in insurance claims, including the issuance of Compulsory Vehicle Insurance Regulation No 52 of 2024, pursuant to which the injured party's right to compensation is waived in the event of assigning their rights to a third party or collecting any amounts from third parties other than the driver and owner. Also relevant is Article No 12 thereunder, which obliges the insurance company to settle claims amicably, to issue a decision within 14 days from the date of inspection of the damaged vehicle and to pay the compensation within a specified period.

In addition, the Medical Committees Regulation of 2025 was issued, pursuant to which specialised judicial medical committees were established to evaluate bodily injuries. Their mandate is to consider cases before the judicial authorities issue the necessary decisions concerning those cases, and to determine percentages regarding disability in order to ascertain the value of compensation payable.

LEBANON

Law and Practice

Contributed by:
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Obeid & Medawar

Contents

Obeid & Medawar was founded in 2007 by Amer Obeid and Rachad Medawar. The firm operates in Lebanon, the UAE, and the Kingdom of Bahrain with a highly qualified team of trilingual lawyers from diversified backgrounds. Its practice spans from basic consultation to the widest spectrum of legal services. Obeid & Medawar has three main departments: Consultation; Litigation, Arbitration and Alternative Dispute Resolution; and Legislative Practice/Policymaking, handling a wide range of practice areas. These include, but are not limited to, corporate and commercial law; civil, administrative and labour law; real estate and construction law; insurance and reinsurance; banking and finance law; M&A; wealth management; management of family offices; IP law; aviation law and medical law.

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1. Rules Governing Insurer Disputes

1.1 Statutory and Procedural Regime

Statutory Regime

The insurance sector in Lebanon is governed by Decree No 9812 of 4 May 1968 ("the Law"). This Law outlines the regulations for insurance companies operating within the country, applying to both Lebanese and foreign insurers conducting any of the insurance activities covered under the Law's listed branches and sub-branches.

In addition, insurance activities in Lebanon are regulated by decisions from the Insurance Control Commission (ICC) which operates under the Lebanese Ministry of Economy and (MOET). The ICC is the authority overseeing the insurance industry in Lebanon. It aims to protect the interests of policyholders and has the authority to enforce regulatory and supervisory frameworks through interventions and sanctions. The ICC issues decisions and directives that insurance companies must adhere to, and that can influence the handling of insurance disputes by setting standards and practices.

Insurance operations are also subject to the provisions of the Code of Obligations and Contracts, specifically Articles 950 to 1023.

Procedural Regime

Article 48 of the Law allows policyholders or the beneficiary to pursue claims against insurance companies before the Insurance Arbitration Council, established within MOET. This Council comprises experienced insurance professionals that can handle financial claims resulting from medication and hospitalisation insurance policies, as well as insurance policies covering vehicles, carriages and traffic accidents. However, its jurisdiction is limited to claims of LBP75 million or less, on condition that the plaintiff has not previously initiated a court action regarding the same matter.

While the laws governing insurance activities in Lebanon do not specify other dispute resolution mechanisms applicable for insurance disputes in Lebanon, the commercial and financial courts remain competent to handle insurance cases. Judges in these courts possess the necessary experience to handle various insurance disputes. Such disputes will follow the standard litigation procedure before Lebanese courts and regulated by the Lebanese Code of Civil Procedure.

1.2 Litigation Process and Rules on Limitation

Litigation in Lebanon is governed by the Lebanese Code of Civil Procedure, established by Decree-Law No 90/1983 and its subsequent amendments. Lebanon follows a civil legal system that adheres to the inquisitorial model, where the legal process is primarily conducted through written submissions, with a focus on formal documentation and written evidence.

The general rules on limitation concerning claims arising out of or in association with an insurance policy is two years from the event of the occurrence (Article 985 of the Lebanese Code of Obligations and Contracts). However, the two-year limitation period will not begin at the time of the incident in certain cases:

- if there is concealment of an insured risk, omission, incorrect or invalid disclosure, the limitation period will start from the date the insurer becomes aware of the occurrence;
- in emergencies, the limitation period will begin on the day the parties became aware of the occurrence, provided they can demonstrate that they were unaware of it before that time.

In addition, lawsuits that remain inactive for two years from the last valid procedural step may be dismissed by the court, either upon the request of a party or ex officio, on the court's own initiative.

1.3 Alternative Dispute Resolution (ADR)

In Lebanon, Alternative Dispute Resolution (ADR) is increasingly recognised and encouraged as a viable means of resolving disputes outside the traditional court system. Courts and legal professionals are becoming more open to ADR, particularly as it helps reduce the burden on the judicial system and provides a more flexible and often faster method of dispute resolution.

The most recognised forms of ADR in Lebanon are Arbitration and Mediation. Arbitration proceedings are regulated by the Lebanese Code of Civil Proce-

dure (CCP). The CCP contains a dedicated chapter (Chapter 2) on arbitration, distinguishing between local arbitration (Articles 762 to 808) and international arbitration (Articles 809 to 821).

For instance, the parties to an insurance contract may choose arbitration as an alternative dispute resolution method. However, it is important to note that clauses under an insurance policy issued in Lebanon concerning risks existing in Lebanon and falling under the branches stated in Article 2 of the Law are considered null and void if the chosen arbitrator is not domiciled in Lebanon and does not issue their award within the country.

Mediation was formally recognised in Lebanon in 2005 through the establishment of specialised mediation centres, each with its own rules and procedures. It has been endorsed through the enactment of Law No 82 of 18 October 2018 on Judicial Mediation and Law No 286 of 14 April 2022 regarding Conventional Mediation.

With the Judicial Mediation, the parties have the option to initiate mediation proceedings even after court proceedings have begun.

2. Jurisdiction and Choice of Law

2.1 Rules Governing Insurance Disputes

As previously mentioned, the insurance sector in Lebanon is governed by regulations outlined by the Law. Subsequent amendments to the Law have been limited, with no significant updates since 1999. Insurance law is currently being revised by parliament, and the new regulations might introduce significant changes to the legal framework for insurance companies in Lebanon.

In addition, and as already mentioned, insurance operations in Lebanon are subject to decisions issued by the ICC and its bylaws, and provisions outlined in the Code of Obligations and Contracts (Articles 950 to 1023).

2.2 Enforcement of Foreign Judgments

In Lebanon, the enforcement of foreign judgments, including those involving insurers, is governed by the Lebanese Code of Civil Procedure, in particular Articles 982 to 987.

Under such provisions, some conditions should be met in order for Lebanese courts to enforce the foreign decisions in Lebanon. In particular, (i) the foreign judgment should be final and not subject to appeal or further proceedings in the originating jurisdiction; (ii) the foreign country's legal system should allow the recognition in its jurisdiction of Lebanese judgements; (iii) the foreign court must have had proper jurisdiction over the case, and such court must have complied with Lebanese laws and principles of justice when ruling; and (iv) the foreign judgement should be compliant with the Lebanese public policy or fundamental legal principles.

For insurance disputes, in addition to the above, the judgement to be enforced should align with the relevant insurance laws and regulations in Lebanon.

In addition, Lebanon is a party to various international treaties and conventions that may affect the recognition and enforcement of foreign judgements, such as those relating to arbitration and commercial matters.

2.3 Unique Features of Litigation Procedure

As previously mentioned, Article 48 of the Law provides for the establishment of arbitration councils to resolve disputes related to financial claims arising from insurance coverage. This option is available to individuals in addition to the standard litigation procedures before Lebanese courts, as outlined in the Lebanese Code of Civil Procedure.

A notable feature of these councils is that they offer a guaranteed right for individuals. Specifically, any provision in an insurance policy intended to exclude the jurisdiction of the insurance arbitration council is deemed null and void. Furthermore, cases brought before the insurance arbitration council are exempt from judicial taxes and stamp duties, though they are not exempt from costs. Finally, parties can file cases with the council without requiring legal representation, unlike in the courts.

Additionally, awards issued by an insurance arbitration council are only open to limited judicial recourse. The only options available for challenging these awards are opposition; opposition by third parties; and cassation, in accordance with the rules set forth in the Code of Civil Procedure.

3. Arbitration and Insurance Disputes

3.1 Enforcement of Arbitration Provisions in Commercial Contracts

Under Lebanese legislation, there are generally no significant restrictions on including arbitration clauses in commercial insurance and reinsurance contracts.

However, the Lebanese Code of Civil Procedure establishes exclusive territorial jurisdiction for specific insurance matters. For instance, disputes related to health insurance are governed by the courts in the insured party's place of domicile (Article 109), while accidents, including car accidents, are governed by the courts either located where the accident occurred in the insured party's place of domicile (Article 110). Additionally, disputes related to fire insurance matters fall under the jurisdiction of the courts where the fire occurred (Article 111).

In addition, arbitration clauses included in an insurance policy issued in Lebanon concerning risks located within Lebanon and falling under the branches stated in Article 2 of the Law are deemed null and void if they stipulate that the arbitration will be conducted by an arbitrator who is not domiciled in Lebanon or if the chosen arbitrator does not issue their award within the country (Article 11 of the Law).

Based on the above, parties to an insurance contract may opt for arbitration as an alternative dispute resolution method, as long as the dispute does not pertain to any of the restricted matters outlined above and complies with the above-mentioned limitations.

3.2 The New York Convention

Lebanon ratified the New York Convention on 9 November 1998, with a reservation based on reciprocity. This means Lebanon will only recognise and enforce arbitral awards issued by other contracting states that are also parties to the convention.

Lebanese courts have enforced several foreign arbitral awards under this convention. A legitimate interest is required for a court to accept jurisdiction over such proceedings. The applicant must produce as evidence: (i) the arbitral award (either the original or a certified copy); and (ii) the arbitration agreement. The proceedings are conducted ex parte, where the judge will only verify: (i) the existence of the award; and (ii) whether the recognition of the award would be manifestly contrary to international public policy.

The competent court for granting exequatur depends on the type of dispute. The president of the Beirut First Instance Court handles civil and commercial matters, while the president of the Council of State deals with administrative matters.

Foreign awards must be translated into Arabic for enforcement, and the court will verify that recognising the award does not breach Lebanese public policy, as per Article 814 of the Lebanese Code of Civil Procedure. Decisions denying recognition or enforcement can be appealed. However, decisions granting recognition or enforcement can only be appealed within 30 days of notification in specific cases, for example, if: (i) the award was made without a valid arbitration agreement; (ii) it was delivered by arbitrators not appointed according to the law; (iii) it exceeded the mission for which the arbitrator or arbitrators were appointed; (iv) it was delivered without due respect for rights of defence; or (v) it violated international public policy. Appeals can be made to the Court of Cassation, but it will only review legal grounds, not factual ones.

3.3 The Use of Arbitration for Insurance Dispute Resolution

Arbitration in Insurance Dispute Resolutions in Lebanon

Lebanon is known for being arbitration-friendly. Under Article 964 of the Lebanese Code of Obligations and Contracts, arbitration is permitted for disputes arising from insurance contracts, reflecting a positive attitude towards arbitration in this field. Consequently, parties may choose arbitration to resolve insurance disputes, with the exception of specific limitations strictly and

expressly outlined in applicable laws. Therefore, aside from the limitations mentioned in **3.1 Enforcement of Arbitration Provisions in Commercial Contracts**, all other insurance disputes can be resolved through arbitration.

As mentioned, for insurance claims below LBP75 million, and related to medical and hospitalisation insurance, as well as vehicle and traffic accident insurance, disputes are handled by the Insurance Arbitration Council (ICC) within the Ministry of Economy and Trade.

That said, there are no particular areas of insurance that are predominantly resolved through arbitration. However, large-scale insurance contracts are more likely to be settled through arbitration compared to smaller-scale insurance cover.

Applicable Rules and Regulations

Insurance disputes in Lebanon are mostly governed by common law rules and principles under the Lebanese Code of Obligations and Contracts, the Lebanese Code of Civil Procedure, and the provisions of the Law. Unlike public litigation proceedings, these disputes are handled privately and confidentially.

Challenging the Arbitral Awards in Lebanon

In domestic arbitration, awards can be challenged through:

- an ordinary appeal before the Court of Appeal, although this is not available for awards rendered on an ex aequo bono basis unless explicitly reserved in the arbitration agreement;
- a recourse in annulment before the Court of Appeal based on grounds specified in Article 800 of the Lebanese Code of Civil Procedure; or
- a retrial before the Court of Appeal under Article 808 of the above-mentioned code, subject to specific conditions.

For administrative matters, only one level of recourse is available. Objections to decisions denying enforcement can be raised before the judicial section of the Council of State.

In addition to information above applicable to international arbitrations, appeals against decisions granting recognition or enforcement of an international award or recourses in annulment for awards rendered in Lebanon are limited to the grounds specified in Article 817 of the Lebanese Code of Civil Procedure.

4. Coverage Disputes

4.1 Implied Terms

Certain terms are inherently included within insurance contracts, as follows.

- The Duty of Information, which requires the insured party to provide all relevant information to the insurer at the time of entering into the agreement. This allows the insurer to accurately assess the risks involved and to be informed of any changes that may subsequently increase these risks.
- The Duty of Good Faith, which requires honest and complete disclosure by both parties, as mandated by general legal principles governing contracts.

Other implied terms may vary depending on the type of insurance contract and the general legal principles of common civil law, specifically the Code of Obligations and Contracts, which outlines rules regarding both the form and substance of the contract.

4.2 Rights of Insurers

The insurer is not liable for damage or destruction caused intentionally by the insured party, or for damage resulting from the latter's omissions or mistakes, even if such damage would otherwise be covered by the policy (Article 966 of the Lebanese Code of Obligations and Contracts).

Additionally, the insurer is not liable for any damage that was not disclosed at the time of the policy agreement.

4.3 Significant Trends in Policy Coverage Disputes

In Lebanon, recent insurance coverage disputes have centred around several key trends, as follows.

- *War-risk insurance* – Lebanon has been significantly affected by the recent war with Israel and ongoing geopolitical tensions in the region, largely due to its geographic location amid frequent conflicts in neighbouring countries. Since the outbreak of war in September 2024, which particularly impacted southern Lebanon and parts of the Beirut suburbs, insurers have revised Passive War Risk (PWR) coverage under life insurance several times. While southern Lebanon was previously classified as a war zone, this approach shifted and the war-zone classification was expanded following the conflict and in response to evolving regional circumstances. War-risk coverage was excluded from new policies issued in the specified high-risk zones and war-related medical and life coverage was frozen or heavily restricted across multiple portfolios. By November 2024, the insurance sector reintroduced PWR on a limited basis. Under these adjusted terms, existing clients could obtain PWR with a maximum cap of USD50,000, but only outside key exclusion zones, which included the South Lebanon Governorate, Nabatiyeh, Bekaa, Balbek-Hermel, and the Southern Suburbs of Beirut. These exclusions were contractually imposed via signed policy endorsements. After ceasefire, PWR coverage became available to both new and existing policyholders, with an increased cap of USD100,000 by May 2025. However, geographic limitations were still imposed with no coverage within a 10km radius of the southern border (as defined in policy endorsements mentioning over 50 villages/cities). Premium rates increased accordingly: common gross premiums at 1.69/1000 for Death and 3.38/1000 for Death and Disability.
  In late June 2025, Lebanon was classified as an "orange zone", as per the list issued by the Joint War Committee (JWC). This means that premiums slightly eased, but war-risk coverage remains excluded or highly restricted. Although the country is no longer labelled a war zone, a high level of risk is acknowledged. The insurance industry remains highly vigilant, carefully observing the potential escalation of the conflict both regionally and locally.

It is important to emphasise that the scope and enforcement of the aforementioned exclusions remain contractual in nature and reflect insurer discretion, reinsurer constraints and risk assessments. As such, each phase of conflict has directly translated into tailored exclusions, caps, and premium structures.

- *Aviation and war-risk insurance* – the ongoing local and regional conflicts have also affected Lebanese airspace, leading to a heightened aviation risk. As a result, war-risk insurance for both international and local airlines operating in Lebanese airspace has become severely restricted. Following Lebanon's classification as a "red zone" by global reinsurers, foreign carriers suspended operations to and from Beirut due to the withdrawal of war-risk coverage and inability to assume full liability. War-risk premiums for active policies sharply increased, contributing to increased ticket prices, while new policies imposed strict warranties, such as mandatory 24-hour routing notifications and exclusions tied to prior landings in high-risk zones. Middle East Airlines (MEA) nevertheless continued limited operations, under higher war-risk premiums and restrictive policies. This led to surging ticket prices, as insurers imposed high premiums, narrow routing warranties, and advance-notice clauses. Lebanon's airspace remained classified as a red/orange zone, with war-risk insurance limited to endorsement-based coverage amid geopolitical volatility.
- *Climate change and emerging diseases* – there have been negotiations over whether insurance policies should impose restrictions on coverage of damages caused by natural events, such as floods and fires, particularly during relevant seasons. In addition, as climate change also leads to the emergence of new diseases and viruses in Lebanon, insurers are increasingly debating how these evolving risks will affect future insurance cover.
- *Pandemics and epidemics* – following the COVID-19 pandemic, insurance companies are now offering additional cover for pandemics and epidemics at additional costs, to avoid any conflicts in the future.
- *Ambiguity in policy wording* – disputes have also increased due to unclear or ambiguous policy terms. Insurers and policyholders have faced legal battles over the interpretation of policy limits and exclusions, highlighting issues with policy drafting and clarity.

4.4 Resolution of Insurance Coverage Disputes

Disputes are typically resolved through negotiation between the insurer and the insured party, aiming to settle issues amicably without or before proceeding to court, thus avoiding additional costs. This approach applies equally to both insurance and reinsurance contracts.

4.5 Position If Insured Party Is Viewed as a Consumer

The Lebanese legal framework offers several consumer protections for insurance policyholders. The Consumer Protection Law (No 659 of 2005) ensures the provision of high-quality services to consumers. These provisions apply to all contracts between professionals and consumers, provided they do not contradict the legal provisions governing insurance companies.

Moreover, consumers have the right to file complaints before the Consumer Protection Directorate, which is responsible for safeguarding the rights of purchasers of insurance products and services.

Additionally, Article 983 of the Code of Obligations and Contracts describes as null and void: (i) any clause imposing forfeiture penalties on the insured party for violating laws and regulations, unless that violation was an extremely serious; and (ii) any clause imposing forfeiture penalties the insured party for failure to directly inform the authorities of emergencies or to present required documents.

Moreover, owners of motorised vehicles must obtain insurance policies covering third-party liability for bodily injury and material damage. Similarly, employers of foreign workers must obtain insurance policies covering death, disability, and medical expenditures for these workers. The insurance companies are bound by the pricing rate of these insurance policies set by the ICC.

4.6 Third-Party Enforcement of Insurance Contracts

Third parties cannot file a direct claim against an insurer unless they have suffered damage and their policy expressly permits this.

Third parties can pursue an indirect claim against the insurer on behalf of the insured party through a subrogation of rights, provided the legal conditions for subrogation are met and the insured party has not already filed a claim.

4.7 The Concept of Bad Faith

While Lebanese law does not specifically define the concept of “bad faith”, it places great importance on the principle of good faith in negotiating, concluding, and terminating contracts. However, acts of bad faith are certainly penalised in various areas of Lebanese law. For instance, in insurance contracts, if an insured item has been destroyed at the time the insurance contract is concluded, the contract is deemed null and void. Heavy penalties are imposed on the insured party having acted, as such, in bad faith (Article 981 of the Lebanese Code of Obligations and Contracts). Additionally, any false declaration or concealment of information by the insured party, if carried out in bad faith, will also render a contract null and void (Article 982 of the Lebanese Code of Obligations and Contracts).

4.8 Penalties for Late Payment of Claims

If an insurer consistently delays payments or fails to settle claims within a reasonable time limit, the insured party may take legal action. Courts can award damages or impose penalties, in addition to the initially covered amount as stipulated by Article 970 of the Code of Obligations and Contracts.

For example, if an insurer delays payment of a valid claim, they may be required to pay interest on the overdue amount from the time it was due until it is paid, as per Article 265 of the above-mentioned code. Additionally, insurers may be liable for compensating the insured party for any extra costs or losses incurred due to the delay, in accordance with Article 257 of the same code.

Lebanese law also mandates that insurers compensate the insured party for damages if the insurer delays responding to a request or renewing the insurance beyond 15 days of notification, as outlined in Article 984 of the Lebanese Code of Obligations and Contracts.

These penalties are intended to ensure timely fulfilment of obligations by insurers and to protect the rights of policyholders.

4.9 Representations Made by Brokers

In Lebanon, the insured party is typically bound by representations made by their broker, as long as the broker was acting within the scope of their authority. The insured party should carefully review and verify all information provided by the broker to avoid potential issues with the insurance contract.

If a broker makes false representations or omits important information, the insured party might still be bound by these representations. However, if the insured party can prove that the broker acted outside their authority or engaged in fraudulent behaviour, the insured party may have grounds to dispute the validity of the representations.

However, it is worth mentioning that, in Lebanon, there are three types of insurance intermediaries, each serving different roles in the marketplace (Article 38 of the Law).

- *Independent insurance brokers* – these brokers offer technical advice and work on behalf of the insured party, aiming to represent their interests. They can be either individuals or entities authorised by insurers. They are independent from insurance companies and must disclose any direct or material relationships with insurers that could affect their impartiality. Brokers help clients by presenting options form multiple insurers and guiding them to choose the most suitable policy.
- *General insurance agents* – these agents are licensed to conduct business on behalf of insurance companies but are not employed by them. They work independently and can be either individuals or entities authorised by insurers. General agents typically work under an agency agreement that is renewed annually and may represent multiple insurance companies.
- *Insurance delegates* – these are individuals who work exclusively for and under the responsibility of a single insurance company, broker or general agent. They may also work for others in a secondary capacity, provided it does not conflict with their primary role and they have authorisation from their main employer.

Insurance companies will be held responsible, in the civil field, for any errors committed against the public by the independent broker, if it is proved that they either represent an insurance company or operate for its benefit. Likewise, the insurance companies will be held responsible, in the civil field, for any errors committed against the public by its general agent; and any clauses to the contrary in the agency contracts shall be considered as null and void. Insurance companies, as well as the general insurance agent, and the independent insurance broker, if they are juridical persons, shall be held responsible for the errors of their delegates.

4.10 Delegated Underwriting or Claims Handling Authority Arrangements

It is common practice in Lebanon for insurance companies to delegate underwriting or claims handling to other parties or entities, such as brokers, or Third-Party Administration (TPA), or other intermediaries. This is a form of outsourcing which is not restricted within the country.

The relationship between these parties and insurance companies is governed by the scope of authority granted to them, as detailed in **4.9 Representations Made by Brokers**.

5. Claims Against Insureds

5.1 Main Areas of Claims Where Insurers Fund the Defence of Insureds

Professional Liability Insurance primarily protects professionals against legal costs and expenses incurred in their defence if they are alleged to have provided inadequate advice, services, or designs that result in financial loss for their clients. This insurance covers claims related to business or professional practices, including negligence, malpractice, or misrepresentation. The key aspect of this coverage is indemnity for third-party claims.

Additionally, insurance coverage for legal costs in the defence or settlement of claims is available in various

types of insurance policies, either as optional coverage or as a standard feature. This includes, but is not limited to: (i) General Liability Insurance (for risks associated to bodily injury, property damage, and personal injury claims); (ii) Directors and Officers Liability Insurance; (iii) Employment Practices Liability Insurance; and (iv) Product Liability Insurance.

It is important to carefully review policy terms to understand what is covered and what is not, as exclusions for certain types of claims or legal costs might apply, as well as any limits on the coverage amount for legal expenses.

5.2 Likely Changes in the Future

The areas where insurers fund the defence of the insured party may evolve (decrease or increase) based on emerging trends in litigation claims that will appear with time. These changes will be influenced by the key themes outlined in **4.3 Significant Trends in Policy Coverage Disputes**, as well as other future developments affecting the insurance sector in Lebanon.

5.3 Trends in the Cost or Complexity of Litigation

In recent years, the Lebanese economic and financial crisis has led to a rise in insurance claims, influenced by inflation and other market factors.

More complex disputes have emerged regarding coverage for business interruptions and financial losses. Policyholders and insurers have often clashed over claims related to the economic downturn and its impact on business operations. Litigation costs, including those for insurance claims, have also increased, reflecting the adaptation of the Lebanese judicial system to current market rates.

However, the cost and complexity of litigation related to insurance claims may change further based on the significant trends that will affect the insurance sector in the future.

In addition to the above, it is worth mentioning the Beirut Port Explosion on 4 August 2020 that resulted in numerous insurance claims for damages. The complexity of the case and the involvement of various parties indicate that a resolution may be long delayed. Should the explosion be classified as an accident, insurance and reinsurance companies could face significant financial liabilities, potentially leading to a crisis in the insurance sector due to the high volume of claims. On the other hand, if the explosion is classified as an act of war, insured parties will not be covered unless the policy specifically includes coverage for acts of war. This could further destabilise the already unsettled regional politics, adding to the severe crises Lebanon already faces.

5.4 Protection Against Costs Risks

Claimants can protect themselves against the risks of litigation costs by purchasing insurance that covers expenses related to disputes and court settlements – ie, legal defence costs as described in **5.1 Main Areas of Claims Where Insurers Fund the Defence of Insured Parties**.

6. Insurers' Recovery Rights

6.1 Right of Action to Recover Sums From Third Parties

Insurers are entitled to recover amounts from third parties responsible for causing an insured loss.

According to Article 972 of the Lebanese Code of Obligations and Contracts, once an insurer has paid an insurance indemnity, it is subrogated by right to all the rights and claims of the insured party against any third parties involved. This means the insurer can pursue recovery from those third parties who are at fault for the loss. However, the same article imposes a limitation to this right. Specifically, the insurer's right to subrogation is limited to third parties who are not the insured party's children, successors, ascendants, employees, or individuals living in the same household. Additionally, if the subrogation of rights is impossible due to actions or omissions by the insured party, the insurer may have the right to refrain from providing coverage.

6.2 Legal Provisions Setting Out Insurers' Rights to Pursue Third Parties

Please see **6.1 Right of Action to Recover Sums from Third Parties**.

7. Impact of Macroeconomic Factors

7.1 Type and Amount of Litigation

As mentioned, the insurance sector in Lebanon has been significantly affected by various factors, including ongoing financial and economic challenges. This has led to numerous disputes over the settlement of insurance premiums, with insurance companies hit by a significant drop in the amount of insurance being taken out.

The Lebanese insurance sector was also rocked by the Beirut Port Explosion of 4 August 2020, which caused extensive destruction across Beirut, resulting in over 200 deaths, more than 7,000 injuries, and the displacement of 300,000 people. The explosion inflicted damage exceeding USD15 billion, affecting homes, businesses, and essential services.

Insurance and reinsurance companies have faced a surge in claims related to the incident. However, all litigation concerning coverage for damages from the tragedy has been suspended pending the outcome of the investigation into the cause of the explosion – ie, whether it was an accident, an act of war, or of indeterminate cause. This uncertainty complicates the claims process, particularly since insurance policies often exclude coverage for acts of war or similar events. Political and security issues have repeatedly held up the investigation. A definitive determination by the authorities is crucial for resolving these claims and expediting the process.

Additionally, global developments such as new diseases, climate change, and pandemics have compelled insurance companies to reassess and update their policies to address these new emerging risks, which have not been consistent features of the insurance landscape until now.

7.2 Forecast for the Next 12 Months

The insurance sector, like other sectors in Lebanon, has adapted to economic and financial challenges by adjusting premium pricing, and revising policies to address discrepancies and ambiguities.

With greater clarity added to policies, insurance litigations are expected to decrease in the future. However, we believe that certain protective provisions should be mandated in insurance policies, and this will require changes in the applicable laws.

7.3 Coverage Issues and Test Cases

The developments outlined in **4.3 Significant Trends in Policy Coverage Disputes** have urged insurance companies to update their policies to address them more precisely. This includes (i) limiting coverage and imposing exclusions for war zones using different colour categories, (ii) addressing pandemics and epidemics, and (iii) detailing coverage for new or emerging diseases, as well as (iv) risks emerging from unexpected climate changes.

Another area of coverage friction emerged in the life insurance sector due to the collapse of the Lebanese banking system and currency fluctuations in Lebanon which significantly reduced consumers' purchasing power. Insurers consequently reported that new business turnover dropped by almost 50% annually at the height of the crisis. Policyholders downgraded coverage tiers and classes or shifted to more affordable alternatives, such as cooperative and mutual funds. To maintain coverage continuity, insurers introduced premium deferrals options and policyholder loan mechanisms. These measures reflect the industry's efforts to adapt its offerings amid ongoing financial instability.

7.4 Scope of Insurance Cover and Appetite for Risk

Please see **7.3 Coverage Issues and Test Cases**.

8. Emerging Risks

8.1 Impact of ESG on Underwriting and Litigating Insurance Risks

There is no comprehensive global regulatory framework for ESG in Lebanon.

8.2 Data Protection Laws

Lebanon does not have comprehensive data-protection legislation, and there are therefore no specific restrictions or requirements governing the transfer of customer data in this field.

However, with awareness around privacy concerns increasing, particularly in connection with Law No 81 of 10 October 2018 related to electronic transaction and personal data, we cannot rule out the possibility that the competent authority will take action in this regard in the near future.

9. Significant Legislative and Regulatory Developments

9.1 Developments Affecting Insurance Coverage and Insurance Litigation

Amendments to current insurance law have been minimal, with no substantive changes since 1999. While there have revisions applicable to the insurance sector, none have specifically addressed insurance coverage of litigation or claims related to the right of defence. A new draft law for the organisation of the insurance sector was introduced in 2004 and later approved by the Council of Ministers, and still awaits the review and approval of Parliament. We anticipate that the new regulations could introduce significant updates to the legal framework for insurance companies in Lebanon.

MEXICO

Law and Practice

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Contents

De la Garza & Acosta is a leading Mexican law firm with a distinguished track record in high-stakes insurance litigation and complex dispute resolution. The firm represents major domestic and international insurers and reinsurers in contentious matters involving policy coverage disputes, reinsurance claims, civil liability, punitive damages, and non-material damage compensation. Its team combines deep sector knowledge with extensive experience in civil, commercial and constitutional litigation, as well as arbitration and bankruptcy proceedings. Renowned for its strategic approach and technical precision, the firm regularly advises the financial sector on high-profile and precedent-setting cases before Mexican courts and arbitral tribunals.

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DE LA GARZA ACOSTA
ABOGADOS

1. Rules Governing Insurer Disputes

1.1 Statutory and Procedural Regime

In Mexico, the regulation of insurance matters falls under the exclusive competence of the Federal Government. This regulation is primarily established by the Law of Insurance and Bonding Institutions (*Ley de Instituciones de Seguros y de Fianzas*, LISF), and its enforcement is overseen by the National Insurance and Bonding Commission (*Comisión Nacional de Seguros y Fianzas*, CNSF).

As regards the legal framework applicable to the resolution of insurance-related disputes, there are various statutes of relevance. Insurance law is classified under the commercial branch of law, since Article 75 of the Commercial Code (*Código de Comercio*) deems insurance as a commercial act.

Unlike other commercial proceedings where the principle of strict law (*estricto derecho*) prevails, insurance litigation is subject to multiple principles that impose evidentiary and procedural burdens upon the insurer in order to achieve a favourable judicial outcome. This is due to the fact that, in many cases, legislation grants the status of "consumer" to users of this financial service, and because insurance policies and their general conditions – comprising the insurance contract – are generally imposed upon the policyholder and the beneficiary as an adhesion contract. In such contracts, the policyholder is not able to negotiate the inclusion or removal of clauses; their participation is limited to accepting the contractual terms, which, by law, must be registered for publicity purposes before the National Commission for the Protection and Defence of Financial Services Users (*Comisión Nacional para la Protección y Defensa de los Usuarios de Servicios Financieros*, CONDUSEF).

The insurance contract is the only contract in Mexico regulated by a special statute, the Law on the Insurance Contract (*Ley sobre el Contrato de Seguro*, LCS), published in the *Diario Oficial de la Federación* (Official Gazette of the Federation) on 31 August 1935, which has only undergone minor amendments – the most recent being over a decade ago. As a result, much of the legal understanding and dispute resolution in this area relies on jurisprudence, making it essential to know the prevailing interpretations and existing judicial criteria. Disputes between insurers and reinsurers are, as a general rule, resolved through arbitration by agreement between the parties.

Below are the main legal provisions and regulations applicable to insurance matters, along with a brief description of their content.

Law on the Insurance Contract (LCS)

- Governs contractual relations between insurers and insured parties.
- Contains provisions on obligations, nullity, limitation periods, risk declaration, premium payment and claims.

Law of Insurance and Bonding Institutions (LISF)

- The primary statute regulating the organisation, operation and supervision of insurers in Mexico.
- Establishes requirements for authorisation, solvency, corporate governance and investment regime.
- Regulates certain procedural matters of relevance, such as the determination of judicial jurisdiction in insurance matters, the calculation of default interest, and insolvency proceedings of insurance institutions.

Single Insurance and Bonding Circular and its Annexes (Circular Única de Seguros y Fianzas, CUSF)

- Regulates solvency requirements, technical reserves and risk management for insurers and bonding companies, under a risk-based supervisory model.
- Establishes corporate governance and internal control obligations, including the actuarial function, audit and comprehensive risk management.
- Imposes accounting, valuation and regulatory reporting standards, and grants the CNSF powers to supervise and impose corrective measures.
- Although essentially organisational in nature, it may have indirect relevance in judicial disputes as it imposes specific obligations on insurers in respect of customer information, contractual transparency, underwriting policies and claims handling.
- Provides for the supervisory and corrective measures the CNSF may impose, including monitoring mechanisms, intervention and additional require-

ments when operational or financial risks are detected.

Law for the Protection and Defence of Financial Services Users

- Creates a specialised body for the protection of the rights of financial services consumers and may be used as a pre-litigation stage.

Commercial Code

- Governs commercial procedure applicable to insurance disputes, establishing the general rules for the *juicio oral mercantil* (oral commercial trial), the most common forum for disputes relating to compliance with the insurance contract, including evidentiary rules, procedural stages and formalities.
- Contains provisions on the burden of proof and the evidentiary value of documents, relevant for proving the existence and content of the insurance contract, as well as the parties' obligations.
- Provides for precautionary measures and summary proceedings, useful for securing contractual compliance during litigation or for enforcing judgments in insurance disputes.

Federal Code of Civil Procedure and the Local Codes of Civil Procedure of Each Mexican State

(From April 2027, the Federal Code of Civil Procedure and the 32 local codes will be replaced by the National Code of Civil and Family Procedure.)

- Regulates procedural aspects concerning civil actions, relevant when bringing civil liability claims against an insurer under an applicable policy.
- Serves as supplementary procedural law to the Commercial Code where the latter is silent or insufficient.

Navigation and Maritime Commerce Law

- Establishes specific provisions on marine insurance as a specialised form of insurance contract, applicable to vessels, cargo, civil liability and other risks inherent to navigation.
- Defines the requirements and effects of compulsory insurance in maritime operations, including liability insurance for third-party damages, pollution and salvage.
- Imposes an obligation to maintain valid insurance for the navigation and operation of vessels, and sets out the legal consequences of non-compliance.
- Recognises the right of direct action by an affected third party against the insurer in civil liability cases, thereby strengthening victim protection in maritime accidents.
- Complements the LCS with special rules applicable to maritime transport and insurable interests in that sector.

Civil Aviation Law

- Requires compulsory insurance for aircraft, including coverage for passenger, crew, baggage and cargo damage, and liability to third parties on the surface.
- Makes the operation of aircraft in national territory subject to proof of valid insurance as a condition for obtaining and maintaining permits and concessions.
- Complements the LCS with a special regime for aviation insurance, regulating the strict liability of concessionaires and permit holders towards third parties and service users.
- Imposes obligations on concessionaires and permit holders to maintain minimum coverage and to have such coverage verified by the aviation authority.
- In the event of air accidents, policies under this Law may give rise to direct actions against insurers in accordance with applicable civil or commercial legislation.

Amparo Law (Ley de Amparo)

Governs the *Juicio de Amparo* (constitutional relief proceeding), which in most insurance disputes – resolved in oral commercial trials where no ordinary appeal lies – serves as the mechanism to seek modification of judicial resolutions.

1.2 Litigation Process and Rules on Limitation

The Litigation Process

In Mexico, the process for compelling performance of an insurance contract may include an optional pre-litigation stage before the CONDUSEF, available to the insured, the policyholder or the beneficiary. Initiating this procedure has the important effect of interrupting the statute of limitation period and can serve as a

means to avoid litigation if the parties reach a satisfactory settlement. This stage even allows the parties to submit the dispute to CONDUSEF's arbitration.

Once such a procedure is exhausted, if initiated, the judicial claim process commences, generally through the commercial jurisdiction and, exceptionally, through the civil jurisdiction.

The commercial process applies where enforcement of the insurance contract is sought in respect of coverages other than civil liability, for instance payment under policies covering property damage, life or medical expenses.

Under the Mexican Constitution (Article 104, section II), commercial matters may be heard by either local courts or federal courts, since federal laws such as the Commercial Code are involved. The insured may elect to bring proceedings before federal courts or before the local courts of the relevant Mexican state, in the latter case where only private interests are affected.

Article 277, fifth paragraph, of the LISF provides that territorial jurisdiction in insurance disputes is determined at the claimant's discretion, based on the location of any CONDUSEF office (*delegación*) – at least one of which exists in each of Mexico's 32 states. This provision allows many insured parties to litigate in jurisdictions having no substantive connection with the dispute.

Most insurance disputes, being for a determinate amount, must be heard in an oral commercial trial (*juicio oral mercantil*), regulated by the Commercial Code and comprising a written phase followed by an oral phase.

- Written phase: The claim, the defence, and the reply with any defences or counterclaims must be submitted in writing. Evidence must be offered in these pleadings to prove the claim, the defences, or to rebut the opposing party's allegations.
- Preliminary hearing: Once the written phase concludes, the court sets a preliminary hearing at which the procedure is streamlined, and various procedural acts are concentrated to guide the case to its decisive stage. The judge may encourage conciliation or mediation; if successful, the dispute is resolved early. The issues in dispute are identified, agreements are recorded on uncontested matters, and rulings are issued on the admissibility of evidence and any evidentiary agreements. If the case proceeds, the hearing date for the trial is fixed.
- Preparation of evidence: After the preliminary hearing and before the trial hearing, the court arranges the preparation of admitted evidence requiring prior steps – such as summoning witnesses or issuing official letters.
- Trial hearing: The hearing should not be suspended due to unprepared evidence, save for force majeure. Prepared evidence is heard, and each party is given a single opportunity to make final oral submissions (closing arguments).

At the conclusion of the trial hearing, the judge declares the case heard and delivers judgment immediately, stating the factual and legal grounds orally and succinctly, reading only the operative part. A written version is made available to the parties, who may request clarification within the following 60 minutes. In practice, trial hearings are often adjourned to allow the judge time to deliberate, with judgment pronounced at a later continuation hearing.

Judgments in oral commercial trials are not subject to an ordinary appeal. The only recourse available to a party aggrieved by the decision is the constitutional relief proceeding (*Juicio de Amparo*).

In certain cases – where the dispute is not for a determinate amount – the matter is heard in an ordinary commercial trial, which has longer deadlines for pleadings, special rules for adducing evidence, and other procedural distinctions. A key difference is that judgments may be appealed, and the appellate decision may then be challenged through Amparo proceedings.

Where civil liability coverage is claimed against both the direct tortfeasor and the insurer, the dispute must be heard in the civil jurisdiction before the civil courts of the relevant Mexican state. This has been established by the First Chamber of the Supreme Court of Justice of the Nation in binding precedent 1a./J.

127/2022 (11a.), arising from Contradiction of Criteria 100/2022.

The possibility of appealing a civil judgment depends on the Civil Procedure Code applicable in the state concerned, until the National Code of Civil and Family Procedure comes into force nationwide in April 2027.

Rules on Limitation

Article 81 of the LCS sets out special limitation periods for insurance disputes. The general rule is two years for insurance coverage, except for life insurance, where the period is extended to five years.

Notably, the First Chamber of the Supreme Court, in case *Amparo Directo en Revisión*2128/2023, held that where civil liability coverage is claimed in respect of a third party's death, the limitation period is five years, not the two years expressly provided by the LCS. This is grounded in binding precedent 1a./J. 80/2024 (11a.), which has been mandatory for all courts since 6 May 2024.

In Mexico, jurisprudence is a formal source of law and focuses on statutory interpretation. In some cases, courts may act as "negative legislators" by disapplying a statutory provision in a specific case. As with legislation, retroactive application of jurisprudence to the detriment of a person is prohibited.

The limitation period generally runs from the date on which the beneficiary or insured becomes aware of their right under the policy. It may be interrupted by making a formal claim to the insurer or, as mentioned above, by filing a complaint with CONDUSEF.

To interrupt limitation and demonstrate the validity of the action in court, the insured need only prove: (i) the existence of the contract; (ii) timely notice to the insurer of the loss; and (iii) the occurrence of the insured risk. The burden of proof to establish the claim's lack of merit lies with the insurer.

1.3 Alternative Dispute Resolution (ADR)

By express provision of the Commercial Code, judges hearing commercial disputes are under a statutory duty to promote conciliation between the parties.

In recent years, mediation has gained prominence through the creation of specialised centres and the enactment of local laws granting settlement agreements concluded before such centres the same legal effect as a final judgment.

Arbitration, by contrast, is rarely used in insurance disputes. In matters involving disputes between insurers and reinsurers, however, commercial arbitration is the usual route.

The most common ADR method in Mexico for insurance disputes is mediation before CONDUSEF, which offers a specialised forum to encourage settlement between insurers and policyholders.

In January 2024, the General Law on Alternative Dispute Resolution Mechanisms was enacted to further encourage the use of ADR among private parties, with the aim of reducing judicial caseloads and promoting negotiated settlements.

2. Jurisdiction and Choice of Law

2.1 Rules Governing Insurance Disputes

Jurisdiction

The interpretation and application of insurance law falls exclusively to courts competent in commercial matters, whether local or federal.

Jurisdiction or venue clauses are common in insurance contracts and are typically found in the general conditions applicable to each policy. These often mirror the legal rule set out in the last paragraph of Article 277 of the LISF, which provides that claimants may assert their rights before any court with jurisdiction in a location where a CONDUSEF office (*delegación*) is situated – there being at least one in each of Mexico's 32 states.

By express provision of the same article, any agreement contrary to this jurisdictional rule is void.

The applicable rules for resolving insurance disputes depend on the stage of the conflict. In the pre-litigation stage, the dispute may be resolved through

CONDUSEF, in which case the Law for the Protection and Defence of Financial Services Users applies.

Choice of Law

Under the Mexican legal system, the freedom to choose the applicable law in insurance contracts is subject to statutory limitations. Unlike some other jurisdictions, where the governing law may be freely agreed, in Mexico insurance contracts are subject to mandatory provisions.

Insurance contracts entered into in Mexican territory between an authorised insurer and an insured domiciled in Mexico must be governed by the LCS and the LISF. These are public order provisions and cannot be waived by agreement.

Article 19 of the LISF specifically provides that insurance institutions operating in Mexico must conduct their activities in compliance with Mexican law. The CNSF's supervisory powers over the sector reinforce this obligation.

There are limited exceptions in cross-border transactions. For example, if the insured risk is located outside Mexico or the insured is domiciled abroad, the application of foreign law may be permissible. Even then, the choice must not contravene Mexican public order or fundamental legal principles.

Where insurance is contracted with an unauthorised foreign insurer, the LISF imposes strict rules restricting such practice, except in cases expressly allowed – such as certain international maritime or aviation insurance.

Pursuant to Article 24 of the LISF, contracts entered into by unauthorised foreign insurers – even where within a statutory exception – will have no legal effect, without prejudice to the policyholder's or insured's right to recover premiums paid. Additionally, the person or entity involved may incur liability to the policyholder, insured, beneficiary or their lawful successors, and may be subject to applicable criminal or administrative sanctions.

In conclusion, while in rare cases a different governing law may be agreed, the general rule is that insurance contracts must be governed by Mexican law, reflecting its mandatory nature and the aim of protecting policyholders from potential abuse.

2.2 Enforcement of Foreign Judgments

In Mexico, foreign judgments may be enforced both in favour of and against insurers, provided the requirements established in the Commercial Code and, where applicable, in international treaties or bilateral agreements entered into by Mexico are met.

The applicable procedure depends on factors such as:

- whether there is a treaty on reciprocity with the country of origin of the judgment;
- the date on which the foreign proceedings were commenced; and
- the nature of the decision (monetary, declaratory, etc).

Given that such proceedings are relatively uncommon in most Mexican courts and require precise handling, it is advisable to engage legal counsel with expertise in this area.

As a general rule, foreign judgments must undergo a recognition and enforcement procedure (exequatur) before the competent Mexican courts.

For a foreign judgment to be recognised and enforced in Mexico, it must:

- not contravene Mexican public order;
- have been rendered by a competent authority under the rules of private international law;
- have been duly served on the defendant;
- be final and not subject to ordinary appeal;
- be duly legalised or apostilled; and
- be translated into Spanish by a certified court translator, where applicable.

2.3 Unique Features of Litigation Procedure

The Mexican judicial system has features that international insurers should be aware of when involved in local disputes. Proceedings are adversarial in nature. Judges do not have the same active case management role as in some other jurisdictions, but they do

have broad powers to conduct proceedings, control the taking of evidence, and issue precautionary or interim measures.

Furthermore, there is a significant body of binding jurisprudence in insurance matters, imposing procedural and evidentiary burdens on insurers.

Costs Rules and Punitive Damages

Mexico does not apply a general "loser pays" rule. Court costs are governed by the Commercial Code (in commercial trials, as with most insurance disputes) and are subject to judicial discretion.

In principle, costs may be awarded against the losing party if it is proven that they litigated with recklessness (*temeridad*) or bad faith. In practice, costs awards are neither automatic nor reflective of the full legal expenses incurred, and their calculation is usually set by local tariff laws.

There are judicial precedents – such as binding precedent 1a./J. 123/2025 (11a.) – recognising the possibility of awarding punitive damages against insurers who act in bad faith during litigation. In that case, the First Chamber of the Supreme Court of Justice found serious misconduct where an insurer:

- failed to deliver the general conditions of the insurance policy;
- failed to register the adhesion insurance contract entered into with the claimant; and
- subjected the claimant to unnecessary medical examinations to confirm a diagnosis of cervical cancer, causing undue and unjust invasion of her privacy.

This precedent has been binding nationwide since 7 July 2025.

Finally, it is critical to note that in insurance contracts, both general and specific conditions form an essential part of the contract, defining coverage, exclusions, deductibles and other key terms. However, as held in binding precedent 1a./J. 159/2022 (11a.), the mere existence of these conditions is insufficient for them to be enforceable; insurers must fulfil their duty of disclosure and transparency.

To be binding on the insured, the insurer must prove conclusively that these conditions were effectively communicated to the insured.

3. Arbitration and Insurance Disputes

3.1 Enforcement of Arbitration Provisions in Commercial Contracts

In Mexico, arbitration clauses in reinsurance contracts and in insurance contracts between parties with comparable bargaining power – such as agreements between insurers and large corporations – are generally valid and enforceable under the Commercial Code and international treaties on commercial arbitration, such as the 1958 New York Convention.

However, in insurance contracts entered into with individuals or with micro, small and medium-sized enterprises, arbitration is significantly restricted, due to the following factors.

- Insurance contracts are typically contracts of adhesion, unilaterally drafted by insurers and registered with CONDUSEF in accordance with the LCS and the Law for the Protection and Defence of Financial Services Users.
- An arbitration clause cannot be validly imposed unilaterally, nor deemed accepted without an express endorsement and unequivocal consent by both parties after the loss has occurred or the dispute has arisen.
- CONDUSEF may act in a quasi-arbitral capacity at the insured's request and with the insurer's consent, but cannot impose arbitration ex officio or through pre-drafted clauses. In practice, this institutional arbitration is rare, given CONDUSEF's consumer-protection orientation.

Only in exceptional cases, where both parties (insurer and policyholder) expressly agree in writing to submit their dispute to arbitration – either after the loss or through a specific endorsement – will courts decline jurisdiction.

Accordingly, while arbitration is common and viable in reinsurance or heavily negotiated insurance contracts, in most individual or adhesion insurance con-

tracts, arbitration clauses are unenforceable, and the primary dispute resolution mechanism remains the commercial courts, often preceded by CONDUSEF conciliation.

3.2 The New York Convention

Mexico has been a party to the New York Convention on the Recognition and Enforcement of Foreign Arbitral Awards since September 1971. Consequently, Mexican courts recognise and enforce arbitral awards issued in other contracting states, in accordance with the terms and conditions established in the Convention.

The enforcement procedure is regulated in Book Five, Title Four of the Commercial Code, which largely adopts the UNCITRAL Model Law on International Commercial Arbitration.

To request enforcement of a foreign award, the interested party must file a claim before the competent court, complying with the requirements set out in that statute.

Once the application is filed, the court may admit it and order the respondent to present its defence. The respondent may object only on the grounds expressly provided in the New York Convention and the Commercial Code, such as:

- invalidity of the arbitration agreement, lack of proper notice, inability to present a case; or
- contravention of Mexican public policy.

If no valid ground for objection is proven, the award will be recognised and enforced as if it were a final judgment rendered by a Mexican court.

3.3 The Use of Arbitration for Insurance Dispute Resolution

Arbitration is not a common mechanism for resolving insurance disputes in Mexico, especially for policies issued to individuals or small businesses, due to their adhesion-contract nature and regulatory oversight by CONDUSEF. In such cases, the usual mechanism is a commercial court proceeding, often preceded by conciliation before CONDUSEF.

In contrast, arbitration is frequently used for reinsurance contracts, where the parties enjoy greater contractual freedom and bargaining power. In these commercial relationships, it is common to agree on arbitration clauses referring disputes to either international or domestic arbitral institutions, or to ad hoc arbitration.

In Mexico:

- arbitration is private;
- awards are not appealable;
- enforcement is governed by the Commercial Code; and
- an award may only be challenged through a nullity action on the limited grounds set out in Article 1457 of the Commercial Code (eg, non-arbitrability of the dispute, or violation of public policy).

4. Coverage Disputes

4.1 Implied Terms

In Mexico, the LCS incorporates a number of provisions into the insurance contract by operation of law, even if not expressly stated in the policy. Examples include, among others:

- Article 91: valuation of the insured interest; and
- Article 92: proportional indemnity where the sum insured is less than the insured interest.

These implied terms form part of the contract and bind the parties as if expressly agreed.

4.2 Rights of Insurers

Mexican law grants insurers specific rights regarding the presentation of risk prior to entering into the contract, as set out in the LCS. These rights are essential to allow proper assessment of the risk and the decision whether to accept it and on what terms.

The LCS imposes on the proposer the duty to declare in writing all material facts that may influence the assessment of the risk. Omission or misrepresentation entitles the insurer to rescind the contract ipso jure, even if the omission or misrepresentation did not contribute to the occurrence of the loss.

If the insurer decides to rescind, it must do so within 30 calendar days of becoming aware of the omission or misrepresentation, by giving formal notice to the insured or beneficiary.

The LCS also provides that the contract is void if, at inception, the risk has already ceased to exist or the loss has already occurred, unless there is an express agreement on retroactivity. In cases of retroactivity:

- if the insurer knew the risk no longer existed, it cannot demand the premium or expenses; and
- if the policyholder knew, they forfeit the right to a refund of the premium and must reimburse the insurer's expenses.

4.3 Significant Trends in Policy Coverage Disputes

Over the past 12 months, several disputes have arisen concerning the scope of coverage in insurance contracts, which have been addressed in judicial precedents showing a trend toward restrictive interpretation of exclusions, limitations, and liability clauses.

Key developments include the following.

- Validity of exclusions for employees under strict liability policies.
  - (a) The courts have upheld the validity of exclusions relating to employees in strict liability civil policies where such exclusion has a reasonable justification, based on the different nature of the legal relationship between the insured and their personnel.
  - (b) These exclusions are not considered unconstitutional where they meet criteria of rationality and proportionality, as reflected in binding precedent 1a./J. 80/2024 (11a.).
- Commencement of limitation periods for direct actions.
  - (a) The limitation period for victims or beneficiaries to exercise a direct action against an insurer starts when they become aware of both the loss and their right to claim.
  - (b) This has been deemed consistent with the right of access to justice and legal certainty, as recognised in binding precedent 1a./J. 78/2024 (11a.).
- Reaffirmation of the indemnity principle.
  - (a) Where the sum insured is less than the value of the insured interest, the insurer is only obliged to indemnify proportionally, unless agreed otherwise.
  - (b) This aims to prevent unjust enrichment and preserve the economic function of insurance (binding precedent 1a./J. 76/2024 (11a.)).
- Obligations in "insurance for the account of another".
  - (a) The proposer is obliged to disclose all relevant facts they know or ought to know regarding the risk, even if such information comes from the third-party insured or its intermediary.
  - (b) Failure to do so may justify rescission of the contract (binding precedent 1a./J. 79/2024 (11a.)).
- Validity of risk delimitation clauses.
  - (a) Such clauses are valid provided they do not conceal unconstitutional or ambiguous exclusions.
  - (b) They must be clear, comprehensible, and not involve an undue waiver of substantive rights (binding precedents 1a./J. 81/2024 (11a.), 1a./J. 77/2024 (11a.), and 1a./J. 75/2024 (11a.)).

These interpretations strengthen legal certainty, precisely define policy scope, and confirm the balance between insurers' rights and the legitimate interests of insureds and third parties.

4.4 Resolution of Insurance Coverage Disputes

In Mexico, insurance coverage disputes are generally resolved through commercial court proceedings under the Commercial Code, the LCS and other applicable provisions. The most common forum is the oral commercial trial, brought by the insured or beneficiary against the insurer.

Lower-value disputes may be resolved through conciliation before CONDUSEF. However, high-value disputes with significant disagreements over contract performance typically proceed to litigation.

Reinsurance contracts, due to their technical nature and the fact they are negotiated between industry pro-

fessionals, generally include arbitration clauses and alternative dispute resolution mechanisms. Disputes often involve interpretation of follow-the-fortunes clauses, participation arrangements, and duties of utmost good faith in risk administration.

In summary:

- insurance coverage disputes are generally before Mexican commercial courts; and
- reinsurance coverage disputes are predominantly through arbitration, with a more specialised and private approach.

4.5 Position If Insured Party Is Viewed as a Consumer

In practice, there is no clear statutory or jurisprudential distinction between insureds who are consumers and those with an entrepreneurial or sophisticated profile. Courts and authorities – including CONDUSEF – tend to apply consumer protection principles broadly, regardless of the insured's technical expertise or corporate status.

This leads to uniform application of protective principles, such as:

- interpretation of ambiguous terms in favour of the insured;
- nullity of abusive clauses; and
- heightened disclosure duties on the insurer.

Such treatment is applied even in cases involving legal entities with considerable experience in contracting complex insurance (eg, hotels, construction companies, transport fleets).

From a comparative law perspective, Mexico has not adopted a segmented approach distinguishing consumers from sophisticated policyholders, which has prompted doctrinal debate regarding fairness in disputes involving large companies capable of negotiating bespoke cover.

4.6 Third-Party Enforcement of Insurance Contracts

Mexican law expressly recognises certain scenarios in which a third party may sue an insurer directly, even if they are neither the contracting party nor the insured.

A key example is civil liability insurance, which covers indeterminate persons. Article 147 of the LCS grants the third party who suffered damages the right to sue the insurer of the liable party directly.

This right allows the third party to claim indemnity under the policy without first obtaining judgment against the insured or requiring the insured's involvement in the proceedings.

In life, accident or property insurance, designated beneficiaries may also sue the insurer directly to enforce the policy.

Moreover, third parties with an insured interest (eg, pledgees, mortgagees, trustees) may have standing to enforce the contract or participate in proceedings, depending on the policy terms or endorsements.

While the insurance contract is typically bilateral, Mexican law allows certain third parties to exercise rights against the insurer, particularly in liability insurance and policies naming express beneficiaries.

4.7 The Concept of Bad Faith

The concept of bad faith (*mala fe*) is expressly recognised in Mexican insurance law and can have significant legal consequences for both contract validity and insurers' obligations.

- An insurer is not obliged to indemnify if it proves that the loss was caused by fraud or bad faith on the part of the insured, beneficiary or their successors.
- In property insurance, the contract is void if, at inception, the insured item had already perished or was not exposed to the risk; where one party knew this fact in bad faith, they must compensate the other.
- If the sum insured is intentionally set above the real value of the insured object and there is fraud

or bad faith, the other party may seek nullity and damages.

Overall, the law upholds good faith (*buena fe*) as an essential principle in the insurer-insured relationship.

4.8 Penalties for Late Payment of Claims

The LISF imposes economic consequences on insurers failing to pay valid claims within statutory deadlines.

For obligations in Mexican currency, unpaid amounts are converted to Investment Units (*Unidades de Inversión*, UDIs), an inflation-indexed accounting unit published daily by the Bank of Mexico. Late payments attract default interest, capitalised monthly, at a rate equal to 1.25 times the cost of funds for UDI-denominated liabilities of Mexican commercial banks.

For obligations in foreign currency, the LISF requires monthly capitalised default interest, calculated by applying 1.25 times the cost of funds for US dollar-denominated liabilities of Mexican commercial banks.

While the constitutionality of interest capitalisation has been challenged, the Supreme Court has upheld it, considering it a deterrent to insurers' contumacious conduct and a protection for financial services users.

4.9 Representations Made by Brokers

Generally, the insured is not bound by statements made by their insurance agent unless the agent is expressly acting as their representative or attorney-in-fact at the time of contracting.

Only where the agent acts on behalf of and under instructions from the insured will such statements be deemed the insured's own and carry binding legal effect.

Otherwise, the insurer cannot shift liability to the insured for inaccurate statements made by an agent acting as the insurer's intermediary, especially where exclusivity or agency relationships exist.

Under the LCS, when insurance is contracted for the account of another, the proposer must disclose material facts known to them, the third-party insured, or their intermediary. This can, in exceptional cases, extend liability to the insured if the intermediary truly represents their interests.

4.10 Delegated Underwriting or Claims Handling Authority Arrangements

In Mexico, delegated underwriting or claims-handling arrangements are rare and found mainly in the reinsurance sector.

The insurer remains solely liable to the insured, meaning disputes are generally directed against the insurer rather than the delegate, and litigation arising from such arrangements is exceptional.

Article 18 of the LCS expressly provides that even if the insurer reinsures the risks it has underwritten, it remains the only party liable to the insured.

5. Claims Against Insureds

5.1 Main Areas of Claims Where Insurers Fund the Defence of Insureds

In Mexico, insurers commonly assume the legal defence of their insureds under civil liability insurance policies. This type of coverage often includes, as an additional obligation to indemnification, the duty to provide legal defence against third-party claims.

It is common practice for insurers to:

- appoint lawyers directly to represent the insured; or
- reimburse legal costs if this arrangement has been pre-agreed.

The duty of defence may be subject to limits and conditions stated in the policy, including the right of the insurer to take over the defence or to approve the litigation strategy in advance.

5.2 Likely Changes in the Future

No immediate radical changes are anticipated in insurers' defence obligations. The current practice, based on civil liability insurance contracts, has proven effective in protecting both the insured's interests and the rights of third parties.

However, the sustained increase in civil liability claims indicates a likely trend toward:

- greater litigation; and
- more specialised defence schemes.

This trend is reinforced by a January 2022 ruling from the First Chamber of the Supreme Court of Justice of the Nation, allowing injured parties to claim civil liability damages even where they have already been compensated in criminal proceedings.

In this context, insurers are expected to:

- strengthen the quality of legal services provided to insureds; and
- improve selection and supervision of appointed legal professionals.

An inadequate defence could not only result in heavier judgments but also create direct liability for the insurer under the doctrine of culpa in eligendo if such failure causes damage to the insured.

5.3 Trends in the Cost or Complexity of Litigation

In recent years, there has been a steady increase in both the cost and complexity of insurance litigation in Mexico, particularly in civil liability policies.

This has been driven by:

- the growth of a legal market focused on claims against insurers, sometimes in cases lacking strong legal merit;
- favourable jurisprudence strengthening insureds' rights; and
- some courts issuing high-value judgments, particularly for loss of profit (*lucro cesante*) and moral damages (*daño moral*).

Additionally, the allocation of the burden of proof often falls on insurers, requiring them to hire expert witnesses and other specialised court auxiliaries, increasing defence costs.

The widespread marketing of insurance claim services via social media has also contributed to higher litigation rates.

This trend is likely to continue, meaning insurers will face greater financial risk and technical complexity in litigation.

5.4 Protection Against Costs Risks

In Mexico, there are no structured insurance or financial products specifically designed to protect claimants against the risk of being ordered to pay litigation costs – unlike in jurisdictions where after-the-event insurance (ATE) is available.

However, the risk is relatively low because:

- the Mexican procedural system does not automatically impose costs on the losing party;
- costs are generally awarded only where recklessness (*temeridad*), bad faith, or dilatory conduct is proven; and
- even when awarded, cost amounts are typically limited and do not reflect the actual legal fees incurred.

Many claimant lawyers operate on a contingency fee (*cuota litis*) basis, enabling claimants to litigate without upfront legal fees and transferring most of the financial risk to the lawyer.

6. Insurers' Recovery Rights

6.1 Right of Action to Recover Sums From Third Parties

Mexican law recognises insurers' statutory right of legal subrogation, allowing them to bring actions against third parties responsible for damage covered under the policy, once they have indemnified the insured.

This right arises by operation of law upon payment of the claim and places the insurer in the insured's legal position against the third party, up to the amount paid.

If the insured, through fraud or gross negligence, impairs the insurer's subrogation rights, the insurer

may be released from liability to the extent such rights are affected.

This mechanism is especially relevant in property, transport and liability insurance, where a responsible third party exists. It is frequently used in practice, either through litigation or negotiated settlements.

6.2 Legal Provisions Setting Out Insurers' Rights to Pursue Third Parties

The right of action to recover sums from third parties is expressly provided in Article 111 of the LCS, which states: "The insurer paying the indemnity shall be subrogated, up to the amount paid, to all rights and actions against third parties that, by reason of the damage suffered, belong to the insured".

Subrogation operates automatically by law and requires no judicial declaration.

The First Chamber of the Supreme Court reaffirmed this in binding precedent 1a./J. 56/2022 (11a.), in force since August 2022.

The claim is generally brought in the insurer's own name, as the subrogated party, exercising the rights formerly held by the insured.

7. Impact of Macroeconomic Factors

7.1 Type and Amount of Litigation

The COVID-19 pandemic had a significant impact on the type and volume of claims in the insurance sector, particularly in life and major medical expenses insurance. Many insurers faced a considerable increase in coverage requests, some of which escalated into litigation due to:

- claim denials;
- restrictive interpretations of exclusions;
- disputes over pre-existing conditions, and
- use of non-approved medication.

In the post-pandemic period, there has been a marked rise in the importance of civil liability coverage, both for individuals and corporations. This evolution has led to an increase in:

- the number of claims; and
- litigation concerning third-party damage, moral damage, and loss of profit, particularly in sensitive sectors such as healthcare, construction and professional services.

This environment has fostered the growth of specialised law firms handling claims against insurers, often recruiting clients through social media and digital platforms. The result has been not only greater litigation volume but also more technically sophisticated and systematic approaches.

While geopolitical factors, such as the war in Europe, have had more pronounced effects in reinsurance markets and certain specialised lines (eg, maritime or cyber), their direct impact on domestic insurance litigation in Mexico has been limited and indirect, mainly through premium adjustments or product restructuring.

7.2 Forecast for the Next 12 Months

The upward trend in insurance litigation volume is expected to continue over the next year, driven mainly by:

- the ongoing specialisation of law firms focused on claims against insurers;
- the increasing litigiousness of civil liability coverage; and
- the economic climate, which encourages insured parties to demand strict performance of their policies, sometimes misusing "pro-insured" criteria to commit fraud or obtain undue enrichment.

Judicialisation is likely to intensify in disputes over:

- the scope of exclusions;
- quantification of non-pecuniary damages (eg, moral damage); and
- third-party liability.

Regulatory and jurisprudential pressure favouring insureds may also increase, influencing judicial criteria and insurers' approach to claims.

A relevant factor is the 2024 Judicial Reform, under which Mexico's Supreme Court justices, federal judg-

es, and state judges are now elected by public vote. This is expected to produce new judicial criteria in the coming months based on the perspectives of newly elected judges.

While no disruptive changes are anticipated from external geopolitical events, reinsurance market pressures could lead to additional strain in certain lines – particularly health, construction, cyber and professional risks.

7.3 Coverage Issues and Test Cases

Macroeconomic factors have given rise to test cases. Recent disputes have focused on:

- the validity of exclusions for alleged undeclared pre-existing conditions in major medical expenses and life insurance; and
- in civil liability coverage, the quantification of loss of profit and moral damage.

These disputes have produced judicial criteria tending to expand insured protection.

7.4 Scope of Insurance Cover and Appetite for Risk

Insurers have adopted a more conservative approach in certain lines – especially civil liability, health and professional risks – by reviewing exclusions, coverage limits and general conditions.

There is also greater caution in underwriting complex risks, driven by rising litigation and tighter reinsurance market conditions.

Judicial decisions have directly influenced product design. For example, the First Chamber of the Supreme Court, in *Amparo Directo en Revisión* 1324/2021 (binding precedent 1a./J. 122/2022 (11a.)), declared unconstitutional the exclusion of moral damage in compulsory automobile liability insurance. This precedent prompted regulatory and contractual revisions in the sector, particularly regarding the legal limits of exclusions.

8. Emerging Risks

8.1 Impact of ESG on Underwriting and Litigating Insurance Risks

In Mexico, the impact of environmental, social, and governance (ESG) factors on underwriting and litigation of insurance risks is still in its early stages, but is increasing.

In underwriting, some insurers are starting to include sustainability criteria and environmental risk assessment in projects involving industrial, energy or infrastructure activities, especially where there is potential for environmental liability or ecological damage.

In litigation, ESG factors may indirectly influence cases involving corporate civil liability, where standards of diligence related to human rights, environmental protection, and corporate governance are considered. Although there are still no consolidated precedents in Mexico, their influence is expected to grow in the medium term as regulatory standards tighten and investor and institutional pressures increase.

8.2 Data Protection Laws

The Federal Law on the Protection of Personal Data Held by Private Parties directly affects both underwriting and litigation.

In underwriting, insurers must obtain the express consent of the insured to collect and process sensitive personal data, such as health or financial information, ensuring compliance with principles of legality, proportionality and purpose.

In litigation, these obligations extend to the handling of case files, evidence and communications containing personal data, including when sharing information with lawyers, experts or courts. Improper use of data can result in administrative sanctions and civil liability.

Importantly, evidence obtained in violation of these rules can be deemed illegally obtained and excluded, undermining the insurer's defence.

9. Significant Legislative and Regulatory Developments

9.1 Developments Affecting Insurance Coverage and Insurance Litigation

To date, there have been no substantive legislative or regulatory reforms significantly altering the framework applicable to insurance coverage, insurance litigation or defence obligations assumed by insurers. The LCS has remained unchanged since its last amendment on 4 April 2013.

While some legislative initiatives have been proposed to strengthen insured protection and limit certain contractual practices, none have progressed sufficiently to produce binding changes.

Notably, a legislator from the Institutional Revolutionary Party (PRI) has submitted several initiatives – published in the Parliamentary Gazette of the Chamber of Deputies on 12 February 2025 – aimed primarily at limiting increases in major medical expenses insurance premiums.

Trends and Developments

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Ocampo 1890 has been operating in the Mexican market for over 130 years. It is a well-organised office which specialises in insurance and reinsurance law. The department covers the full range of contentious and advisory matters in the sector, from corporate and regulatory matters to litigation, coverage analysis and bonding insurance. As its diligent leader, Aldo Ocampo oversees the firm's offering and is particularly focused on contentious matters.

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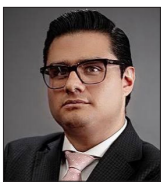

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Introduction

Current understanding of insurance litigation transcends the mere application of commercial or civil procedures. Today, this discipline requires a thorough knowledge of constitutional law and human rights, the application of which is essential in the field of tort law. This co-exists with insurance law, a subject that requires an approach from both a technical and a legal perspective.

It is essential to recognise that the technical approach to insurance law cannot be isolated from other legal areas and its interaction with the rest of the legal system generates considerable pressure on insurance companies. This results in increasingly stringent court rulings and high financial sentences, which seek to benefit victims and policyholders. In essence, the courts appear to be disregarding the technical factors that underpin the viability of the insurance industry globally.

This article aims to give the reader some context on the current trends in insurance litigation in Mexico, offering an in-depth understanding of the reasons behind the current situation.

Current Context

Fourteen years have passed since the groundbreaking constitutional reform that, in a forward-thinking manner, recognised human rights in Mexico's Constitution. This reform not only redefined the interpretation of the Constitution but also encouraged the development of new criteria and interpretative tools of law. It transformed the principles on which classic institutions of the Mexican legal system were understood, such as constitutional defence and supremacy, as well as the hierarchy of norms.

In effect, the reform inaugurated a "new constitutional paradigm" that has permeated all aspects of litigation in Mexico, with a particularly significant impact on insurance law.

Since this constitutional reform, the incorporation of human rights from international sources has been consistently upheld, which considerably broadens the list of rights. These rights are interrelated in terms of harmonisation and co-ordination, relying on the principles of "conforming interpretation" and pro persona. With this vision, Mexico's legal order places the person at the centre; and it is on this criterion that its legal system is based.

The foregoing implies that the Mexican economy must develop around the integral progress of individuals and society in general. This is how the judiciary has been resolving the interpretation of the law, in congruence with what the President of the Supreme Court of Justice of the Nation announced in 2011 as a new era, in which the country's judicial system would begin to generate innovative criteria, which, together with the jurisprudence it dictates in interpretation of the law, will guide the course of justice in Mexico.

A clear example of this evolution is the conclusion of the court itself that, in complex and contemporary societies such as the Mexican one, inequality in the relationships between individuals is undeniable. Various factors may place one of the parties in a position of privilege, which may result in the violation of the human rights of the weaker party. Thus, it has been determined that such violations can be perpetrated by private parties and not exclusively by the state. There are even remedies such as the *amparo* trial, which currently proceeds against acts of private parties, including, for example, the denial of coverage by an insurer. This has unquestionably raised the level of insurance litigation.

It is important to underline that the full application of human rights in 100% of the relationships between private parties is not always feasible, since it is common for a conflict between different human rights to arise. Therefore, it will fall to the adjudicator to identify the constitutionally protected rights and determine whether the violation is attributable solely to the state or whether a private party could be liable for it.

Evolution

Historically, insurance law in Mexico remained virtually unchanged until 2011. With the aforementioned reforms, it has undergone a substantial revolution. Previously, litigation of insurance cases was strictly governed by the rules of commercial contracts and, in general, the burden of proof was on the plaintiff. There were no privileges derived from human rights.

New trends have generated specific risks for insurance companies. For example, the denial of coverage or negligent management of a claim may result in actions against them, demanding compensation for damages, including punitive damages. Thus, insurance litigation now requires that the lawyer representing the insurance institution also be involved in corporate social responsibility.

A recent example of the foregoing is the publication of three jurisprudence theses in the Judicial Weekly of the Federation, which establish assumptions in which insurance companies could be ordered to pay compensation for moral damages and punitive damages, specifically in cases related to major medical expense insurance.

The relevant theses are:

- Thesis: 1a./J. 122/2025 – Digital record: 2030682 – *Daño moral atribuido a las compañías aseguradoras* (can be generated in the event of unjustified breach of an insurance contract in respect of a health condition);
- Thesis: 1a./J. 123/2025 – Digital record: 2030683 – Punitive damages. Proceed in the event of breach of an insurance contract relating to the right to life, integrity or health; and
- Thesis: 1a./J. 79/2025 – Digital record: 2030492 – Breach of an insurance contract. Circumstances in which judgment with a gender perspective must be made.

Although these decisions were issued for a case of major medical expenses, their criteria can be applied to other types of insurance, such as life or liability insurance, for example.

Based on the foregoing, it can be anticipated that, although the insurance contract is in most cases a relationship between private parties and its breach can be analysed through the traditional means of justice, the recent jurisprudential analysis of the Supreme Court of Justice of the Nation has introduced a special protection of human rights for insurers and their agents or representatives.

Specifically, it seeks to establish that moral damages can be presumed under two premises, based on the assumption that the insurer has already concluded from the start that there is no coverage: first, that the performance of additional steps or acts by the insured would not result in the payment of the insured amount; and second, in the case of a health condition, that the requirement of medical examinations and analyses impacts on the most intimate parts of the person.

With this, it seeks to establish proportionality between the information requested and consistency with the insurer's response. Thus, in case of a denial of coverage (which is not illegal), the information requested must be congruent with the reasons for such denial, and even more so when it comes to health-related insurance. If it is shown that the requested information would be useless (because the denial of coverage was previously confirmed for various reasons), there is a presumption of moral damage, and a considerable risk of conviction arises.

The foregoing has led to the analysis of the condemnation of the insurer for punitive damages, if bad faith on the part of the insurer is demonstrated. On the merits of the case, it is shown that bad faith is present when the reason for the denial of coverage is based on a clause or exclusion contained in the general conditions of the insurance policy, and there is no evidence presented at trial that these terms were provided to the insured.

The authors consider this to be relevant, even in the analysis that the judge must carry out when passing sentence, since the lack of reliable delivery of the general conditions of insurance to the insured will not only imply the failure of the exceptions and defences raised, but will also automatically prove the existence of bad faith and, consequently, punitive damages.

Again, this demonstrates a novel and broad protection of human rights. New internal burdens are imposed on insurers, since, even before raising exceptions and defences in court, they must reflect on the viability of these in light of compliance with the regulatory and obligatory framework applicable to them, which will undoubtedly have an impact on the way in which they decide to defend themselves in court.

Finally, and no less importantly, the court ruled on an instance in which it must pass judgment taking gender into account (Thesis: 1a./J. 79/2025), for example, in the analysis of the breach of an insurance contract related to a serious illness that affects the reproductive system of women.

In this regard, the court considered that in this case (*Amparo Directo en Revisión*4306/2020), in the analysis of the breach of an insurance contract related to a health condition that only affects women, the judge must show special sensitivity in resolving the conflict and visualise the situation of inequality in which the woman finds herself.

This duty of the judge becomes more relevant when the condition has a high probability of death; the condition affects the life goal or desire to be a mother; the condition is serious and by itself generates anguish or suffering; and/or the insured is forced to go to trial and is forced to present analyses and medical studies that reveal sensitive information about parts of her body.

It is necessary to emphasise that this analysis will help the judge to determine the level of vulnerability of the insured in the face of the insurer's actions and breaches, and that such analysis that will undoubtedly contribute to the assessment of the moral damages and the need to impose a penalty for punitive damages.

Interpretation of the Insurance Contract

Although the interpretative technique of the insurance contract was proposed, before the constitutional reform, to be contra stipularem, that is, against the interests of the person who drafts it, the introduction of human rights has exacerbated this.

In Mexico, there is no differentiated interpretation in insurance contracts based on their origin; that is, if one was a massive automobile insurance contract and the other was the insurance contract of the only oil producer in the country that is directly placed in the reinsurance market, they would deserve the same interpretative technique. Thus, the jurisprudence issued by the judiciary can become pernicious and completely decontextualise a case.

In the same sense, the Supreme Court of Justice of the Nation has already issued a Judicial Criteria in which it establishes that financial services, such as insurance, also deserve the constitutional protection of users as consumers. Although not well analysed or studied at this point, the result is that the technical merits of the insurance contract can easily be confused.

Burden of Proof

Another of the fundamental changes that has occurred with the development of insurance law in Mexico is that in claims, although the insured has the obligation to prove the occurrence of the loss, the insurer in the legal process has the obligation to prove a series of extremes.

The first thing that the insurer must prove is that it reliably delivered to the insured the insurance contract, including the general conditions and all applicable clauses. The problem lies in that the word "reliably", used by the Supreme Court of Justice of the Nation, encounters certain challenges. The greatest of such challenges is that the term *fehaciente* requires someone who has public faith, and that only notaries public or public brokers have it, which would make the issuance of an insurance policy impossible and infeasible. Thus, insurers have opted for electronic systems that keep record at all times, in addition to conventional means of delivery, such as collecting the signature of the insured.

The foregoing is necessary for the insurer to be able to oppose the exclusions provided for in the insurance contract. If it fails to prove delivery, then there may be the enormous risk that the judge may consider that the insurance contract was subscribed without exclusions.

On the other hand, and within the burden of proof, there is also the obligation of the insurer to prove, in case it has denied the occurrence of the loss, that it occurred under specific circumstances of an exclusion provided for in the insurance contract.

Within the presumption of the right of the insured, the Supreme Court of Justice of the Nation has also created precedents in which it releases the insured from

the obligation to deliver information to the insurer with which the latter may find exclusion to the coverage.

Statute of Limitations

This concept has not been alien to the pro persona interpretation of the law, since in general, the precedents created in this regard seek to protect the insured in the best possible way. For example, in damage insurance, the statute of limitations will begin to run from the time the insurer issues its denial of payment and the insured has knowledge of it, regardless of when the loss occurred. In civil liability insurance, when death is covered, the statute of limitations will be five years and not two, as stipulated in the Insurance Contract Law.

However, the most severe impact has been caused by the criterion created by the Supreme Court of Justice of the Nation by considering that the statute of limitations derived from civil liability insurance begins to run once the victim has knowledge of the right constituted in their favour (the insurance policy), which can make these cases practically imprescriptible.

Conclusion

In light of the above-mentioned discussion, it is evident that the insurance litigation landscape has undergone a profound transformation in Mexico. This evolution is largely due to the constitutional reform of 2011, which has positioned human rights at the centre of the legal system. This has generated a new era in the interpretation of the law by the judiciary, aimed at protecting the individual and ensuring fairness in relationships, even between individuals.

The incorporation of human rights has directly impacted the operation of insurers, imposing new burdens and responsibilities on them. The denial of coverage, especially in cases related to health, is no longer a merely contractual matter, but is analysed under the lens of fundamental rights. This is reflected in case law that allows conviction for moral damages and punitive damages, particularly when bad faith or failure to deliver the general conditions of insurance are demonstrated. The presumption of moral damages and the requirement to judge with a gender perspective in certain cases are clear examples of this new judicial sensitivity.

In addition, the interpretation of insurance contracts has become stricter in favour of the insured, reinforcing the contra stipularem interpretation technique. The equating of users of financial services with consumers also introduces additional complexities in the technical defence of insurers.

The burden of proof has shifted significantly, with the burden now falling on the insurer to demonstrate the reliable delivery of the insurance conditions and the validity of its exclusions. If it fails to do so, the risk of the contract being considered without exclusions is considerable. Also, the statute of limitations for actions has been relaxed to the benefit of the insured, which may lengthen the time periods for claiming.

In short, insurers face a more rigorous legal environment focused on protecting the rights of policyholders. To navigate this new scenario, it is essential that they review and adapt their internal processes, ensuring not only regulatory compliance, but also a thorough consideration of human rights principles at every stage of their operation, especially when assessing the appropriateness of coverage. Diligence in the provision of information, justification of denials and sensitivity to the situation of policyholders will be key to mitigating legal risks in this new paradigm of insurance litigation.

NETHERLANDS

Law and Practice

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Van Doorne NV

Contents

Van Doorne NV has one of the leading and most wide-ranging insurance groups in the Netherlands, with a particular strength in complex and international matters. Chambers has long recognised the firm as a Band 1 insurance firm. Van Doorne's insurance practice forms a key part of its market-leading litigation team. Based in Amsterdam and London, its comprehensive practice covers supervision of the insurance sector, contracts with brokers, coverage disputes, conflicts between insurers (both co-insurance and layering), conflicts between insurers and brokers, acting as monitoring counsel, and acting as defence counsel at the instruction of insurers. Insurance clients benefit from Van Doorne's multidisciplinary approach. The team works closely with highly rated (and equally well-ranked) specialists within the multi-service firm, such as commercial and corporate litigation, white-collar crime and corporate investigations, and restructuring and real estate.

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Van Doorne

1. Rules Governing Insurer Disputes

1.1 Statutory and Procedural Regime

In the Netherlands, no specialised insurance courts exist. Disputes are in principle challenged before the governmental judicial bodies. The (district) civil courts are first in line. Within three months upon receipt of the court's judgment, appeal proceedings can be commenced before the court of appeal. After that instance, the Dutch Supreme Court is the final resort. The Dutch Supreme Court, however, only rules on matters and points of law. Unlike the district courts and the court of appeal, the Dutch Supreme Court will consequently not assess and/or establish the factual merits of the case and will base its exclusively legal judgment on the facts and circumstances presented before the lower courts.

For urgent matters, Dutch law provides for the possibility of initiating summary proceedings enabling swift provisional relief, including payment orders. It is not possible to obtain declaratory relief in summary proceedings: that is against the nature (temporariness and swiftness, also when assessing the merits of the case) of such proceedings.

Dutch is the official language for all types of proceedings before the governmental judicial bodies. It is possible to instruct translators and have them render translation services during the hearing.

Proceedings in the English Language Possible

For international commercial insurance disputes, parties may opt for the Netherlands Commercial Court (NCC) in Amsterdam. The NCC is a special chamber within the Amsterdam district court and the Amsterdam court of appeal. The NCC is the only governmental judicial body in the Netherlands that operates in the English language.

The NCC will have jurisdiction in cases that are international, civil or commercial, that are not subject to exclusive jurisdiction elsewhere, and in which the parties agreed in writing to NCC jurisdiction.

Alternative Dispute Resolution

Disputes can also be resolved via alternative dispute resolution. These will be addressed at **1.3 Alternative Dispute Resolution (ADR)**.

1.2 Litigation Process and Rules on Limitation

Litigation Process

First round of written submissions

Proceedings before the state courts are initiated by claimant(s) by a writ of summons. The writ of summons must be served on the defendants by a bailiff. Defendants then get the opportunity to file their statement of defence.

In this context, it is noted that Dutch procedures are primarily written, with limited scope for oral evidence. It is therefore of great importance to put forward as much written evidence as possible in the written submissions.

Hearing

After the first round of written submissions, the court may permit further briefs but will typically steer the matter towards a hearing. The purpose of the hearing is often for the court to question the parties and their positions, to explore reaching a settlement and/or to address evidentiary issues.

Following the hearing

During the hearing, the court could order witness testimony or expert opinions. This could result in post-hearing briefs in which parties will have to address (evidentiary and/or expert-related) topics raised by the court.

It is also possible that parties, often steered in that direction by the court, decide to explore an out-of-court settlement (with or without a mediator). In such event, after the hearing, the legal proceedings will be put on hold, awaiting the outcome of the settlement negotiations.

However, if the case is ripe for the court to render its judgment, the court will do so. Generally speaking, courts render their judgment in a timeframe ranging from three to six months, but this term could be extended in complex or large cases.

Rules on Limitation

Under Dutch law, legal claims are generally subject to a maximum 20-year limitation period (ultimate "long-stop"), unless otherwise provided (Article 3:306, Dutch Civil Code (DCC). Claims for performance of contractual obligations prescribe five years after the day following the date on which the claim became due and payable (Article 3:307 (1), DCC). In the Netherlands, the limitation period can be interrupted by a written notice to the counterparty (the defendant) in which the claimant reserves its rights to claim and explicitly indicates that the notice letter interrupts the limitation period. Such notice restarts the limitation period.

Insurance claims, however, are subject to a specific regime (Article 7:942, DCC). A claim against the insurer for payment under the policy prescribes three years after the day following that on which the insured became aware that the claim had become due. The limitation period may be interrupted by a written notice asserting the claim, in which case a new three-year period commences on the day after the insurer either acknowledges the claim or expressly rejects it. For liability insurance, the prescription period will be interrupted by any negotiation between the insurer and the insured or the injured party, in which case a new three-year period commences on the day after the insurer either acknowledges the claim or explicitly terminates the negotiations. Contractual derogation from these provisions to the detriment of the policyholder or beneficiary is not permitted (Article 7:943 (2), DCC).

1.3 Alternative Dispute Resolution (ADR)

In the Netherlands, there are three commonly used ADR mechanisms: mediation, arbitration and binding advice.

Arbitration

Arbitration is very common in the Netherlands, including to some extent in the insurance industry (specifically in the maritime, securities and construction sectors). The Dutch Arbitration Act, which is partly based on the UNCITRAL Model Law, provides statutory rules on arbitration but also emphasises party autonomy. See also **3.3 The Use of Arbitration for Insurance Dispute Resolution**.

Mediation

Mediation is increasingly used in the insurance industry as a form of dispute resolution, both in respect of the underlying claim for which the insured seeks cover under the policy and in respect of coverage disputes. It is noted that the importance of mediation was recently (in 2024) confirmed by the Dutch Supreme Court. The Supreme Court held that, under certain circumstances, if parties agreed to first attempt to solve their disputes through mediation, the Dutch court may stay court proceedings if the party that initiated the proceedings did not comply with its obligation to attempt mediation first. Nevertheless, the use of mediation in the Netherlands seems still less common than, for example, in the United Kingdom and the United States.

Binding Opinion

Parties may also opt to submit their dispute to the binding opinion of one or more binding advisers. Under Dutch law, parties opting for such binding opinion proceedings will be bound by the decision rendered via such proceedings (which decision will be laid down in a settlement agreement between the parties). The upside of these proceedings is that there are limited statutory rules, providing great flexibility to the parties involved. The Netherlands Arbitration Institute also offers the possibility of administrating

binding opinion proceedings and has its own set of "Binding Opinion Rules".

Financial Services Complaints Tribunal

Consumers and small businesses may also opt to bring disputes with financial service providers, including banks and insurers, before the Financial Services Complaints Institute. This independent body offers an accessible alternative to the civil courts, handling complaints concerning insurance, credit and investment services. Proceedings before the Financial Services Complaints Institute are conducted in writing, are relatively swift, and are in principle free of charge for consumers; binding decisions can be issued if the financial institution is a member of the Financial Services Complaints Institute and the consumer opts for that route. Although the Financial Services Complaints Institute is not a judicial body, its decisions carry significant weight in practice: affiliated institutions are generally required to comply with its rulings, and Dutch courts frequently take case law of the Financial Services Complaints Institute into account in civil proceedings. As such, the Financial Services Complaints Institute plays an important role in the Dutch financial legal landscape as a specialised and accessible forum for dispute resolution.

Internal Procedures/Processes

Finally, it is noted that many insurers provide the option for internal complaint proceedings, allowing parties to resolve their dispute by the intervention of an internal committee of the insurer. This is particularly significant in low-value disputes, including consumer-related insurance disputes.

2. Jurisdiction and Choice of Law

2.1 Rules Governing Insurance Disputes

European Law

If European Council Regulation EU No 1215/2012 of 12 December 2012 (Brussels I Recast) applies to the dispute, special (mandatory) jurisdiction rules apply in insurance cases that offer (additional) protection to the policyholder, insured and beneficiary (Articles 10–16, Brussels I Recast). Most notably, based on this regulation, the policyholder, insured and beneficiary may sue an insurer before the competent court of their own domicile (Article 11, Brussels I-bis).

National Law

If no EU regulation or treaty applies, the jurisdiction of the Dutch court in international cases must be based on Articles 1–14 of the Dutch Code of Civil Proceedings (DCCP). These provide, as a starting point, that the Dutch court has jurisdiction if the defendant is domiciled or habitually resident in the Netherlands. The international jurisdiction of the Dutch court may also be based on a relevant clause in the parties' contract, ie a choice of law and/or forum provision.

2.2 Enforcement of Foreign Judgments

Judgments of foreign courts are (immediately) enforceable in the Netherlands if they are based on a treaty or an EU Regulation and if, where necessary, leave for enforcement in the Netherlands has been obtained from the Dutch court on the judgment in accordance with the provisions of the treaty or Regulation in question (Article 431 (1), DCCP).

If no treaty or EU Regulation is applicable, the (same) dispute (already challenged before a foreign court) will have to be challenged before the competent Dutch court. There are, however, exceptional cases in which the Dutch Supreme Court held that "re-doing" the case (substantively) before a Dutch court is not required and that it would suffice to request the court to render a judgment similarly to/in accordance with the (outcome of the) foreign judgment.

2.3 Unique Features of Litigation Procedure

Court Cases are Public

In principle, hearings are open to the public, but in certain cases the court may decide that the hearing should take place (partly) behind closed doors (often in criminal proceedings). However, such exceptions are rarely made by the court, certainly not for insurance law disputes.

No Common-Style Discovery

Legal proceedings in the Netherlands do not recognise common law-style discovery. However, specific, targeted disclosure of documents may be ordered on the basis of Article 843a, DCCP if the party has

a legitimate interest in the specific documents being requested.

(Pre-Judgment) Seizure of Insured Sums

In the Netherlands, creditors can obtain conservatory attachment (pre-judgment seizure) relatively easily, often on an ex parte basis. Such attachment may be levied directly on insured sums under an insurance policy by way of third-party garnishment, directed at the insurer. This enables a creditor to secure potential recovery even before judgment, making insurance proceeds a common and effective target for enforcement.

Truth-Seeking is Key

Article 21, DCCP stipulates that parties are obliged to present the facts relevant to the decision completely and truthfully in civil legal proceedings. That also means that if a party is in the possession of documents that go against its position/arguments, it is not allowed to withhold that information. Parties must refrain from presenting their cases in a manner that could mislead the court.

No Rule of Precedent

The Netherlands does not have a rule of precedent in the sense applied in England or the United States. Judicial decisions are not formally binding on other courts; each judge is, in principle, free to decide a case independently. In practice, however, considerable weight is given to rulings of the Dutch Supreme Court, which strongly influence lower courts and play a central role in shaping the development of the law.

Modest Style of Cost Awards for Legal Costs/Fees

Costs follow the "loser pays" rule, though recoverable lawyers' fees are based on modest court-fixed tariffs based on a points system rather than actual costs.

Mass Claims

The Netherlands is also well advanced with the possibility of claiming damages collectively since the Act on the Settlement of Mass Damages Claims in Collective Actions, introduced in 2020. This makes it possible for an association or foundation to stand up for the interests of thousands of individuals and claim damages on their behalf.

Digitisation

The Dutch courts embarked on a digitisation journey. It is now possible to file documents with the courts electronically and to exchange emails with the courts.

There are courts in the Netherlands that are on a pilot scheme for digital litigation in specific matters. It remains to be seen what the results/outcomes of the pilots will report. If the pilots turn out to be successful, the changes will result in all Dutch courts moving onto digital proceedings in more cases.

3. Arbitration and Insurance Disputes

3.1 Enforcement of Arbitration Provisions in Commercial Contracts

Dutch courts will deny jurisdiction if the parties involved concluded a written arbitration agreement and one of the parties invokes the existence of such arbitration agreement. Only in very exceptional circumstances, the court could disregard the reliance on an arbitration agreement if such reliance conflicts with the principle of reasonableness and fairness.

However, such an exception will usually not apply in insurance disputes as insurance disputes are usually simply between the insurer on one hand and the insured on the other hand. They will both have agreed to the applicability of policy conditions that contain a written arbitration agreement. Consequently, both parties will have agreed to arbitration in case of a dispute.

Exception for Parties Who Have Not Signed the Insurance Contract

In specific types of insurance matters, involving third parties or a co-insured party, this could be different as the discussion could arise if all parties involved in the dispute intentionally agreed with the arbitration agreement. It could be argued that the third party/co-insured party were not familiar with the (content of the) policy conditions and therefore neither with the arbitration agreement. In such event, it could be questioned whether agreement on the arbitration clause was reached. Hence, the court could disregard the arbitration agreement and deem itself competent to handle the case.

Exception for Insureds Qualifying as Consumers

Furthermore, although consumer agreements could provide for arbitration agreements, arbitration agreements cannot deprive a consumer of the right to initiate court proceedings via the state court system. Dutch courts will not hold consumers to arbitration agreements.

3.2 The New York Convention

The Netherlands has been a party to the New York Convention since 1964. The Netherlands made the reciprocity reservation, meaning that the Netherlands will only apply the New York Convention to arbitral awards made in other contracting states.

Dutch procedural law provides for the recognition and enforcement of international arbitral awards both under a treaty (such as the New York Convention) and outside a treaty (under Dutch national procedural law). Dutch procedural law contains no national requirements for the enforcement of awards under the New York Convention. Therefore, the Dutch court will directly apply the provisions of the New York Convention, including its grounds for the refusal of recognition and enforcement.

The party requesting the enforcement of an award must file a petition to the court of appeal as the only factual instance handling such requests. The counterparty could then file a statement of defence. After the submission of the statement of defence, the court of appeal generally orders a hearing, followed by its judgment. A final judgment by the court of appeal is subject to cassation appeal before the Dutch Supreme Court.

3.3 The Use of Arbitration for Insurance Dispute Resolution

Arbitration is relatively common in the insurance industry in the Netherlands. Arbitration agreements are most commonly included in policies in relation to CAR/construction-related insurance, D&O insurance, W&I insurance and reinsurance. Confidentiality is an important incentive to opt for arbitration proceedings instead of court proceedings. As third parties not involved in the arbitral proceedings cannot become familiar with the content of arbitral proceedings and (final) awards rendered, the risk of setting an informal precedent is limited (see **2.3 Unique Features of Litigation Procedure** under the heading "No Rule of Precedent").

Dutch Arbitration Act

The statutory rules for arbitration in the Netherlands are laid down in the Dutch Arbitration Act (part of the DCCP). In addition, there are several common Dutch arbitration institutes, each with their own set of additional procedural rules. For example, the Netherlands Arbitration Institute has its own set of arbitration rules (the "NAI Rules") with various provisions such as relating to the procedure, the award, the costs and confidentiality.

Appeal Against an Arbitral Award

Dutch arbitration law provides that an arbitral appeal is available only if the parties have provided for it by agreement. In practice, arbitral appeal is often agreed pursuant to an arbitration agreement to which the parties refer in their arbitration agreement. An arbitral award may be appealed to an arbitral tribunal adjudicating on appeal.

In addition, Dutch arbitration law provides as a mandatory rule that the remedies of annulment and revocation are available against a final or partial arbitral award. These remedies can be used in the ordinary courts. The remedies of annulment and revocation do not suspend enforcement of an arbitral award.

4. Coverage Disputes

4.1 Implied Terms

Dutch law (Book 7, Title 17, DCC) provides for numerous terms that are considered to be part of insurance contracts by operation of law. The DCC explicitly states which provisions cannot be derogated from, and many consumer protection provisions cannot be waived to the detriment of policyholders, beneficiaries or third parties, particularly when the policyholder is a natural person not acting in a professional capacity.

As these terms form an integral part of every policy, they ensure standardised protection and fair dealing in insurance relationships, regardless of what the parties might otherwise agree in their contract. This section

will touch upon some examples. It is noted upfront that Book 7, Title 17, DCC applies to insurance agreements but not to reinsurance agreements. Reinsurance agreements are subject to the general principles of Dutch contract law.

Policy Issuance and Communication

Regarding policy issuance, Article 7:932, DCC stipulates that the insurer must issue a policy document as soon as possible, containing the agreed terms of the contract. All communications required by law or contract must be made in writing, with the insurer able to rely on the last known address of the addressee.

Premium Payment

Regarding premium payment and termination, Article 7:934, DCC provides that non-payment of renewal premiums can only lead to termination or suspension after the debtor has been given notice of the consequences and a 14-day grace period following demand.

Termination of Policy

Furthermore, specific termination procedures are mandated in Article 7:940, DCC, including two-month notice periods for termination at the end of insurance periods, and rights to terminate long-term contracts after five years.

Mitigation Costs

Mitigation costs and reasonable costs to assess the loss are for the account of the insurer pursuant to Article 7:959, DCC.

Interpretation of Insurance Agreements

When interpreting contractual provisions governed by Dutch law, the *Haviltex* decision of the Dutch Supreme Court is the standard: "The interpretation of a contract does not depend solely on the literal wording, but also on what the parties could reasonably expect from each other in the circumstances and the meaning they could reasonably attribute to the terms."

This means that, unlike common law jurisdictions where a more literal approach often prevails, Dutch courts will also take into account the context of the agreement, including:

- pre-contractual negotiations;
- the relationship between the parties;
- the practical execution of the agreement; and
- conduct before and after the contract was entered into.

This *Haviltex* standard also applies to insurance contracts. However, the Supreme Court also emphasised that a more objective approach is in place in respect of insurance contracts that were not individually negotiated. Interpretation should then focus primarily on the wording of the clause, read in the context of the policy as a whole and any explanatory documents, rather than on the subjective intentions of the parties.

4.2 Rights of Insurers

Under Dutch insurance law, insurers have significant rights regarding the presentation of risk before a policy comes into effect.

Right to Full Disclosure

Pursuant to Article 7:928, DCC, the policyholder is obligated before concluding an insurance agreement to disclose to the insurer all facts that he knows or ought to know, and of which, as he knows or ought to understand, the insurer's decision whether, and, if so, on what conditions, it will want to conclude the insurance depends or may depend. This disclosure obligation extends beyond the policyholder in certain circumstances if the interests of a known third party are also covered when entering into the insurance. In such event, the obligation includes facts concerning this third party that he knows or ought to know, and of which, as he knows or ought to understand, the insurer's decision depends or may depend.

If the insurance agreement is concluded on the basis of a questionnaire drawn up by the insurer, the insurer cannot invoke that questions were not answered, or that facts not asked about were not disclosed, nor that a question phrased in general terms was incompletely answered, unless there was intent to mislead the insurer.

Limitations on the disclosure obligation

However, certain limitations to protect policyholders apply. The disclosure obligation does not concern facts that the insurer already knows or ought to know,

nor facts that would not have led to a decision more unfavourable to the policyholder. The policyholder or the third party cannot invoke that the insurer already knows or ought to know certain facts if an incorrect or incomplete answer has been given to a question directed at this.

Also, the policyholder is only obligated to disclose facts about his criminal past or that of third parties, insofar as they occurred within the eight years preceding the conclusion of the insurance and insofar as the insurer has expressly asked a question about that past in unambiguous terms.

The disclosure obligation furthermore does not concern facts about which, pursuant to Articles 3 to 6 of the Medical Examinations Act, no medical examination may be conducted.

Insurer's Rights Upon Discovery of Non-Disclosure

When an insurer discovers that the disclosure obligation has not been met, it has specific rights and procedures to follow.

Time limits for action

First, the insurer who discovers that the disclosure obligation has not been fulfilled can only invoke the consequences thereof if it points out the non-compliance to the policyholder within two months after discovery, mentioning the possible consequences (Article 7:929, DCC).

Subsequently, the insurer can further conduct its investigations to establish what it would have done if it were privy to the withheld information prior to the inception of the policy. Remedies that the insurers could invoke are, for instance (Article 7:930, DCC):

- termination of the policy with immediate effect, but only if the policyholder acted with intent to mislead the insurer or if the insurer would not have concluded insurance if the insurer had known the true state of affairs;
- demand a higher premium if the insurer would have done so knowing the true state of affairs before the inception of the policy; and
- refuse to cover the claim of insurance if the insurer would have included a policy exclusion for that matter had it known the true state of affairs.

4.3 Significant Trends in Policy Coverage Disputes

Coverage Dispute Resolution

The Dutch insurance litigation landscape has experienced substantial evolution in coverage dispute resolution throughout 2024, with particular emphasis on liability, cybersecurity, and directors' and officers' (D&O) insurance matters. Judicial authorities and regulatory bodies have demonstrated an increased commitment to the principles of reasonableness and fairness, policy transparency and procedural diligence in their adjudicative processes.

Supreme Court Ruling on Policy Interpretation

In a precedential decision rendered in February 2024, the Dutch Supreme Court established that insurance providers may no longer invoke rigid categorisation of policy provisions (including warranties and coverage definitions) as grounds for claim denial. The Court determined that all policy conditions are subject to review under the overarching principle of reasonableness and fairness, as codified in Article 6:248 (2), DCC. Where a breach of policy terms has not materially contributed to the occurrence or magnitude of the insured loss, the denial of coverage may constitute an unreasonable exercise of contractual rights – except in circumstances involving intentional breach. This judicial pronouncement significantly constrains insurers' capacity to rely upon technical non-compliance in situations where the underlying insured risk has not materially increased.

4.4 Resolution of Insurance Coverage Disputes

Within the Netherlands, insurance coverage disputes are primarily adjudicated through the civil court system (reference is made to **1. Rules Governing Insurer Disputes**).

State Court System is Predominant

Litigation is the predominant mechanism for dispute resolution concerning coverage, including the scope/applicability of policy exclusions, notification delays and breaches of disclosure obligations. The judiciary

applies the general principles of Dutch contract law, with particular adherence to the doctrines of good faith and the principle of reasonableness and fairness as enshrined in Article 6:248, DCC.

Increase in ADR

Alternative dispute resolution methodologies, particularly arbitration and mediation, are experiencing increased adoption, especially in matters involving continuing commercial relationships or circumstances requiring reputational sensitivity.

4.5 Position If Insured Party Is Viewed as a Consumer

Enhanced Legal Protections for Consumer Policyholders

Where the insured party qualifies as a consumer under Dutch law and in case law, the legal framework differs substantially in several material respects. Dutch judicial authorities apply enhanced standards of protection to consumers in insurance coverage disputes, founded upon both domestic legislation and European Union consumer protection directives.

Statutory Framework for Consumer Contract Terms

The Dutch Civil Code stipulates that provisions within standard-form consumer contracts may be declared void if deemed unreasonably burdensome (Article 6:233 (a), DCC). Within insurance contexts, such judicial scrutiny is typically applied to exclusions, coverage limitations and procedural requirements (including notification periods) that have not been subject to individual negotiation. In circumstances where contractual language is ambiguous, the contra proferentem principle applies, mandating that any interpretative uncertainty must be resolved in favour of the consumer.

Pre-Contractual Information Obligations

Furthermore, insurance providers are subject to statutory obligations to furnish clear, comprehensible and timely pre-contractual information. Failure to discharge these duties may result in judicial findings of consumer deception or inadequate disclosure, with consequential implications for the enforceability of contractual provisions. Courts may additionally reduce or eliminate the consequences of alleged non-disclosure where the insurer has failed to conduct adequate investigation or provide appropriate guidance during the policy inception phase.

Treatment of Small Commercial Entities

Within commercial contexts, the distinction between consumer and non-consumer classifications has become increasingly nuanced, particularly regarding small entrepreneurs or sole proprietors who acquire standard insurance products. Dutch courts have acknowledged that such parties may lack specialised insurance expertise and may warrant analogous protective measures. This judicial approach has been endorsed by the Dutch Authority for the Financial Markets, which has encouraged insurers to extend similar transparency and fairness obligations to micro-enterprises as those afforded to consumers.

Commercial Policyholder Treatment

Conversely, where the policyholder constitutes a professional entity or commercial insured with individually negotiated contractual terms, courts demonstrate greater inclination to enforce agreements as drafted, particularly in reinsurance arrangements or bespoke commercial policies.

4.6 Third-Party Enforcement of Insurance Contracts

Under Dutch insurance law, third parties can only enforce an insurance contract on specific – limited – statutory grounds.

Liability Insurances

The most significant third-party enforcement right exists in liability insurance in case of death or personal injury. When a liability insurance claim has been reported to the insurer under Article 7:941, DCC, an injured party can demand that if the insurer owes a benefit, the amount that the insured would be entitled to claim from the insurer regarding the injured party's damage from death or personal injury be paid directly to them. The injured party can demand this direct payment without prior notification if the insured was a legal entity that has ceased to exist and the obligation to compensate the injured party's damage has not transferred to another party.

Fixed-Sum Insurances

Furthermore, in fixed-sum insurance (particularly life insurance), third parties can acquire direct rights as beneficiaries. A beneficiary third party acquires their right to benefits by accepting their designation, which can only be done through a declaration directed to the insurer. Once accepted, the designation of a third party as beneficiary cannot be revoked if that third party has accepted it.

These third-party rights are strongly protected by law. The provisions regarding direct action rights in liability insurance cannot be derogated from to the detriment of the injured party, and the provisions regarding beneficiary designations cannot be derogated from to the detriment of the third party.

4.7 The Concept of Bad Faith

Absence of Standalone Bad Faith Doctrine

Dutch jurisprudence does not recognise bad faith as an autonomous legal doctrine in the manner characteristic of common law jurisdictions, notably the United States and the United Kingdom. Nevertheless, a comparable and, in certain respects, more expansive concept exists within the civil law framework through the principle of reasonableness and fairness, as codified in Articles 6:2 and 6:248, DCC. These provisions establish mandatory obligations upon contracting parties – including insurance providers and policyholders – to conduct themselves reasonably and equitably towards one another throughout both the formation and performance phases of contractual relationships.

The principle of reasonableness and fairness can also dictate remedies outside the specifications contained in the contract and the court may elect to fashion remedies in order to satisfy an overriding need for fairness (Article 6:248, DCC). Within the insurance context, this principle may be invoked to mitigate the application of stringent contractual provisions or to preclude a party from exercising contractual rights in a manner deemed socially unacceptable under prevailing normative standards. It is stressed, however, that Dutch courts exercise great prudence in this regard.

Remedial Framework and Regulatory Oversight

Dutch law does not provide for punitive damages or tort-based claims for bad faith denial as recognised in certain other jurisdictions. However, regulatory authorities, including the Dutch Authority for the Financial Markets and the Dutch Central Bank, maintain expectations that insurers treat policyholders – particularly consumers and small enterprises – with fairness, transparency and expedition, and may intervene where systematic unfair treatment is identified.

4.8 Penalties for Late Payment of Claims

Statutory Framework for Late Payment Liability

Under Dutch case law, insurers are not subject to punitive penalties for delayed claim payment in the common law sense; however, they face statutory exposure to interest obligations and compensatory damages where they fail to discharge payment obligations when due (Article 6:74, DCC).

Interest Liability Upon Default

Where an insurer fails to perform its payment obligation following default, it incurs liability for statutory interest. The interest rate prescribed under Article 6:119, DCC applies to consumer claims, whilst Article 6:119a, DCC prescribes an enhanced commercial rate applicable to business claims. Default typically commences upon the claim becoming due and payable, which may necessitate formal notice of default, unless the insurer's non-performance is otherwise manifestly unjustified.

Additional Damages for Consequential Loss

Beyond interest obligations, Article 6:74, DCC provides that insurers may incur liability for additional damages resulting from payment delay, provided such damage is foreseeable and attributable to the insurer's conduct. For instance, financial losses sustained by the insured party due to inability to discharge obligations whilst awaiting indemnification may constitute recoverable damages. Case law demonstrates judicial willingness to award statutory interest and, where circumstances warrant, additional damages in cases of unreasonable delay.

Regulatory Supervision and Enforcement

The Dutch Authority for the Financial Markets and the Dutch Central Bank have identified expeditious claims handling as a supervisory priority, particularly in matters involving consumer policyholders. Although regulatory enforcement specifically targeting late payment

remains infrequent, systematic delays may attract supervisory scrutiny under conduct-of-business regulations.

4.9 Representations Made by Brokers

Under Dutch law, an insurance broker is regarded as the representative of the insured, and statements or omissions by the broker in the course of placing or administering insurance are attributed to the insured. The insurer may therefore rely on the broker's representations as if made by the insured, including in relation to the statutory duty of disclosure. Errors or omissions by the broker are at the insured's risk vis-à-vis the insurer, though the insured may have recourse against the broker in a separate professional liability claim.

However, if the broker acts manifestly outside its authority, and the insurer knew or should have known this, the insured could legally argue that the insurer could not legitimately rely on the representations made by the broker.

4.10 Delegated Underwriting or Claims Handling Authority Arrangements

In the Netherlands, delegated authority arrangements – such as underwriting and claims-handling mandates are not common. Any arrangements and/or mandates usually either exist for very specific lines (such as marine) or are agreed upon on a case-by-case basis when multiple insurers are involved in the handling of the same (usually large) claim.

By contrast, experience has shown that such mandates and/or arrangements in the Dutch market seem less pervasive than those on the Lloyd's London market, where cover holders and managing agents often exercise broad binding authority on behalf of syndicates.

5. Claims Against Insureds

5.1 Main Areas of Claims Where Insurers Fund the Defence of Insureds

Insurers fund the defence of insureds in most if not all third-party liability insurances, such as professional liability, directors' liability, securities claims and general liability (subject to policy conditions). By funding the defence, insurers serve their interest in mitigating the insured risk. Insureds may also argue that defence costs qualify as mitigation costs which the insurer is statutorily obliged to pay for under Dutch law. It will depend on the policy's terms and conditions whether the defence costs are included in the insured amount or are covered in excess thereof. Policies may also extend cover for costs of (legal) assistance, which strictly speaking do not mitigate the insured risk of being held liable but address other related needs of the insured such as public relations. Often such extensions are subject to a sublimit.

In practice, the wish of insurers to be involved with the defence of a claim – as regards the choice of defence counsel, defence strategy and any settlement discussions in particular – does not always align with the insured's wish to deal with the problem it is confronted with autonomously. Particular instances include cases that can be devastating for the insured's reputation (which is not an insured risk in general) and/or when faced with a liability claim far in excess of the insured amount.

5.2 Likely Changes in the Future

A development relevant to both insured and insurers is the possibility in the Netherlands of starting class actions and/or pursuing class action settlements rather similar to the United States system. This development facilitates mass claims against insureds. These claims can relate to any and all kind of damages (both property and personal injury as financial loss) and can also concern public interest litigation. Litigation funders are meanwhile very familiar with the possibility of pursuing mass claims under Dutch law.

5.3 Trends in the Cost or Complexity of Litigation

Although cost orders are at the court's discretion, courts most frequently order the losing party to pay the other parties' costs. These costs are relatively low, as these cost orders do not reflect the actual lawyers' fees incurred but only a fixed amount based on a so-called liquidation rate.

Lawyers' rates are traditionally based on an hourly rate. Specific fee agreements can be agreed upon but

not for the entire amount of the fee. Results-based compensation is in principle not allowed in most cases.

Litigation funding is permitted under certain conditions. As regards third-party funding of mass claims, the law aims to protect claimants against "entrepreneurial lawyering", eg, by requiring that the claimant organisation should be in charge of the claim (and not the litigation funder). The contractual arrangements as regards the financial reward of litigation funders are part of the court's considerations when determining whether the interests of the members of the class are sufficiently guaranteed by the plaintiff organisation. For example, this will not be the case if the courts consider the litigation funders' reward to be excessive and/or insufficiently transparent. These considerations are part of a broader assessment by the court as regards the admissibility of a mass claim, which aims to protect the members of the class against possible abuse and/or unprofessional conduct by claimant organisations. As a consequence, it is very difficult to actually get to the stage that mass claims are debated on their merits; claim organisations are trying to convince the legislator to change the law in this respect.

5.4 Protection Against Costs Risks

As noted above, the costs risks in connection with litigation are relatively limited for claimants in the Netherlands. As a consequence, there is not a real need to buy protection against these risks in the form of legal expenses insurance for companies and claimant organisations. Legal aid insurance is rather common for consumers.

6. Insurers' Recovery Rights

6.1 Right of Action to Recover Sums From Third Parties

Dutch insurance law provides insurers with specific rights of subrogation to recover sums from third parties who cause insured losses, but this applies only to indemnity insurance (not fixed-sum insurances) and is subject to important limitations. More specifically, to the extent that the insurer compensates damage, the rights that the insured has against third parties regarding that damage pass to the insurer by operation of law. This automatic transfer of rights occurs upon payment of the claim and gives the insurer direct recourse against liable third parties.

The subrogation right is comprehensive but has key restrictions. The insurer cannot exercise the transferred rights to the detriment of the insured. This protective provision ensures that the insured's position is not prejudiced by the insurer's recovery actions. Also, the insurer gets no claim against the policyholder, a co-insured, the spouse or registered partner of an insured who is "not separated from bed and board" from the insured (meaning: is not (factually or legally) divorced or in a divorce), the other life partner of an insured, nor against blood relatives in the direct line of an insured, an employee or the employer of the insured, or someone who is employed by the same employer as the insured.

6.2 Legal Provisions Setting Out Insurers' Rights to Pursue Third Parties

The subrogation right is specifically set out in Article 7:962, DCC. The first paragraph, states: "If the insured has claims for damages against third parties in respect of damage suffered by him other than from insurance, those claims pass to the insurer by way of subrogation insofar as the insurer compensates that damage, whether obliged to do so or not."

The law makes clear that claims are brought in the name of the insurer, not the insured. This follows from the legal mechanism of subrogation, where the rights "pass to the insurer by way of subrogation". Once subrogation occurs, the insurer "steps into the shoes of" the insured and acquires the right to pursue third parties directly.

This article cannot be derogated from, ensuring that these protective provisions cannot be contractually excluded.

7. Impact of Macroeconomic Factors

7.1 Type and Amount of Litigation

The financial distress caused by various macroeconomic factors such as the COVID-19 pandemic and uncertainties caused by growing international ten-

sions, supply chain problems, scarcity of raw materials, lack of grid connections and a lack of personnel also translates into litigation, such as among (former) business partners and shareholders both in civil courts and in inquiry proceedings before the so-called Enterprise Chamber, by trustees in bankruptcy against D&Os, by companies against governmental agencies, in securities claims and in post-M&A litigation. Climate litigation and PFAS-related claims are on the increase. Ground-breaking victories of public interest organisations in claims against the Dutch state (Urgenda) and Shell also inspire more and more organisations to use litigation as a means to force the government and/or companies to effect a legal or policy change.

As regards insurance-related litigation, macroeconomic factors such as sanctions and terrorist or war-related cyber-attacks trigger coverage disputes.

7.2 Forecast for the Next 12 Months

The aforementioned developments are expected to continue in the coming 12 months and possibly increase, with a view to the political crises and increasing distrust towards governments in many countries and increasing international tensions leading to (trade) wars. Also, AI will probably lead to cases which concern both liability issues and coverage disputes.

7.3 Coverage Issues and Test Cases

The aforementioned factors have not led to specific test cases (absent a rule of precedent under Dutch law, test cases are in general not a common feature in the Dutch legal system), although the impact of the judgments in the climate litigation is significant. Sanctions are expected to remain a topic of coverage debates. In addition, the increased use of IT and the impact of the new EU product liability directive might lead to coverage debates about the meaning of property damage and software qualifying as property.

7.4 Scope of Insurance Cover and Appetite for Risk

Whether the above-mentioned factors have affected the scope of insurance cover available or changed appetites for risk is a difficult question to answer in general. Without uncertainty and risk there would be no insurance that offers commercial opportunities for insurers, but, at the same time, there are many (macroeconomic) developments at the moment which make it difficult to adequately "price" a risk and to protect insurers against cumulation of risks.

8. Emerging Risks

8.1 Impact of ESG on Underwriting and Litigating Insurance Risks

Public reports indicate that insurers in the Netherlands increasingly integrate ESG developments in their business strategies. For example, insurers increasingly take into account climate-related risks and the increasing ESG-related regulatory framework (such as CSRD and SFRD). Insurers also increasingly review and assess corporate governance structures and ESG-related disclosures to assess long-term risk exposures. This is further confirmed by various ESG-related initiatives in the Dutch insurance industry, including initiatives driven by the Dutch Trade Association of Insurers (such as developing ESG reporting standards for the insurance sector).

In addition, the Netherlands has an increasing class action landscape, most significantly since the Dutch Act on the Settlement of Mass Damages Claims in Collective Actions entered into force in 2020. This Act is increasingly used by claim vehicles and NGOs to hold (insured) companies liable for ESG-related failures.

There is also an increasing amount of (class action) litigation around environmental damages against large industry companies. Also because of this development, insurers increasingly use ESG-related exclusions, such as an environmental damage exclusion.

8.2 Data Protection Laws

As for the underwriting and litigating of insurance risks practice, for each (re)insurer/underwriter it is important to assess the risks of a portfolio, and more specifically from a GDPR perspective to what extent personal data must and may be provided. If personal data is provided, it should be assessed under what conditions this is permitted in line with the GDPR, including what the applicable legal ground is. This is not only relevant in the litigation phase, but also during the pre-judicial phase. The Dutch Supreme Court ruled

in 2023 on the sharing of patient medical data during the pre-proceeding phase in relation to a claim against an insured by a claimant alleging personal injury. According to the Dutch Supreme Court, the insured should ask for the claimant's consent for sharing the claimant's health data with a third party, such as an insurance company, in the extrajudicial phase of a liability claim. Such consent should in any case be sought if the medical professional confidentiality duty applies to the insured, but it may be recommendable to always apply the consent requirement in the extrajudicial phase, when the claimant's health data will be processed.

9. Significant Legislative and Regulatory Developments

9.1 Developments Affecting Insurance Coverage and Insurance Litigation

It follows from the above that legislative developments in relation to ESG, AI, cybersecurity, privacy legislation and product liability are expected to trigger litigation and increase the need for insurance coverage. The envisaged reform of the Dutch pension system also causes a lot of tension and might lead to litigation.

Besides, the possibility for class actions for monetary relief attracts the interest of (foreign) litigation funders and public interest litigation is on the rise.

Regulatory authorities are under increasing pressure from the public to prosecute or investigate publicly debated issues – eg in relation to climate goals, "excessive" bonuses granted to the C-suite and #MeToo allegations.

Reference is made to the Trends and Developments chapter of this guide for more detail.

Trends and Developments

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Van Doorne N.V. has one of the leading and most wide-ranging insurance groups in the Netherlands, with a particular strength in complex and international matters. Chambers has long recognised the firm as a Band 1 insurance firm. Van Doorne's insurance practice forms a key part of its market-leading litigation team. Based in Amsterdam and London, its comprehensive practice covers supervision of the insurance sector, contracts with brokers, coverage disputes, conflicts between insurers (both co-insurance and layering), conflicts between insurers and brokers, acting as monitoring counsel, and acting as defence counsel at the instruction of insurers. Insurance clients benefit from Van Doorne's multidisciplinary approach. The team works closely with highly rated (and equally well-ranked) specialists within the multi-service firm, such as commercial and corporate litigation, white-collar crime and corporate investigations, and restructuring and real estate.

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W&I Insurance Policies

The warranty and indemnity (W&I) insurance market has experienced significant growth and evolution in recent years, with the product becoming increasingly mainstream in M&A transactions. What was once considered a niche insurance product has become standard practice, with the majority of M&A deals today being covered by buyer-side policies. This market expansion has been driven by the fact that W&I insurance provides a less adversarial solution to warranty breaches compared to traditional seller warranties, thereby enabling smoother deal execution and better risk allocation.

It has been observed that the Dutch market is maturing. Underwriters and insurers are developing sophisticated underwriting capabilities and expanding their appetite across various deal types and sectors. Financial statement breaches remain the most common type of claim, followed by breaches relating to information, tax and material contracts, which demonstrates the product's effectiveness in covering key buyer concerns in M&A transactions. The increasing prevalence of W&I insurance has recently been accompanied by important judgments by the District Court of Amsterdam that provide greater market clarity.

The W&I market is well positioned to play a crucial role in the anticipated growth in M&A activity, with insurers continuing to provide substantial coverage while maintaining competitive terms.

Mass Claims

The Netherlands is well advanced in the area of collective actions, including class actions for monetary relief. This has attracted the interest of litigation funders and public interest organisations. Collective actions can relate to personal injury, property damage and/or financial loss. Examples of current collective actions are:

- a privacy claim against Oracle and Salesforce;
- farmers claiming drought damage as a result of water extraction by Dutch drinking water companies;
- securities claims from (institutional) investors against Philips in connection with alleged non-disclosures in respect of certain of its respiratory devices;
- climate litigation by Friends of the Earth Netherlands against Dutch financial institution ING; and
- claims relating to "Dieselgate".

Often, such proceedings are started with a view to the possibility of having a settlement agreement declared binding by the Amsterdam Court of Appeal. In such case the settlement agreement also applies to class members who were not involved with the conclusion of the settlement, unless they opt-out. This has been possible since July 2005 when the Class Action Financial Settlement Act came into operation in the Netherlands.

In practice, the combination of judicial pronouncements that clarify uncertainties as a result of a collective action and the possibility of entering into a class action settlement contribute to a willingness to enter into settlement negotiations. A well-known example is the settlement that has been reached between (the legal successor of) Fortis, its directors and supervisory directors and shareholders in June 2018.

Since 1 January 2020, the Act on the Settlement of Mass Damages Claims in Collective Actions has made it possible to start collective proceedings to also claim monetary relief. Collective actions can, since that date, be brought before all courts and must be listed in a central register. Collective actions addressing the same facts and events will be treated as one claim. If (almost) at the same time competing collective actions are brought before different courts, referral will have to take place in order to join the proceedings. If several representative entities wish to bring a collective claim that addresses the same damage-causing events, the court will designate the most qualified organisation to act as the exclusive representative (lead plaintiff) on behalf of all injured parties.

After the appointment of the lead plaintiff, parties have to enter settlement discussions. Where they reach an agreement, the court can declare the settlement binding on the whole class (as was the case under the Class Action Financial Settlement Act). Where no agreement is reached, the court may ask the parties to submit proposals for the manner in which to com-

pensate the damages. Damages will not be assessed individually but will be categorised (damage scheduling). Dutch residents who are part of the class can opt out in order to avoid being bound by the proceedings. For non-Dutch members of the class, an opt-in is required. However, at the request of a party, the court can decide that the opt-out regime will also apply to non-Dutch class members.

The Class Action Financial Settlement Act and the Act on the Settlement of Mass Damages Claims in Collective Actions are inspired by the United States class settlements approach and have attracted the attention of the United States plaintiff bar and litigation funders. Many of the class actions presently listed in the central register are funded by commercial litigation funders.

Of course, this development is of interest both to insureds who might be confronted with a mass claim and to insurers covering such liability risks. One of the foremost worries of insureds when faced with mass litigation is often their financial ability to fund a settlement and/or pay for their defence costs. An insurance programme with adequate limits helps to address these worries. However, insureds should realise that they may have to deal with a large number of insurers, participating on different layers of the insurance programme and/or different policy years, with possibly conflicting interests, as a consequence. Another complicating factor could be the statutory right of injured parties to claim damages directly from the insurer of their counterparty. These rights are often granted on the basis of the assumption that all injured parties can be identified and any available insured amount distributed fairly between these parties. However, such assumption is often not correct in mass claims. If insurers run the risk of having to pay twice in case they agree to fund a settlement with (a large part of) the insured amount leaving as yet unknown injured parties empty-handed, agreeing upon such contribution (which in turn is often part of a settlement between insurers and insureds) becomes far less attractive for the insurer.

Directors and Officers Are More Often Targeted and in Need of Cover for (Legal) Assistance

Directors are increasingly faced with liability claims and/or regulatory action in the Netherlands, both for financial motives and as a means by public interest organisations to pressurise the company the directors are heading to change its policies – eg, to manufacture its products in a more sustainable fashion or to withdraw from countries for political reasons.

In general, a more litigious climate seems to have been introduced in the wake of the financial crisis of 2008 onwards, and directors are often the scapegoat in bankruptcy or other situations where things have taken a turn for the worse. As directors' duties are laid down in more detail, especially in sector-specific legislation, violation of these duties often offers a useful starting point for a liability claim. Moreover, directors' liability is more frequently mentioned and considered as an appropriate sanction for the non-compliance of companies with applicable laws and regulations, in particular in (public debate about and proposals for) legislation in respect of areas like ESG and the use of AI. Allegations of greenwashing and AI washing are also more common.

Criminal liability for directors is an increasing risk, especially in respect of environmental matters. The pressing of charges against de facto managers of steel producer Tata Steel for endangering public health in 2021 illustrates this risk. Directors of financial institutions ING and ABN AMRO have also been confronted with criminal investigations into violation by these institutions under money-laundering legislation. Huge public indignation as to the possibility that management would escape liability led to these investigations and criminal prosecution. Other areas in which criminal liability poses an increased risk for directors are workplace accidents and faulty products.

Over the last ten years there has also been an increase in regulatory laws and regulatory authorities in the Netherlands. Directors might breach rules themselves or may be liable to pay a fine by reason of the company having breached regulatory provisions. Well-known examples are violations of competition and tax laws, and laws and regulations applicable to the financial market. Important enforcement agencies in regulatory

matters involving directors include the Dutch Central Bank and the Dutch Authority for the Financial Markets, which are the financial market supervisors. The organisational structure of supervision in the Netherlands is a so-called twin peaks model. In this model, the Dutch Central Bank is responsible for prudential supervision and the Dutch Authority for the Financial Markets is responsible for what is called conduct-of-business supervision. Another important enforcement agency is the Netherlands Authority for Consumers and Markets, which ensures fair competition between businesses and protects consumer interests. Another relevant supervisory authority is the Dutch Healthcare authority for the healthcare sector. The Dutch Data Protection Authority is increasingly important and supervises processing of personal data in order to ensure compliance with laws that regulate the use of personal data.

In general, the authors expect all regulatory authorities to studiously supervise the activities of directors and possibly fine them more frequently. The pressure for regulatory authorities to demonstrate that they are "on the ball" with regard to oversight and are successful in preventing problems is considerable.

It should also be noted that the increased risk of financial difficulties due to geopolitical instability, scarcity of natural resources and other threats to the continuity of companies is expected to lead to more bankruptcies. In the Netherlands, the most common claimants against directors are trustees in bankruptcy. This is largely due to the specific statutory grounds for the personal liability of directors, which can only be invoked by trustees. The threat of directors' liability on the basis of these provisions is a common route for Dutch trustees to increase the estate's assets, in particular if covered by D&O liability insurance. Whereas trustees often have the benefit of certain evidentiary presumptions and directors cannot invoke a final release by way of defence, the incentive for directors and their insurers to settle increases.

It is further noted that divergent expectations and obligations of parties in different jurisdictions – with the present backlash against ESG in the United States and Europe's continuing efforts to foster these values as a prime example – complicate the decision-making process and increase the risk of directors being faced with litigation and/or criminal or regulatory proceedings in multinational companies.

These developments bring along the need to carefully evaluate the scope of coverage under D&O liability insurance, in particular in respect of legal defence costs or assistance by other experts: eg, in the area of public relations and the adequacy of insured amounts. As regards legal defence costs, there has been an increased need to bring together experts from different practice areas, such as civil litigation lawyers and criminal lawyers, next to specialists in administrative law. Even though working efficiently, a bigger team in general means increased costs. As regards fines, many D&O liability insurances now offer cover "to the extent allowed for under law". To what extent such cover is permitted under Dutch law is, however, still the subject of debate. The prevailing point of view has always been that an insurance agreement cannot cover fines or penalties for public policy reasons: fines would lose their meaning as a sanction if covered by insurance. Most authors nowadays tend to agree that it is permissible to pay for defence costs under an insurance until a court decides that the director was fined on valid grounds. As regards administrative fines, the argument is made that penalties incurred for reason of violation of open standards – norms which do not necessarily make it clear upfront what qualifies as a violation of that standard – may be covered.

Cyber and AI Risks

Within the cyber-insurance sector, coverage disputes have increasingly centred upon exclusions relating to ransom payment obligations, sanctions compliance requirements and deficient cybersecurity protocols. In the writers' experience, Dutch insurance providers have implemented more stringent underwriting criteria and have placed greater emphasis on policyholders' information technology resilience capabilities. Regulatory oversight from the Dutch Central Bank, particularly in response to the European Union's Digital Operational Resilience Act (DORA), has materially influenced insurer practices and policy formulation.

Another important topic for insurers are so-called silent cyber and AI risks. Reference to "silent" risks means the potential, unintended cover for – in this

case – cyber or AI risks under traditional insurance policies, such as general liability insurance, directors' and officers' liability or professional indemnity insurance. The scope of coverage under these common insurance products is often broad enough to cover risks that were unknown at the time of the underwriting process. As a result, insurers may be confronted with huge losses that were not anticipated nor properly assessed and not factored into the premium. Coverage disputes may follow.

Sanctions

It has been observed that international sanctions increasingly cause problems in the smooth settlement of coverage claims by insurers. Most insurers being part of a multinational group of companies, they might need to comply with sanctions laws and regulations which are not necessarily also applicable to their insured and/or the claimants. Such sanction laws can stand in the way of the insurer funding a settlement between its insured and the claimant or otherwise reimbursing loss under the policy. This may lead to a close co-operation between insurer and insured to find a way to make reimbursement possible but may also, or instead, lead to coverage disputes. In such coverage disputes, the discussion often focuses on the interpretation of the sanctions exclusion in the policy.

Modernisation of Dutch Evidence Law: Reform of Right to Disclosure Brings Challenges and Opportunities

As of 1 January 2025, the Act on Simplification and Modernisation of Evidence Law came into effect. As its name suggests, it aims to simplify and modernise the law of evidence, building upon the 2002 revision of civil procedural law and subsequent reforms aimed at strengthening fact-finding. The Act has significant consequences for insurers, who can expect to be confronted with an increase in disclosure requests.

Under the new law, provided that three core requirements are satisfied, information must be provided unless a ground for refusal exists. These three core requirements are:

- sufficient interest in the requested information;
- sufficiently specific requested information; and
- a legal relationship between the requested information and the (potential) claim that the information is needed for.

The information requested can encompass not only written documents, but also other forms of information, such as image and sound carriers, computer files and other electronic information.

This new framework has clearly lowered the threshold for disclosure, first and foremost because of removal of the condition of sufficient plausibility of the legal claim for which discovery is requested. Whereas under the previous legal framework it was required that the potential claim had "sufficient plausibility", the new right of discovery is based on a "yes, unless" approach as the purpose of disclosure request is also to enable a party to be able to assess its legal position and whether or not a valid claim can be made. Under the current framework, if the requirements for discovery are met, information should be provided unless one of the grounds for refusal occurs.

Insurers possess extensive data regarding their clients, making them likely to face increased disclosure requests, including for disputes where the insurer is not a party, positioning them as third parties. Under the new law, insurers can reject third-party disclosure requests by referring requesters to their own counterparties for data that the counterparty also possesses.

The insurer's position as a third party is further strengthened because the requesting party must summon not only the third party from whom disclosure is sought, but also their own counterparty when it comes to a procedural disclosure claim. This obligation did not exist under the old framework. The advantage for insurers is that the debate over whether disclosure should be granted can largely be left to the disputing parties themselves.

The new disclosure right presents both challenges and opportunities for insurers. Insurers should develop comprehensive policies for handling these new disclosure obligations whilst maintaining appropriate confidentiality safeguards for sensitive commercial information and the personal data of their clients.

Of course, insurers can also make use of the lowering of the threshold for disclosure in the Netherlands if they are seeking disclosure themselves.

Digital Transformation in Dutch Courts

The legal world in the Netherlands, including the courts, embarked on a digitisation journey. It is now possible to file documents with the courts electronically and to exchange emails with the courts.

Some courts in the Netherlands are on a pilot scheme for digital litigation in specific matters. For example, digital litigation is already mandatory in cases in which leave is sought for preservation orders. It is anticipated that the next step will be that digital litigation will be declared mandatory for all filings in civil summary proceedings.

It remains to be seen what the results/outcomes of the pilots report – but if the pilots turn out to be successful, the change will be that all Dutch courts will move increasingly in the direction of digital proceedings.

PERU

Law and Practice

Contributed by:
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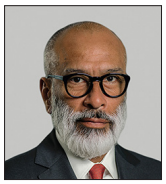
Muñiz, Olaya, Meléndez, Castro, Ono & Herrera Abogados

Contents

Muñiz, Olaya, Meléndez, Castro, Ono & Herrera Abogados is a full-service law firm providing cutting-edge legal assistance. Solid commitment blended with best practices and experience allows the firm to provide unparalleled efficient solutions and tailored advice to the clients. Muñiz is the largest law firm in Peru, housing an impressive number of 360 lawyers working in a broad range of practice areas. With a nationwide network of thirteen offices, the firm ensures the provision of depth and sophisticated services oriented to approach legal problems thoroughly and based on business objectives. Muñiz has extensive experience assisting clients in litigation and arbitration matters. With more than 35 practice areas, including tax, labour, environment, antitrust, intellectual property, litigation and arbitration, mining, oil & gas, among others, Muñiz handles matters across the entire spectrum of industries.

Authors



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1. Rules Governing Insurer Disputes

1.1 Statutory and Procedural Regime

Current Status of the Insurance System

The Peruvian insurance market has expanded significantly in the post-pandemic period, which has naturally led to an increase in insurance-related disputes.

The most frequent conflicts concern health insurance (coverage denial based on the insurer's interpretation of policy clauses) and motor vehicle accidents.

Corporate insurance, which covers complex or high-value operations, is often issued abroad, with disputes commonly resolved through arbitration outside Peru.

General Regulatory Framework for Insurers

Insurance companies are governed by a special regime established under the General Law of the Financial and Insurance System (Act No 26702). This statute sets forth specific requirements for the incorporation and operation of local insurers, including the obligation to maintain reserve funds that guarantee solvency and liquidity, restrictions on indebtedness, and a prohibition on granting guarantees in favour of directors and employees.

Insurers are supervised by the *Superintendencia de Banca y Seguros* (SBS), which must pre-approve policies and general contract clauses. The SBS is also empowered to sanction administrative infringements, including requesting the Supreme Court to dissolve an infringing company. In addition, the consumer protection authority, Indecopi, has sanctioning powers when insurers violate consumer rights, as provided in the Consumer Protection and Defence Code (Act No 29571).

The Insurance Contract Law (Act No 29946) complements this framework by regulating the contractual relationship between insurers and insureds, covering policy content, prohibited clauses, limitation periods, and dispute resolution mechanisms (judicial and arbitral).

Finally, certain types of insurance are compulsory under special laws, such as mandatory vehicle insurance (SOAT, Act No 27181) and insurance for high-risk work (Act No 26790).

Dispute Resolution Mechanisms

Insurance disputes may be addressed through different procedures outlined below.

- Administrative proceedings before the SBS (Act No 26702): For claims filed by policyholders or investigations initiated ex officio.
- Administrative proceedings before Indecopi (Act No 29571): Aimed at sanctioning insurers and ordering corrective measures in cases of consumer rights violations, such as misleading information or inadequate services.
- Administrative proceedings before Susalud (Supreme Decree No 031-2014-SA): Focused on monitoring insurers' compliance with health insurance contracts.
- Judicial proceedings (Civil Procedure Code and the Extrajudicial Conciliation Law, Act No 26872): Available for any dispute involving insurers, reinsurers, insureds, and related parties.
- Arbitration (Legislative Decree No 1071): If agreed by the parties. Arbitration is not mandatory for any type of insurance, and the law grants preference to judicial proceedings, as arbitration can only be agreed upon after the occurrence of the insured event.

Conclusion

Insurers in Peru operate under a regime of strict state oversight. Accordingly, a variety of procedures exist to resolve disputes, most of which are designed to monitor and, where necessary, sanction insurers for failure to comply with their obligations.

1.2 Litigation Process and Rules on Limitation

Legal System in Insurance Disputes

Peru follows the civil law tradition, in contrast to common law systems, relying primarily on statutes as the principal source of law.

To address the lack of consistency in judicial decisions, the Peruvian system has incorporated binding precedents through two mechanisms:

- *pleno casatorio* (plenary session of the Supreme Court) – where the justices unify their interpretation on significant issues frequently litigated; and
- binding precedents – also issued by the Supreme Court, generally in disputes originating from administrative proceedings.

In insurance disputes, the Supreme Court has not yet issued a plenary session or binding precedent; however, this is likely to occur in the near future, given the growing number of cases.

Currently, there are consistent judgments regarding vehicle leasing contracts and liability for traffic accidents. The Supreme Court has held that a leasing company must get its clients to insure the leased vehicles; otherwise, the company itself will be held liable for damages.

Judicial Structure

Insurance disputes are heard by specialised commercial courts (Justicia Comercial, Administrative Resolution 006-2004-SP-CS). These courts also handle other commercial matters, such as promissory notes, checks, and disputes related to foreign trade.

- First instance: Commercial Courts.
- Second instance: Commercial Chamber of the Superior Court.
- Supreme Court: Only for cassation appeals.

These specialised courts have greater familiarity with insurance law and the technical evidence required to assess claims (eg, loss adjusters' reports).

Proceedings

The applicable procedure depends on two factors:

- the amount in dispute:
  (a) *proceso de conocimiento* (ordinary proceedings) – claims exceeding approximately USD 152,000;
  (b) *proceso abreviado* (abbreviated proceedings) – claims between USD 15,000 and USD 152,000; and
  (c) *proceso sumarísimo* (summary proceedings) – claims up to USD 15,000; or
- whether the claim is supported by an enforceable instrument:
  (a) *proceso único de ejecución* (special enforcement proceeding) – applicable when the claimant holds an enforceable title (eg, arbitral award), regardless of the amount.

All proceedings generally follow five stages: postulatory, evidentiary, decisional, appellate, and enforcement.

- In the postulatory stage, the claimant files the lawsuit and the defendant may submit preliminary objections or substantive defences. Before admission, parties must attempt extrajudicial conciliation.
- In the evidentiary stage, admitted evidence is produced, including expert reports and witness testimony.
- In the decisional stage, the court issues a judgment, which may order payment, performance, or interpretation of policy terms.
- Judgments may be appealed; cassation appeals to the Supreme Court are exceptional and limited to questions of law.
- Once final, judgments are subject to enforcement.

Limitation Periods

Under Article 78 of the Insurance Contract Law (Act No 29946), claims arising from insurance contracts are subject to a ten-year limitation period, running from the occurrence of the insured event. This period may be suspended or interrupted under Articles 1994 and 1996 of the Civil Code.

1.3 Alternative Dispute Resolution (ADR)

Conciliation as State Policy

Since the enactment of the Extrajudicial Conciliation Law (Act No 26872), Peru has promoted conciliation as an ADR mechanism to reduce the judicial backlog. Conciliation is now a prerequisite to filing most lawsuits, including insurance disputes, and is conducted in private conciliation centres.

Conciliation in Insurance Disputes

Results of conciliation in insurance cases can be categorised as follows:

- low-value or simple disputes – conciliation has been successful, as parties often prefer settlement to avoid costs and delays; and
- high-value or complex disputes – parties generally reject conciliation, preferring judicial proceedings where judges and experts can resolve technical issues such as damage quantification.

Conciliation may also take place before Indecopi as a preliminary phase to sanctioning proceedings.

Negotiation During Litigation

Given the duration of judicial proceedings, parties often negotiate in parallel with litigation. Negotiations may last months or years, but are usually prompted by a court ruling, when the losing party seeks to obtain more favourable settlement terms. Technical experts play an important role in insurance-related negotiations.

2. Jurisdiction and Choice of Law

2.1 Rules Governing Insurance Disputes

Applicable Rules

In Peru, insurance disputes are primarily governed by the Civil Code (Articles 2057 et seq on jurisdiction and Articles 2096 et seq on choice of law) and the Civil Procedure Code. These are complemented by special statutes, including the Insurance Contract Law (Act No 29946) and the General Law of the Financial and Insurance System (Act No 26702).

In both questions of jurisdiction and choice of law, the primary reference point for courts is the insurance policy or contract itself. If the parties have agreed on a jurisdiction or applicable law, such provisions will usually be upheld unless they conflict with mandatory or exclusive jurisdiction rules under Peruvian law.

Jurisdiction

The Civil Code provides that Peruvian courts have jurisdiction over disputes concerning persons or property located in Peru. Where the dispute involves immovable property situated in the country, the jurisdiction of Peruvian courts is exclusive.

Nevertheless, the law also recognises party autonomy to submit disputes to foreign courts, provided the matter is not one of exclusive jurisdiction of Peruvian courts (Article 2060 of the Civil Code). In practice, international insurers frequently agree on a foreign jurisdiction, especially for complex risks or corporate insurance programs.

Choice of Law

Peruvian law provides for broad freedom of choice of law. Article 2096 of the Civil Code expressly recognises the parties' right to determine the law applicable to their contract. Thus, insurance policies may be governed by either Peruvian law or foreign law, depending on the parties' agreement.

If the parties do not expressly designate a governing law, the Civil Code establishes that the law of the place of performance governs contractual obligations. This default rule has particular relevance in insurance contracts covering cross-border risks, where the place of performance may vary depending on the insured event.

2.2 Enforcement of Foreign Judgments

General Rule

Peruvian courts consistently recognise and enforce foreign judgments, including those involving insurance contracts, through the exequatur procedure. This process is regulated by Articles 2102–2112 of the Civil Code and Articles 837–840 of the Civil Procedure Code.

Judicial Approach

The Peruvian judiciary generally favours recognition and enforcement of foreign judgments, subject only to limited exceptions. One such exception is the absence of reciprocity: if the foreign jurisdiction does not recognise Peruvian judgments, a Peruvian court may deny enforcement. However, reciprocity is presumed under Article 838 of the Civil Procedure Code, and the burden of proving its absence falls on the party opposing enforcement.

Requirements

For a foreign judgment to be recognised, it must meet specific requirements: that it does not concern matters under the exclusive jurisdiction of Peruvian

courts (Article 2058, items 1 and 2 of Civil Code); that the foreign court had jurisdiction and the defendant was duly served with sufficient time to appear; that the judgment has res judicata effect; that no parallel proceeding between the same parties and concerning the same subject matter was initiated earlier in Peru; that it is not incompatible with another judgment already meeting the recognition and enforcement requirements; that it does not contravene public order or good morals; and that reciprocity exists with the state of origin.

2.3 Unique Features of Litigation Procedure

In Peru, there are certain procedural features that international insurers should carefully consider.

- Judges are constantly moved from their offices and reassigned to other locations to handle new cases. This causes judges not to thoroughly understand each case, which certainly affects the quality of their judgments.
- The judiciary has no prior preparation in insurance technical issues, such as the valuation of damages. That means a judge will decide a case using limited tools, essentially their legal knowledge, when an insurance case requires much more.
- It is required to obtain a conciliation as a prerequisite before filing lawsuits concerning free disposable rights. Failure to comply with this step results in the claim being dismissed or placed on standby until conciliation is completed.
- Peruvian judiciary faces a heavy case backlog, which often results in excessive delays before a final and enforceable judgment is obtained.
- Regarding appeals, it should be noted that the cassation is exceptional in nature and does not function as a third instance. Its purpose is to ensure the correct application of the law and the uniformity of jurisprudence.
- Under Article 388 of the Civil Procedure Code, it may only be admitted when the judgment or order suffers from specific defects, such as violations of constitutional guarantees, serious procedural errors, misapplication or misinterpretation of the law, lack of reasoning, manifest illogicality in reasoning, or departure from binding precedents of the Constitutional Court or the Supreme Court.
- When the first and second instance decisions are consistent, the "cassation" is rejected. In such scenarios, only an extraordinary admission may be pursued. The Supreme Court will evaluate on a discretionary basis when deemed necessary for the development of jurisprudence.

3. Arbitration and Insurance Disputes

3.1 Enforcement of Arbitration Provisions in Commercial Contracts

Peruvian courts consistently uphold and enforce arbitration clauses, not only in commercial insurance and reinsurance contracts but also in virtually all contractual relationships. This obligation derives from Legislative Decree No 1071, which grants arbitration agreements the same binding force as judicial jurisdiction clauses.

Accordingly, if one party files a judicial claim despite an arbitration clause, the counterparty may raise the arbitration agreement as a defence, and the court is required to decline jurisdiction.

Even in cases where the validity of the arbitration agreement is challenged, it is the arbitral tribunal itself that has the authority to decide on its jurisdiction. This principle, known as *kompetenz-kompetenz*, is expressly enshrined in Article 41 of Legislative Decree No 1071, which empowers arbitrators to resolve any objection regarding the validity or scope of the arbitration agreement.

3.2 The New York Convention

Peru is a State party to the 1958 New York Convention on the Recognition and Enforcement of Foreign Arbitral Awards. This adherence is particularly relevant because it eliminates the requirement of "double exequatur," meaning that a foreign arbitral award does not need to be recognised in its country of origin before being recognised and enforced in Peru.

Foreign arbitral awards may be recognised and enforced in Peru pursuant to Articles 74–78 of Legislative Decree No 1071 (see below).

Recognition

Jurisdiction lies with the Civil Chamber specialised in commercial matters of the Superior Court of Justice, where the respondent is domiciled, or otherwise with the competent Civil Chamber. The request is processed as a non-contentious proceeding, and the counterparty has 20 days to respond. An appeal to the Supreme Court (*recurso de casación*) is available only if recognition is fully or partially denied.

Enforcement

Once the award is recognised, enforcement jurisdiction corresponds to the specialised commercial judge or, failing that, to the civil judge of the respondent's domicile, or the location of assets if the respondent is not domiciled in Peru.

Grounds for Refusal

Peruvian law incorporates the standards of the New York Convention, including incapacity of the parties or invalidity of the arbitration agreement, lack of notice or due process, the award addressing matters beyond the scope of the arbitration agreement, irregularities in the constitution of the tribunal or procedure, lack of binding effect of the award, or annulment in the country of origin. Recognition may also be denied if the subject matter is not arbitrable under Peruvian law or if the award is contrary to international public policy.

3.3 The Use of Arbitration for Insurance Dispute Resolution

Arbitration is a relevant mechanism for resolving insurance disputes in Peru, particularly in cases that exceed the monetary threshold of 20 UIT established by the *Superintendencia de Banca, Seguros y AFP* (SBS). As a result, arbitration is commonly used in lines of business involving high-value operations or assets, where the commercial significance of the dispute justifies this form of resolution.

The rules governing arbitration depend largely on the parties' agreement, including the choice of arbitral seat and applicable law. Where Peru is the chosen seat, arbitration is governed by Legislative Decree No 1071.

Arbitration proceedings are private. Arbitral awards are final and binding, and they cannot be appealed on the merits. The only recourse available is an annulment action (*proceso de anulacion de laudo*), which is limited to the specific grounds exhaustively listed in Article 63 of Legislative Decree No 1071.

4. Coverage Disputes

4.1 Implied Terms

Under Peruvian law, the content of insurance contracts is regulated by the Insurance Contract Law (Act No 29946), which establishes certain obligations that are incorporated into every policy by operation of law. Among the most relevant are:

- the duty of the insured to provide accurate and complete information regarding the risk;
- the insurer's obligation to deliver the policy or coverage certificate;
- the prohibition of abusive or invalid clauses, such as those that exclude liability for the insurer's own fraud or bad faith; and
- the recognition of limitation periods and subrogation rights.

These provisions apply regardless of whether they are expressly included in the policy, since they form part of the mandatory legal framework of insurance contracts in Peru.

4.2 Rights of Insurers

Insurance companies are protected regarding the presentation of the risk prior to the inception of the policy, as established in Articles 8 to 13 of the Insurance Contract Law (Act No 29946).

The insured is obliged to respect the principle of good faith in contracts, which also applies at the pre-contractual stage. Accordingly, the insured has the duty to disclose all relevant circumstances and situations that may influence the assessment of the risk.

Failure to comply with this duty is subject to legal regulation. Article 8 of the Act No 29946 provides that concealment or misrepresentation made with fraud or gross negligence renders the contract void. In such a case, the insurer has a period of 30 days to invoke the nullity of the policy. If a loss occurs before

the expiration of this period, the insurer is released from the obligation to pay the indemnity. However, the rejection of the claim requested by the insured may ultimately need to be judicially justified by the insurance company.

On the other hand, according to Article 10 of the same law, when concealment or misrepresentation is due to slight negligence, the insurer may offer to revise the contract within 30 days of becoming aware of it, proposing an adjustment of premiums and/or coverages. If the policyholder does not accept within 10 days, the insurer is entitled to terminate the contract, in which case the insurer is entitled to the premiums accrued on a pro rata basis up to the date of termination.

4.3 Significant Trends in Policy Coverage Disputes

Over the past 12 months, the courts have seen a rise in claims related to two main issues:

- health insurance, where the company has denied coverage to policyholders and the parties involved are disputing the interpretation of the policy clauses; and
- car and major vehicle insurance, where, in the event of an accident, the company has again denied coverage based on its interpretation of the policy.

In addition to these cases, the Peruvian market will face a significant and highly complex claim from Petroperu, the public oil company, against Mapfre for the denial of coverage. This denial is once again a result of an interpretation of the insurance contract.

4.4 Resolution of Insurance Coverage Disputes

In Peru, when a conflict arises regarding insurance coverage, the insured may initiate administrative or judicial proceedings to report the company's refusal to fulfil its obligation. Thus, the competent administrative entities are SBS, INDECOPI or the courts.

Compared with reinsurance contracts, the situation is different: these are agreements between insurance and reinsurance companies, so consumer protection mechanisms do not apply.

In such situations, reinsurers may seek judicial proceedings to protect their rights or turn to arbitration if an agreement for it has been established. Once they engage in these processes, the stages and methods of protection will remain consistent.

Consequently, the approach to a reinsurance contract should be treated as a commercial case.

4.5 Position If Insured Party Is Viewed as a Consumer

The Insurance Contract law establishes that when the insured qualifies as a consumer, the rules contained in the Consumer Protection and Defence Code will apply. Therefore, the question arises as to when an insured qualifies as a consumer.

In this regard, the Consumer Protection and Defence Code states that consumers are:

- natural or legal persons who acquire, use, or enjoy a good or service for their own benefit or that of a family member (a person does not qualify as a consumer if, in relation to the acquired good or service, they carry out an economic activity); and
- micro-entrepreneurs who are in a situation of informational asymmetry regarding goods or services that are not part of their business activity.

The qualification as a consumer is relevant in a dispute, since the consumer will be considered the weaker party in the contract, and the existence of an informational asymmetry will be presumed.

The regulation creates stronger standards for information, transparency and a more advantageous environment for consumers. For example, it includes the following provision: "In cases of uncertainty regarding the terms of adhesion contracts, the interpretation must be made in the most favourable way for the consumer."

In conclusion, if the insured qualifies as a consumer, they will be entitled to certain advantages in administrative proceedings. In judicial proceedings, although the procedural rules formally provide for equality of arms, courts are often inclined to empathise with the insured as the weaker party to the contract.

4.6 Third-Party Enforcement of Insurance Contracts

There are circumstances (exceptionally) in which a third party may assert rights against the insurance company. For example, if a family member is designated as the beneficiary in a life insurance policy, that third party acquires the right to demand payment upon the occurrence of the insured event.

This situation can be framed within Article 54 of the Insurance Contract law, as it constitutes insurance for the benefit of another. Another case arises in liability insurance. For example, if an insured driver causes a traffic accident that injures a pedestrian, the latter may bring a direct claim against the insurer to collect compensation.

4.7 The Concept of Bad Faith

Peruvian law does not contain a written concept of bad faith, even when the term is mentioned repeatedly; laws do not specify the elements that should form a bad faith behaviour. However, one can find numerous case law examples that illustrate what constitutes bad faith.

Notwithstanding, the Insurance Contract law indicates situations that reflect bad faith on the part of the insurer, particularly when abusive clauses and practices are prohibited (Articles 39, 40, and 41 of said law). Again, using examples, the legislator provides sufficient details to grasp a concrete concept of bad faith.

4.8 Penalties for Late Payment of Claims

Insurers may be sanctioned for delays in the payment of claims, primarily pursuant to the *Ley del Contrato de Seguro* (Act No 29946) and the *Reglamento para la Gestión y Pago de Siniestros* (Resolution SBS No 3202-2013).

According to this regulation, once the claim has been accepted, the insurer has 30 days to make the corresponding payment. If this deadline is not met, the insurer must pay the insured or beneficiary default interest equivalent to 1.5 times the average lending rate in Peru, calculated in the currency of the insurance contract, for the entire period of delay.

Likewise, the policyholder, even if in possession of the policy, cannot collect the indemnity or benefit without the express consent of the insured, unless the policy has been endorsed in their favour.

4.9 Representations Made by Brokers

There is no express legal provision establishing that the insured is automatically bound by the statements made by their broker. In practice, the interpretation of insurance contracts is governed by the principle of good faith and by what is effectively agreed upon in the policy. Generally, the broker's statements do not create direct obligations for the insured vis-à-vis the insurer, unless they have been expressly incorporated into the contract.

4.10 Delegated Underwriting or Claims Handling Authority Arrangements

They are not common, as the regulation issued by the *Superintendencia de Banca, Seguros y AFP* (SBS) can be interpreted to mean that both underwriting policies and managing and paying claims are non-delegable functions of insurers.

5. Claims Against Insureds

5.1 Main Areas of Claims Where Insurers Fund the Defence of Insureds

Insurers usually finance the defence of the insured in claims covered by the policy, mainly in areas such as civil liability or property damage. It may also include defence in transportation, maritime, labour, and environmental insurance. This obligation is limited to the terms, insured sums, and specific conditions of the contract.

5.2 Likely Changes in the Future

No significant changes are expected in the areas where insurers fund the defence of their insureds.

Coverage will most frequently continue to apply in cases of civil liability, property damage, transportation, labour risks, or environmental risks. At the same time, new scenarios may always arise (such as those related to cyber risks), but the general trend is for these areas to remain stable in the years to come.

5.3 Trends in the Cost or Complexity of Litigation

The complexity of litigation is directly related to the existence of a greater number of coverages in insurers' policies, which requires lawyers to have higher specialisation and, consequently, increases the costs.

For example, providing advice on a claim related to a motor vehicle accident coverage does not carry the same cost as handling a case linked to an insured Project Finance, where the sophistication of risk coverage and the analysis required are considerably greater.

Upon analysing last year's cases, a trend toward more complex conflicts in insurance involving technology and e-commerce policies emerged.

5.4 Protection Against Costs Risks

Claimants can obtain protection against the risk of costs related to their claims through legal expenses insurance.

This type of policy covers expenses arising from their participation in administrative, arbitral, or judicial proceedings, including legal advice and assistance, claims management, and defence against liable third parties.

6. Insurers' Recovery Rights

6.1 Right of Action to Recover Sums From Third Parties

The insurance contract law recognises the insurer's right of subrogation. This means that the insurer who has paid the indemnity is subrogated to the rights of the policyholder and/or insured against third parties responsible for the loss, up to the amount of the indemnity paid.

6.2 Legal Provisions Setting Out Insurers' Rights to Pursue Third Parties

The right of subrogation is defined in Article 99 of the Insurance Contract Law (Act No 29946) and in Articles 1260 and following of the Civil Code. Under this provision, when an insurer compensates the insured for a loss, the insurer gains the insured's rights against the third party responsible for the damage. This means that the insurer effectively steps into the insured's position, allowing them to file a claim in the insurer's name.

7. Impact of Macroeconomic Factors

7.1 Type and Amount of Litigation

The COVID-19 pandemic led to an increase in claims related to health insurance, business interruption, liability, and travel insurance.

On the other hand, international conflicts, such as the wars in Europe, have affected international trade insurance as well as political risk coverage. Insurers have faced a rise in claims for damages, supply chain interruptions, and political risks, which has increased both the volume and complexity of litigation.

7.2 Forecast for the Next 12 Months

The situation regarding insurance litigation is likely to remain unchanged in the next 12 months, as many claims related to COVID-19 are still in the initial stage of judicial proceedings.

Even after the pandemic is behind us, the uncertain landscape concerning international conflicts remains. Factors such as geopolitical tensions, fluctuations in financial markets, and major infrastructure projects intertwined with political issues may continue to lead to complex insurance disputes.

7.3 Coverage Issues and Test Cases

Although global factors such as international conflicts have increased litigation and the complexity of certain claims, no test cases or judicial precedents have yet arisen that alter the interpretation of existing coverages.

7.4 Scope of Insurance Cover and Appetite for Risk

There is no evidence that the above-mentioned factors have significantly affected the scope of insurance coverage available in the Peruvian market or the risk appetite of insurers.

8. Emerging Risks

8.1 Impact of ESG on Underwriting and Litigating Insurance Risks

ESG factors are increasingly impacting insurance underwriting and litigation in Peru. In underwriting, environmental risks – such as climate change and natural disasters, which are common in the country – lead insurers to adjust premiums or even limit coverage for companies with significant environmental impacts.

Social factors, such as inadequate labour practices or a lack of corporate social responsibility, are also carefully assessed. Companies that fail to meet minimum standards of ethics and good practices may face greater difficulty accessing certain insurance products. Additionally, corporate governance, evaluated in terms of transparency, compliance, and ethics, is critical, as deficiencies in this area can signal significant legal and financial risks.

8.2 Data Protection Laws

For proper determination of the insurance rate, insurers must ensure that they collect, process, and store policyholders' information in order to accurately assess the risk to be covered.

However, the handling of such information must comply with the requirements outlined in Act No 29733, Personal Data Protection Law, and its regulations. This requires careful evaluation of which data can be used to set insurance rates or determine coverage, avoiding practices that could be considered invasive or discriminatory.

Improper handling may expose insurers to liability for violating privacy rights, potentially leading to litigation.

9. Significant Legislative and Regulatory Developments

9.1 Developments Affecting Insurance Coverage and Insurance Litigation

This year, the SBS issued a regulation that promotes the comprehensive management and structuring of risks associated with assets and liabilities. Specifically, through the Regulation on Asset and Liability Management for Insurance Companies (SBS Resolution No 1660-2025), published on May 9, 2025, it seeks to implement a methodological framework and guidelines for the integrated management of assets and liabilities in general and life insurance, covering both short- and long-term policies.

SPAIN

Trends and Developments

Contributed by:
Gonzalo Ardila, Fátima Mallén, Paloma Martínez and Alberto Witzl
Hogan Lovells International

Hogan Lovells International has 2,800 lawyers on six continents who provide practical legal solutions and fresh thinking combined with proven experience to deal with a fast-changing, interconnected world. Its experience in cross-border and emerging economies gives it the market perspective to be a global partner and to ensure that its legal solutions are aligned with its clients' diverse business strategies. The team's range of backgrounds and experience gives them a broader perspective, which they can use to their clients' advantage. As advocates of justice, equality and opportunity, they believe in giving back to their communities and society as a whole. All staff at Hogan Lovells are asked to volunteer for at least 25 hours a year as part of their normal work duties. Around the world, the firm is making a difference through pro bono activities, community investment and advocating for social justice.

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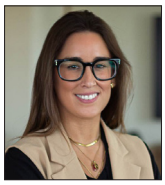

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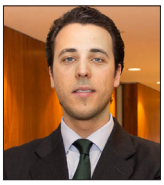

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Introduction

In 2025, insurance litigation in Spain has been shaped by two main drivers: the consolidation of Alternative Dispute Resolution Mechanisms (MASC) as a mandatory pre-litigation step, and the impact of the April 28th blackout.

Organic Law 1/2025, of 2 January, reinforced the "MASC first, court second" approach, requiring parties in civil and commercial disputes to explore consensual solutions before commencing litigation – a particularly relevant change for insurance disputes, where swift resolution and technical claims handling are crucial. Entering into force on 3 April 2025, the law introduced practical adjustments (time limits, proof of attempted resolution, minimum standards) that claims departments and law firms have already incorporated into their internal protocols.

The 28 April 2025 blackout – which affected Spain and Portugal – has been the other major change. Beyond the technical debate over its origin, the event triggered a surge in claims for business interruption, property damage and loss of profits, as well as disputes over exclusions (power failure, force majeure, cyber-risk) and sub-limits. Public and industry reports have anticipated a significant volume of potential losses for insurers, prompting more sophisticated litigation strategies (expert evidence and concurrent causation analysis, among others). Preliminary government findings ruled out a cyber-attack as the primary cause, pointing instead to a multifactorial origin, complicating liability allocation and claim aggregation.

A further development in 2025 has been the rise of ESG-related litigation, particularly in connection with Directors' and Officers' (D&O) liability policies. ESG compliance has become a decisive factor in underwriting and claims handling, with lawsuits increasingly targeting directors for alleged greenwashing, failure to adopt preventative environmental measures, cybersecurity breaches, lack of diversity in governance, and insufficient transparency in executive remuneration. Spanish courts are beginning to address these claims, often inspired by trends in other European jurisdictions, and their rulings are expected to shape the interpretation of policy exclusions and the scope of coverage for ESG-related risks. This evolution is turning D&O insurance into a key risk management tool not only for financial protection but also for driving good corporate governance and sustainable business practices.

Against this backdrop, insurance litigation is becoming more strategic, technical and outcome-oriented. From a business perspective, insurers are reviewing policy wordings and claims protocols to anticipate disputes and reduce exposure, while law firms are strengthening their pre-litigation capabilities and technical expert networks. From a jurisprudential standpoint, key rulings expected in the coming months are likely to clarify coverage issues and set standards for quantifying damages. All signs indicate that 2025 will be a trend-setting year, with lasting effects on the practice of insurance litigation in Spain.

This chapter of the guide will now address several issues that are relevant in Spain's courts and tribunals or that deserve, due to their interest, to be analysed in this chapter.

ESG Litigation and the Transformation of D&O Insurance in Spain

In 2025, ESG has become a decisive factor in insurance litigation in Spain, with a particular impact on directors' and officers' liability (D&O) policies. Sustainability is now a central element of the global economy, and insurers must not only provide coverage against climate-related risks but also adapt their own operations to ESG standards.

D&O policies – originally designed to safeguard the personal assets of decision-makers against third-party claims – are now confronted with an expanded risk landscape driven by regulatory and societal pressure on sustainability. As highlighted by Berkley España, corporate activity is increasingly subject to regulation across diverse areas, and breaches of ESG obligations are already giving rise to a surge in claims and litigation against executives.

Common causes include proceedings related to climate change impacts, lawsuits for greenwashing, failures to implement preventative measures against environmental or cyber risks, claims regarding the lack of diversity on boards, and allegations of opacity in

executive remuneration. Underestimating these risks can prove costly, leading to reputational and financial harm, higher premiums and greater difficulty in securing coverage.

WTW's global survey on D&O risks confirms that ESG factors are now among the top concerns for directors and officers. Environmental litigation has grown exponentially: by the end of 2023, more than 2,280 climate-related lawsuits had been filed worldwide, many against senior executives accused of mismanaging the energy transition or persisting in carbon-intensive investments. In Spain, while the trend has developed more slowly than in other European jurisdictions, ESG-related litigation is also on the rise.

Spanish directors additionally face heightened responsibilities under the CSRD and CSDD Directives, which require not only accurate disclosure of non-financial information but also the implementation of measures to prevent negative impacts on human rights and the environment. Non-compliance opens the door to litigation from shareholders, consumers and NGOs, with direct consequences for D&O coverage.

Insurers, for their part, are incorporating ESG criteria as critical underwriting variables – penalising companies with deficient sustainability policies or internal controls and rewarding those with robust ESG frameworks. This evolution is transforming the traditional function of D&O insurance: from a passive shield against conventional liability to an active tool for ESG risk management.

Greenwashing litigation exemplifies this shift. In Spain, environmental groups have filed complaints against major energy companies over allegedly misleading campaigns on biofuels. Moreover, in February 2025 the courts ruled in favour of Repsol against Iberdrola in a case concerning alleged "eco-posturing", underlining the legal challenges in framing certain forms of corporate communication.

Cybersecurity is another emerging axis. As Berkley notes, insufficient safeguards against cyber-attacks may give rise to negligence claims against directors. The transposition of the NIS2 Directive into Spanish law further intensifies this framework, introducing fines of up to EUR10 million for breaches of cybersecurity obligations and significantly expanding the exposure covered under D&O policies.

In conclusion, ESG litigation has moved from being a diffuse threat to a concrete reality that is redefining the function of D&O insurance in Spain. Directors can no longer ignore their ESG responsibilities, while insurers adjust underwriting and pricing according to compliance levels. Today, D&O insurance serves not only as a shield for personal assets but also as a catalyst for sound corporate governance and sustainable business practices.

The Insurer's Exoneration From Default Interest Under Article 20.8, LCS: Can ADR Mechanisms Suspend the Accrual of Interest?

Paragraph 8 of Article 20 of Law 50/1980, of 8 October, on the Insurance Contract (LCS), establishes a significant exception to the general regime of default interest: "The insurer shall not be liable for default interest where the failure to pay the compensation or the minimum amount is based on a justified cause or one not attributable to it." The interpretation of this concept has been the subject of extensive case law, as the scope of "justified cause" determines the extent of protection afforded to the insured against delays in payment.

The Spanish Supreme Court has traditionally adopted a restrictive interpretation of "justified cause". In judgments such as STS 317/2018 (30 May), STS 47/2020 (22 January) and STS 643/2020 (27 November), the Court has clarified that the mere existence of litigation or the filing of a claim in court does not constitute a justified cause exempting the insurer from paying default interest. The exception is only recognised when there is genuine uncertainty or a rational doubt as to the existence or scope of the obligation to indemnify, or when the insurer's position is based on a reasonable interpretation of the policy or of the case law prevailing at the time.

The Court has also identified specific situations where "justified cause" may be found: when there is a reasonable dispute over coverage, the claimant's inclusion in the policy, the date of the triggering event, or the basis for calculating compensation. Conversely,

mere disagreement as to the quantum, lack of liquidity of the claimed amount, or the use of judicial proceedings as an excuse to delay payment do not constitute justified cause (STS 56/2019, 25 January; STS 556/2019, 22 October; STS 419/2020, 13 July).

The recent Supreme Court Judgment 1227/2025 synthesises and reinforces this doctrine. In its seventh legal ground, the Court held that

"there is no justified cause excusing the insurer's passivity in settling the claim when: (i) the existence of the loss is not disputed; (ii) the insured's liability is not contested; and (iii) coverage under the policy is acknowledged. Likewise, mere disagreement as to the amount of compensation claimed does not constitute justified cause for avoiding the accrual of interest."

The Court added that justified cause only exists when it is necessary to resort to judicial proceedings to resolve an objective situation of uncertainty or rational doubt regarding the insurer's obligation to indemnify – that is, when judicial determination is indispensable to dispel existing doubts regarding the reality of the loss or its coverage.

Against this background, the entry into force of Organic Law 1/2025, of 2 January, on measures to improve the efficiency of the Public Justice Service, introduces a novel element: the mandatory requirement to attempt an Alternative Dispute Resolution (ADR) mechanism as a precondition for the admissibility of civil and commercial claims. This raises the question of whether initiating a legally required ADR procedure, carried out in good faith, could constitute a "justified cause" for the purposes of Article 20.8, LCS.

It is reasonable to argue that, if the insurer actively participates in the ADR process and makes a reasoned and fair offer, it would be acting consistently with the spirit of Article 20.8, since the delay in payment would not be attributable to it but rather the result of a mandatory extrajudicial process. However, ADR mechanisms are still in the early stages of judicial interpretation. A prevailing view seems to be emerging that a merely formal attempt at settlement – without a genuine effort to negotiate – does not qualify as a valid ADR and therefore cannot easily be deemed a justified cause. The key will lie in the good faith and substantive reality of the extrajudicial attempt: only where the ADR process reveals an objective and reasonable dispute as to the obligation to indemnify should justified cause be recognised.

In conclusion, the recent procedural reform opens the door to a new scenario in which ADR may play a significant role in the management of default interest, but its effectiveness will depend on how the courts interpret the sufficiency and good faith of its use. The debate is now open, and it will likely be case law that ultimately defines the limits of "justified cause" in the context of these new procedural efficiency mechanisms.

The Retroactive Application of the Compensation Scale Under Law 35/2015: Jurisprudential Shift, Admissible Scenarios and Impact on the Insurance Sector

Supreme Court Judgment No 951/2025, delivered by the Civil Chamber on 17 June 2025, marks a turning point in the doctrine governing the application of the compensation scale (*baremo*) set out in Law 35/2015. In this landmark decision, the Supreme Court revises its traditional approach and, for the first time, admits the possibility of applying the *baremo* retroactively in extra-contractual cases unrelated to motor vehicle traffic. This doctrinal shift has significant implications both for judicial practice and for insurers' calculation of compensation.

Until this ruling, the Supreme Court's consolidated case law held that the *baremo* applicable for quantifying damages was the one in force at the time of the harmful event or the diagnosis of the injury. This position was supported by judgments such as STS 429/2007, STS 460/2019 and STS 453/2021.

Judgment 951/2025 departs from this line of reasoning. In its Second Legal Ground, the Court acknowledges that, although the transitional provision of Law 35/2015 limits its mandatory application to accidents occurring after its entry into force, this restriction applies only to road traffic accidents. In disputes outside this scope, the *baremo* has merely guiding value, which allows the judge to use the most up-to-date system as a reference for assessing the damage.

The Court held that applying the previous *baremo* could result in insufficient compensation and run counter to the principle of full reparation (*principio de indemnidad plena*) that governs the law of damages, thereby overcoming the limitations of the former system. As the judgment expressly states:

"The use of the compensation scale set out in Law 35/2015 as a guiding criterion for assessing personal injury in cases unrelated to motor vehicle traffic does not infringe the principle of non-retroactivity, provided that its application is grounded in reasons of equity and proportionality and is not imposed automatically. In other words, it is not applied as a mandatory rule but as an interpretative tool that enables a fairer valuation."

The Supreme Court therefore justifies the change in approach on the grounds that the 2015*baremo* may be used for guidance without infringing the principle of non-retroactivity, thus respecting the transitional provision of Law 35/2015.

However, retroactive application of the *baremo* is not admitted in a generalised manner but is limited to specific circumstances:

- matters unrelated to motor vehicle traffic;
- where there has been an express request by the parties; and
- in cases involving progressive harm or damage whose temporal determination is particularly complex.

Judgment 951/2025 is a watershed moment for the insurance sector, as it allows the 2015*baremo* to be applied to losses pre-dating its entry into force. This jurisprudential shift compels insurers to review their technical reserves in anticipation of potentially higher compensation awards, to prepare for a likely increase in litigation – particularly in industrial, healthcare and environmental contexts – and to rethink their litigation strategies, as courts may accept the *baremo* as a guiding criterion even in the absence of a mandatory rule. Furthermore, insurers will need to revisit indemnity limits and coverage clauses in new policies, with particular focus on professional, industrial and environmental liability insurance.

Irrevocable Beneficiary Clauses in Life Insurance and the Effect of Divorce: A Doctrinal and Jurisprudential Overview Under Spanish Law

The designation of beneficiaries in life insurance contracts is one of the most significant mechanisms for transferring wealth outside the succession process. Spanish law, following the model of continental systems, allows the policyholder wide discretion to name, revoke or modify beneficiaries, provided that the formal requirements of the Insurance Contract Act (*Ley de Contrato de Seguro* – LCS) are met. A decisive inflection point arises when the policyholder waives the right of revocation under Article 87, LCS. This waiver converts the beneficiary's position from a mere expectancy into a legally fortified right conditioned only upon the occurrence of the insured event, while at the same time restricting the policyholder's economic powers over the policy, such as surrender, advance payment or pledge. The irrevocable beneficiary thus acquires a stronger legal status, often described in doctrine as a vested credit right that may even be assignable under the general rules of credit assignment.

However, irrevocability does not insulate the designation from all challenges. Spanish contract law places central importance on the concept of cause (*causa*), understood as the underlying reason or purpose of a legal act. Beneficiary designations are typically made *causa donandi*, out of liberality, though they may also be *solvendi causa*, as consideration for an obligation. The distinction is crucial: a designation linked to a debt or contractual duty will generally persist even if the personal circumstances of the parties change, while a designation motivated by marital status may lose its foundation when that status ceases.

The question of what happens upon divorce has been addressed indirectly by Spanish courts through analogy with succession law. In its judgments 539/2018 and 531/2018, the Supreme Court held that testamentary dispositions in favour of the spouse or cohabiting partner lose effect if the marriage or partnership is dissolved before death, since the reason for the appointment ceases to exist. Several appellate courts have followed this approach in the insurance context, interpreting the designation of the "spouse" as presuming the normal continuity of the marital bond and not a sit-

uation of crisis or rupture. Accordingly, separation or divorce may render the designation ineffective unless there is clear evidence that the policyholder wished the benefit to survive beyond the marital relationship.

This reasoning can extend even to irrevocable designations. Article 87, LCS merely removes the policyholder's power of revocation; it does not prevent a court from examining whether the designation continues to have effect when the underlying cause has disappeared. In this sense, irrevocability restricts the policyholder, not the judge's duty to ascertain the real will of the disposer. Where the beneficiary clause explicitly refers to the status of spouse and that status no longer exists at the time of the insured event, courts may consider that the clause has lost its purpose, even if it was initially made irrevocable. Academic commentary supports this interpretation, viewing it as consistent with the principle of fairness and the need to honour the policyholder's true intention.

The practical consequences of this line of reasoning are significant. For insurers, post-divorce claims can generate conflicting demands from ex-spouses and heirs, with the risk of double payment if the proceeds are delivered to the wrong party. Many insurers now encourage policyholders to keep beneficiary designations updated and review them at major life events. For policyholders, the key takeaway is the importance of reviewing designations upon separation or divorce to ensure that the policy reflects current intentions.

In sum, the figure of the irrevocable beneficiary under Spanish law is a powerful estate-planning tool but not an immutable one. Divorce may extinguish a designation whose cause was the marital bond, even if irrevocable, unless there is evidence of a contrary will or a designation made as consideration for a debt. The prevailing interpretative trend suggests that Spanish courts will prioritise the policyholder's real intention and the principle of equity, balancing the security of irrevocable designations with the need to adapt them to supervening circumstances. For both insurers and insureds, clarity in drafting and proactive review of beneficiary clauses remain the best safeguards against future litigation.

UAE

Law and Practice

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Contents

Kennedys is a global law firm specialising in dispute resolution, insurance and advisory services. The firm helps clients mitigate risks and maximise opportunities proactively by adopting an entrepreneurial, realistic and tailored approach. If required, clients have access to a global network of 76 offices, associated offices and co-operations across 36 countries around the world. Kennedys has been established in the Gulf region since 2006, with offices in Oman and the UAE. Its market-leading lawyers have expertise in the relevant local laws as well as extensive practical experience of local market conditions. Kennedys' vision is to be the go-to firm for straightforward expert legal advice, no matter how complex the issue, wherever in the world clients require it.

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1. Rules Governing Insurer Disputes

1.1 Statutory and Procedural Regime

Statutory Regime Governing Insurance Contracts and Disputes

The primary legislation governing insurance in the UAE is Federal Decree-Law No 48 of 2023 Regulating Insurance Activities (the "Insurance Law"), which regulates the onshore insurance sector (ie, outside the financial free zones). It sets out the regulatory framework, including corporate governance and capital requirements for insurers, and establishes a basic dispute resolution mechanism for insurance claims. This mechanism is further detailed in Federal Administrative Decision No 10-A/1/2024, Federal Law No 14 of 2018, and Central Bank Decision No 1659/2023. Together, they set out the procedural steps for handling insurance disputes.

Insurance contracts and coverage issues are primarily governed by the UAE Civil Code (Federal Law No 5 of 1985).

Onshore Procedural Regime

Onshore, in the absence of a valid arbitration agreement, insurance disputes must first be referred to the UAE's financial ombudsman, Sanadak. Sanadak reviews complaints by insureds and may refer matters to the Insurance Disputes Settlement and Resolution Committee (IDSRC), which adjudicates disputes between insureds or beneficiaries and insurers. IDSRC proceedings are conducted in Arabic.

IDSRC decisions are appealed directly to the Court of Appeal (CoA), bypassing the Court of First Instance (CFI). Decisions involving claims of up to AED50,000 cannot be appealed by insurers but may be appealed by insureds. Further appeals of CoA decisions may be made to the Court of Cassation. Unless appealed, Sanadak/IDSRC decisions are final and enforceable.

Offshore Procedural Regime

The Insurance Law, and the dispute resolution procedures within it, do not apply to insurance companies operating within financial free zones such as the Dubai International Financial Centre (DIFC) and Abu Dhabi Global Market (ADGM).

Within the DIFC and ADGM, insurance disputes are resolved either by their respective courts or through arbitration, depending on the agreed forum and governing law. In the absence of an agreement, the respective laws of the DIFC or ADGM apply.

The DIFC courts have three levels:

- the small claims tribunal (for claims below AED500,000);
- the CFI; and
- the CoA.

They follow a modified English common law system, where certain aspects of English law are codified into specific DIFC laws and regulations, such as the DIFC Contract Law and the DIFC Law on Damages and Remedies. The DIFC courts apply these laws, as

well as their own judicial precedent, allowing them to depart from English law at their discretion.

The ADGM courts, similarly structured, comprise:

- the CFI; and
- the CoA.

They directly apply selected English statutes and common law, meaning English case law is binding in ADGM proceedings.

1.2 Litigation Process and Rules on Limitation

Litigation Process

Onshore

The first step in an onshore insurance dispute is for the complainant (insured or beneficiary) to complain directly to the insurer, who has 30 business days to respond. If the matter is not resolved, the complainant may file a complaint via Sanadak's website, submitting contact details, the complaint's subject, and supporting documents (in Arabic or English).

Sanadak may conduct preliminary inquiries or interviews, or request written responses from the insurer. If the complainant remains dissatisfied, they may request referral to the IDSRC. Sanadak will either resolve the complaint or refer it to the IDSRC within five business days. Sanadak's determinations may be appealed to the IDSRC within 30 business days.

IDSRC proceedings require payment of a fee equal to 4% of the claim value (minimum AED100, maximum AED30,000), or a fixed AED3,000 for unvalued claims.

The IDSRC first explores amicable resolution. Failing that, it proceeds to determine the dispute through hearings or documentary review, potentially involving experts. A decision is issued within 20 working days after the IDSRC concludes its procedures, subject to extension by the IDSRC. Any appeal must be filed within 30 days to the competent CoA (geographical jurisdiction determined by the Federal Civil Procedures Code).

If a dispute falls outside Sanadak/IDSRC jurisdiction, it proceeds through the ordinary course in onshore courts under the Civil Procedures Code, from the CFI to the Court of Cassation. Claims are initiated online with a statement of claim, followed by a court-issued service of summons. Proceedings typically involve multiple "hearings" for filing of written memorandums, expert appointments, case management and argument.

Courts frequently appoint an expert to evaluate the matter. Although not binding, the courts often adopt the expert's findings. Parties have limited ability to challenge the expert's findings, and in practice, a complex insurance dispute may be determined by a professional without specific subject matter knowledge or experience.

Appeals are common, with minimal cost consequences. Although costs technically follow the event, awards are generally limited to court fees, court expert fees, and modest legal costs.

Litigation timelines vary, but a full appellate cycle may take up to two years or longer in complex cases.

Offshore

In the DIFC and ADGM, claims are governed by their respective procedural rules, which follow an English-style process. Proceedings are commenced by filing the appropriate claim form and paying the filing fee.

Arbitration

Arbitration can be used to resolve insurance disputes. However, under onshore UAE law, arbitration agreements are unenforceable unless agreed separately in a standalone contract and signed by an authorised person, rather than forming part of a policy's general terms.

Rules on Limitation

Onshore, there is a default limitation period of 15 years in civil and commercial matters, unless the law provides for a shorter limitation period in particular cases. Some of these are:

- commercial contracts – five years from any breach of contract;
- tort (eg, negligence) – three years from the claimant's awareness of the harm and responsible party,

subject to a 15-year longstop from the date of the event;
- non-marine insurance claims – three years from occurrence or knowledge of occurrence; and
- marine insurance – one year (commencement depends on claim type).

Limitation may be suspended or interrupted by a "lawful excuse", initiation of judicial proceedings, admission of liability, and waiver. Limitation periods cannot be modified by agreement.

In the DIFC and ADGM, the limitation period for most claims (including breach of contract and tort claims) is six years from the date a cause of action has accrued, which varies depending on the facts. Negligence claims are subject to extension depending on when the proposed claimant had the required knowledge to bring a claim, but subject to an overriding 15-year time limit. In the ADGM, a claim for personal injury is limited to three years from the injury or (if later) the claimant's date of knowledge (as defined under the Limitation Act 1980 and incorporated into ADGM law); or if the injured person dies, three years from the date of death or the personal representative's date of knowledge.

1.3 Alternative Dispute Resolution (ADR)

Alternative dispute resolution (ADR) is encouraged in the UAE.

Many forms of ADR can be used in the UAE, although arbitration and mediation are the most commonly used.

UAE law recognises a right to refer disputes to arbitration. Moreover, a number of arbitration centres have been established throughout the UAE, including the Dubai International Arbitration Center, and the Abu Dhabi International Arbitration Center ("arbitrateAD"), to manage, regulate and make arbitration more accessible. The rules of these institutions broadly mirror those of the well-established arbitration centres around the world.

Mediation is a less-prevalent form of ADR in the UAE than in other more established jurisdictions like England and Wales. However, it has gained traction in recent years. UAE authorities are promoting mediation and ADR, and Federal Decree-Law No 40 of 2023 on Mediation and Conciliation in Civil and Commercial Disputes was issued to introduce a framework for mediation in the UAE. Court-annexed mediation is also available in the DIFC and ADGM.

One impediment to ADR is that, outside the DIFC and ADGM, the common law doctrine of "without prejudice privilege" is not recognised to protect from disclosure communications and documents created to progress a settlement. Under the civil law system, those documents can be adduced as evidence in court. Unless and until there is a clear equivalent privilege doctrine under onshore law, parties are likely to approach mediation and ADR with caution.

The popularity of ADR is driving an increasing number of commercial entities to integrate it into agreements, either as an alternative to local courts, or as a step to be taken before formal proceedings. Indeed, certain disputes with government entities are obliged to be first referred to mediation.

2. Jurisdiction and Choice of Law

2.1 Rules Governing Insurance Disputes

Onshore

Article 39 of the Federal Civil Procedures Code (Federal Decree-Law No 42/2022) provides that jurisdiction lies with the courts at the insured's domicile or the location of the risk. Agreements contrary to this are void, but this rule applies only to onshore disputes, given the UAE's dual court structure.

Read together with the legislation establishing the UAE's insurance dispute resolution mechanisms, this means that in onshore insurance matters, jurisdiction will ordinarily rest with Sanadak and the IDSRC. These bodies operate at the federal level and handle claims from across all the Emirates. Any appeal of their decisions is heard by the competent Court of Appeal, whose geographical jurisdiction is determined by the insured's domicile or risk location. Sanadak and the IDSRC lack jurisdiction over subrogated recoveries or disputes between insurers, which are heard by the court of first instance or resolved via arbitration, if validly agreed.

Offshore

DIFC and ADGM court jurisdiction is governed respectively by Dubai Law No 12 of 2004 (the "Judicial Authority Law"), and Abu Dhabi Law No 4 of 2013 and the ADGM Courts Regulations 2015. These courts may assume jurisdiction where: (i) a DIFC/ADGM entity is involved, or the contract is linked to, or performed in, the DIFC/ADGM; or (ii) the parties have agreed to submit to DIFC/ADGM jurisdiction (ie, "opted in").

Jurisdictional Ambiguity and Conflict

There is, however, tension between the offshore courts permitting parties to opt in, and the onshore Civil Procedures Code prohibiting contracting out of its jurisdictional rules. This can lead to parallel proceedings and forum shopping where both onshore and offshore courts have arguable competence. Choice of jurisdiction clauses should be precise. For example, clauses referring simply to "the courts of the UAE" might include both DIFC and onshore courts. To avoid ambiguity, clauses should identify the specific court, seat, and governing law.

In Dubai, jurisdictional conflicts may be referred to the Judicial Authority for Resolving Jurisdictional Conflicts (Dubai Decree No 29 of 2024). This body has authority over all jurisdictional disputes involving any Dubai judicial body, not just onshore and DIFC courts. Upon referral, proceedings and limitation periods are suspended until a final decision is made, which cannot be appealed.

Conflicts involving the ADGM courts are typically resolved through co-operation between the ADGM, Abu Dhabi courts, and the Ministry of Justice.

2.2 Enforcement of Foreign Judgments

Foreign judgments can be enforced in the UAE but are not automatically recognised. The process varies depending on whether enforcement is sought in the onshore UAE courts (civil law jurisdiction) or in the offshore courts (DIFC and ADGM, which follow common law principles).

Treaties such as the GCC Convention and the Riyadh Arab Agreement simplify recognition and enforcement between signatory states by providing special enforcement regimes. The UAE has also entered into several bilateral treaties that address judicial co-operation and the mutual recognition of judgments.

Where no treaty applies, enforcement in onshore courts is governed by Article 222 of the UAE Civil Procedure Law (Federal Decree-Law No 42 of 2022). Reciprocity is essential. A foreign judgment will only be enforced if the originating country would enforce UAE judgments on the same terms.

Even where reciprocity exists, the foreign judgment must meet five substantive criteria under Article 222:

- the UAE courts must not have exclusive jurisdiction over the matter, and the foreign court must have had proper jurisdiction under its own conflict rules;
- the judgment must be duly issued and ratified in accordance with the law of the issuing country;
- the litigants must have been duly summoned and properly represented;
- the judgment must have the force of res judicata, either inherently or by subsequent finalisation; and
- the judgment must not conflict with any UAE court decision and must not violate UAE public order or morals.

These conditions can pose difficulties. For example, default judgments, particularly where the defendant was not substantively represented, may be open to challenge under Article 222 (c). Public order objections might include matters involving interest (*riba*), foreign penalties not recognised in the UAE, alcohol, gambling, family matters, or inheritance.

The DIFC courts, which apply common law principles, routinely enforce foreign judgments without requiring reciprocity or public policy review. In contrast, the ADGM courts still require recognition of reciprocity.

2.3 Unique Features of Litigation Procedure

Federal Law

The UAE is a federal state comprising seven emirates. Three of these, Dubai, Abu Dhabi, and Ras Al Khaimah, operate their own court systems. The remaining four emirates, Sharjah, Ajman, Fujairah, and Umm Al Quwain, all operate under the federal judicial framework. Each emirate retains legislative power over matters not assigned to the federal government, and most

substantive laws are UAE federal laws. In all cases, federal law takes precedence over local emirate laws.

Court System

The UAE court system is structured in three tiers. The court of first instance serves as the primary venue for hearings and factual examination. Its judgments can be appealed to the Court of Appeal, where parties have an automatic right to challenge both facts and law, provided the appeal is filed within 30 days of the first-instance judgment for most matters. A further appeal may be made to the Court of Cassation, also within 30 days. This is the final appellate stage and is limited to points of law, albeit interpreted broadly. In most cases, no permission is required to appeal, and it is common for parties to appeal as a tactical measure.

Use of Arabic

Arabic is the official language of the UAE courts. All claims, pleadings and evidence must be submitted in Arabic, and any documents in other languages must be translated by a Ministry of Justice-certified translator. Some onshore courts have introduced English as a secondary official language for specialised commercial disputes, but implementation of this is piecemeal, slow and subject to the discretion of each court's president.

Appointment of Experts

In complex litigation, court-appointed experts play a central role. Judges frequently appoint technical experts to examine evidence and prepare independent reports, particularly in insurance, construction and financial disputes. Courts rely heavily on these reports and often adopt them without modification. While invaluable in clarifying technical matters, expert appointments can significantly extend the duration of proceedings, with first-instance cases involving experts often lasting up to two years, or longer in complex cases.

In conclusion, international insurers litigating in the UAE must be prepared for a civil law environment that emphasises procedural compliance, regulatory oversight, the decisive influence of court-appointed experts, and a court process centred on the Arabic language. Careful contract drafting and early engagement of local specialist legal advice can help navigate these complexities.

3. Arbitration and Insurance Disputes

3.1 Enforcement of Arbitration Provisions in Commercial Contracts

While the courts in the UAE have a general tendency to respect and enforce arbitration provisions in commercial contracts of insurance and reinsurance, there are certain distinct provisions of law to be complied with. Failure to comply will almost certainly prove fatal to the enforceability of the arbitration agreement.

Article 1028 (d) of the Civil Code states that an arbitration agreement in an insurance contract must not form part of the general conditions. It must be a separate standalone agreement and be signed by persons expressly authorised to bind the entity to arbitration.

The UAE courts have consistently invalidated arbitration clauses that fall foul of these requirements.

3.2 The New York Convention

The UAE adopted the 1958 New York Convention on Recognition and Enforcement of Arbitral Awards in 2006 (Federal Decree No 43 of 2006), and its courts are generally supportive of enforcing foreign arbitral awards in line with the convention's principles.

The domestic legal basis for enforcement of foreign awards is now found in Articles 222 and 223 of the Civil Procedure Law (Federal Decree-Law No 42 of 2022). This requires, among other things, that the award does not violate public policy, that due process was observed, and that the dispute could be resolved by arbitration under UAE law.

A party seeking the enforcement of the foreign award must submit an application directly to the relevant onshore execution judge, together with the original award and supporting documents. The execution judge is required to render their decision within five days, and their order may be appealed within 30 days. The court's review is limited; it does not re-examine the merits of the case. While a counterparty may challenge and/or appeal enforcement, for instance on

jurisdictional or procedural grounds, in recent years the courts have become increasingly consistent in applying the New York Convention and upholding enforcement unless clear and serious irregularities are present.

Foreign arbitral awards may also be enforced by the DIFC and ADGM courts, each of which has its own arbitration and enforcement regime. Awards recognised in these courts can be executed in mainland UAE using reciprocal enforcement procedures.

3.3 The Use of Arbitration for Insurance Dispute Resolution

Arbitration in the UAE is a well-established and popular method for resolving disputes, especially in the context of international trade, commerce or insurance. The legal regulations provide a structured approach to arbitration proceedings, enhancing the UAE's position as an arbitration hub.

Arbitration is often preferred due to its efficiency, confidentiality, and the ability to select arbitrators with specialist expertise.

Arbitration in matters of insurance is most often found in commercial lines, such as marine, aviation, reinsurance, and complex property or construction-related insurance.

Generally, awards cannot be appealed and reviewed on the merits, but can nonetheless be challenged or set aside before and by the UAE courts on a number of specific grounds outlined in the UAE Arbitration Law (ie, Article 53 of the Arbitration Law): procedural irregularities, lack of jurisdiction, public policy violations or invalidity of an arbitration agreement.

For foreign awards, the challenge can also be based on the grounds found in the New York Convention of 1958 (ie, Article V), which are generally more limited than those related to domestic awards and found in local regulations.

In general, the grounds for refusing enforcement and appeal of a foreign award under the New York Convention and the UAE regulations are limited and do not ordinarily permit a merits review.

4. Coverage Disputes

4.1 Implied Terms

The UAE has an onshore civil law system and terms can only be implied into contracts by a specific code or legislation. This is in contrast to the DIFC and ADGM where legal principles and rules established in case law may also be impliedly incorporated into contracts or agreements.

Certain obligations are implied into all contracts through the UAE's Civil Code, such as the requirement to perform a contract in good faith (Article 246 (1) Civil Code). Insurers specifically are bound to act in accordance with the principle of utmost good faith in their dealings (Article 3, Insurance Authority Resolution 3, 2010).

The Civil Code also mandates that a party's contractual obligations are not restricted only to what is written in the contract but extend to the contract's "essentials in accordance with the law, custom and the nature of the transaction" (Article 246 (2)). The effect is to convert into a term of the contract anything generally regarded as a mandatory or necessary practice in the relevant sector or industry. Certain ancillary provisions may therefore find their way into a contract in the absence of their explicit inclusion.

Given the lack of binding legal precedent, there is limited guidance on how such provisions should be interpreted and applied in the context of insurance contracts. However, it indicates to both insurers and insureds alike that, even under UAE law, their obligations are likely to extend far beyond the express terms set out in writing in their policy documentation and they will generally be bound to act in accordance with established industry practices.

Similar legislative provisions apply in the DIFC. Article 62 of the Law of Obligations No 5 of 2005 imposes a duty of honesty and utmost good faith on all parties to an insurance contract.

The DIFC's Contract Law of 2004 also creates implied contractual obligations which arise from:

- the nature and purpose of the contract;

- practices established between the parties and usages;
- good faith and fair dealing; and
- reasonableness (Article 57).

Additionally, DIFC courts will tend to refer to English case law when determining a party's obligations in any given case, which should provide greater certainty in the interpretation of insurance clauses than in cases decided by the UAE's onshore courts.

4.2 Rights of Insurers

UAE onshore law (Article 1032 (b) of Federal Law No 1 of 1987) imposes on the insured an obligation to reveal, at the time of conclusion of the contract, all information that the insurer considers to be of importance in order for it to assess the risks it is being asked to cover.

The position under UAE law is however less clear with respect to:

- the format in which such information must be provided, ie, to avoid data dumping on the insurer; and
- whether the insurer has any corresponding obligations, eg, to act as a prudent insurer in making reasonable enquiries or investigating information provided by the insured.

Further, under UAE law, the insured must inform the insurer of all matters which occur during the contract period and which lead to aggravation of the risk (Article 1032 (c), Federal Law, No 1, 1987).

The consequence of failing to disclose relevant information to an insurer is that the insurer may "cancel" the policy. The immediate effect of this on any ongoing claims is not clearly defined under UAE law and is likely to be determined on a case-by-case basis, having regard to the facts and policy terms. "Cancellation" is not an automatic process and must be obtained via application to the court.

On cancellation, an insurer can retain the premium only if it can prove "bad faith" on the part of the insured (essentially, fraudulent misrepresentation or non-disclosure). Otherwise, the premium is pro-rated for the period during which the insurance policy was on risk.

Slightly different rules apply to marine insurance, with a similar pre and post-contract disclosure obligation on the insured (Article 293, Maritime Code), but with different consequences. The premium can also be retained upon cancellation even after an innocent non-disclosure, but only if the insurer can prove it would not have issued a policy at all had it been aware of the true nature of the risk (Article 298, Maritime Code).

Again, in the DIFC, similar duties are imposed on the insured to disclose to the insurer facts within their knowledge which would influence the judgment of a prudent insurer in determining the conditions of the contract or whether to enter into it, and which duty subsists throughout the life of the insurance contract (Article 61, Law of Obligations No 5, 2005). Knowledge held by an agent is explicitly imputed to the insured.

Further, the duty of utmost good faith contained in Article 62 of the same law involves specific disclosure requirements (of both parties) in relation to every fact relevant to the insurance contract. The parties must also refrain from making any misrepresentations.

4.3 Significant Trends in Policy Coverage Disputes

Over the past 12 months, the UAE insurance market has seen a number of coverage disputes arising from extreme weather events, regional instability, and evolving lines of insurance.

Most notably, the April 2024 floods gave rise to a large volume of property, construction and motor claims, with some coverage disputes ongoing. These have focused on issues such as the application of deductibles and sub-limits, the interpretation of relevant exclusions and warranties concerning the actions of or precautions taken by the insured, and the application of wide area damage principles, particularly in relation to business interruption cover where losses were sustained across multiple locations.

The regional geopolitical environment has also contributed to claims activity. In particular, the seizure of vessels by Iranian forces in and around the Strait of

Hormuz has led to coverage issues under and between marine hull and war risks policies. These include the proper identification of policy triggers, and whether and when the insured has suffered loss. Attention has also been drawn to the relatively short one-year limitation period for marine insurance claims under the UAE Maritime Code (UAE Federal Decree-Law No 43/2023) and the statutory threshold for constructive total loss under the same law.

Cyber-insurance continues to develop as a line of business. While still relatively young in the UAE, there has been a noticeable increase in claims notifications, particularly for incidents involving ransomware, social engineering, and business interruption. The few disputes that have arisen have involved interpretation of exclusions, questions over whether a loss falls within scope, and challenges in evidencing and quantifying losses.

4.4 Resolution of Insurance Coverage Disputes

Onshore

(Re)insurance disputes in the UAE are primarily resolved through court proceedings under a civil law system based on codified legislation. Sharia applies only where statutory gaps exist. The courts follow an inquisitorial approach, focusing on written submissions rather than oral advocacy. There is no case law in the sense of binding precedent. The courts have discretion to determine matters by application of the codified civil law on a case-by-case basis.

In the absence of an arbitration clause, disputes begin with Sanadak and the IDSRC reviewing the case and making a determination before any appeal to the Court of Appeal, bypassing the court of first instance.

Appeals to the Court of Cassation are common and relatively low cost. Costs generally include court fees and nominal legal costs. A full appeal cycle may last up to two years, or longer for complex cases.

Courts do award interest, generally from the date of claim or judgment, with rates up to 9% depending on the emirate.

Where a valid arbitration agreement exists, disputes may proceed to arbitration.

Arbitration

Arbitration of insurance coverage disputes is possible and would be governed by the UAE Arbitration Law (Federal Law No 6 of 2018). This law requires that the arbitration agreement: (i) be in writing; (ii) be separately agreed; and (iii) be signed by an authorised person. UAE law also requires that arbitration agreements be agreed separate to the insurance policy.

Offshore

The DIFC and ADGM courts handle both insurance and reinsurance matters. The DIFC applies its own codified laws, heavily influenced by English law, while the ADGM directly applies English law and a selection of English statutes.

Cases in these jurisdictions are determined under a common law framework following an adversarial approach to litigation similar to what is found in other international common law jurisdictions, like England and Wales. As such, judicial precedent in (re)insurance cases from other common law jurisdictions is influential. English case law is binding in the ADGM.

4.5 Position If Insured Party Is Viewed as a Consumer

UAE law generally provides significant consumer protection. In the context of insurance, there is nothing which covers all lines of business, but there is a general understanding that individual policyholders have greater rights and safeguards compared to a commercial entity. This would apply in most coverage disputes, where a court/tribunal is likely to see that individual policyholders are often in a weaker position, lacking legal and technical expertise and negotiation power, leading the court/tribunal to be more “insured friendly”.

There are also certain additional protections and other regulators in respect of certain types of policies. By way of example, for medical insurance policies in Dubai, there are other laws, which include the Dubai Health Insurance Law No 11 of 2013 and its implementing regulations, such as the Dubai Health Authority General Circular 1 of 2020 and Administra-

tive Resolution 78/2022. These restrict an insurer in certain situations from cancelling a policy solely due to a non-declaration of a condition, and where an insurer *is* able to cancel, it would first need to co-ordinate this with the Dubai Health Authority.

4.6 Third-Party Enforcement of Insurance Contracts

Third parties can enforce an insurance contract or sue an insurer under certain circumstances.

Under UAE contract law, a contract cannot impose obligations on third parties without their agreement, but it may establish a right in their favour. The UAE Civil Code (Federal Law 5 of 1985) also recognises that insurance proceeds may be payable to a policy beneficiary, rather than the direct named insured (Article 1034).

In general, exclusions within an insurance contract that restrict the rights of third parties are not likely to bind those third parties if a UAE court in its discretion determines that the (re)insurance policy confers a benefit on the third party. This heightens the risk of direct third-party action against insurers.

4.7 The Concept of Bad Faith

UAE law refers to "bad faith", but does not provide an explicit definition of what constitutes "bad faith".

That said, as discussed above, certain obligations are implied into all contracts through the UAE's Civil Code, such as the requirement to perform a contract in "good faith" (Article 246 (1) Civil Code). In addition, if an insurer cancels an insurance policy for misrepresentation and/or non-disclosure, an insurer can retain the premium only if it can prove "bad faith" on the part of the insured (which is, essentially, fraudulent misrepresentation or non-disclosure).

4.8 Penalties for Late Payment of Claims

There are no explicit penalties for delayed claim payments, but there are three forms of penalties that could be applied to insurance companies:

- damages (if litigated) – these are rarely (if ever) awarded by the UAE courts, however, as there are onerous requirements to proving actual direct damage caused by the delay;
- interest – which, as discussed above, courts award from either the date of claim or judgment, with rates up to 9% simple interest depending on the emirate; and/or
- regulatory fines and penalties.

As to regulatory fines, the Insurance Authority Board Resolution No 3 of 2010 (concerning the Code of Conduct and Ethics for insurance companies) requires under Article 9.(2) for insurers to settle claims without delay, and under 9.(4) to notify the insured of coverage within 15 days of receipt of complete documents, unless an explanation is provided for a longer period. There is a specific penalty for breach, but Article 33 of the Insurance Law (Federal law 48/2023) gives the regulator, the Central Bank of the UAE (CBUAE), powers to conduct periodic inspections on insurers which include powers to verify if insurers are complying with their obligations. If the CBUAE determines that an insurer has failed to do this, it could, among other things: (i) restrict the insurer's policy issuance; (ii) suspend the licence; or (iii) apply fines (that cannot exceed AED100 million).

4.9 Representations Made by Brokers

An insured is bound by the representations made by their insurance broker, as the broker is considered the agent of the insured, provided the insurance broker has the requisite authority. This position is reinforced by both insurance regulations and the UAE Civil Code.

- Insurance Brokers' Regulation 2024: Per Article 12.1 an insurance broker must (i) obtain written authorisation from its client to act on their behalf; (ii) explain to the client the importance of accurate disclosure and the consequences of providing incorrect information; and (iii) provide the insurer with "accurate and adequate information necessary for underwriting purposes".
- UAE Civil Code (Federal Law 5 of 1985): Article 149 states that a contract can be made through a representative. Article 152 further clarifies that if a contract is made by a representative acting within their scope of authority, the principal (the insured) cannot claim ignorance of any circumstances that the representative knew or should have known.

4.10 Delegated Underwriting or Claims Handling Authority Arrangements

Delegated underwriting in the UAE is generally limited. The CBUAE does not recognise the concept of managing general agents or managing general underwriters and, while the ADGM and DIFC financial free zones permit the licensing of these activities, this is limited to reinsurance.

In relation to health insurance lines of business, claims handling is commonly delegated by insurance companies to third-party administrators (TPAs). In recent years, there has been increasing use of TPAs for related lines of business such as group life and personal accident. In relation to the administration of health insurance claims, TPAs are regulated by the CBUAE and must operate in accordance with Insurance Authority Board Resolution No 9 of 2011 Concerning the Instructions for Licensing Health Insurance Third Party Administrators and Regulation and Control of their business (the "IA Board Resolution"). Obligations include a requirement for TPAs and insurance companies to enter into an agreement to document the parties' respective rights and obligations, including the matters specified in the IA Board Resolution. Consequently, any dispute between an insurance company and a TPA would typically be handled as a matter of breach of contract. A TPA acts as an agent of the insurance company and, as such, in the event of a coverage dispute, an insured party would usually pursue the insurance company rather than the TPA.

5. Claims Against Insureds

5.1 Main Areas of Claims Where Insurers Fund the Defence of Insureds

As in many jurisdictions, in the UAE, insurers commonly fund the legal defence of their insureds in third-party liability claims, provided it is part of the insurance cover.

Defence costs are a standard feature in various liability policies, including:

- Comprehensive general liability (CGL) policies – these cover legal expenses for claims involving bodily injury or property damage that occur during the insured's business operations.
- Professional indemnity (PI) policies – these cover professionals like doctors, lawyers and engineers against liabilities arising from their services.
- Directors and officers (D&O) policies – these provide coverage for legal costs associated with claims against a company's leadership for wrongful acts.
- Employers' liability (EL) policies – these cover legal defence for claims alleging employment practice violations, such as wrongful termination or discrimination.
- Motor liability insurance: this funds the defence for third-party claims resulting from a motor vehicle accident.

Insurance policies are typically drafted with one of the following approaches to managing legal defence:

- Duty to defend – the insurer takes direct control of the defence, appointing legal counsel and covering all reasonable legal costs within the policy's limits.
- Right to defend – the insurer has the option, but not the obligation, to take over the defence. This provides them with flexibility.
- Claims co-operation – the insurer does not directly manage the defence but agrees to reimburse the insured for reasonable legal costs, provided the insured co-operates fully and obtains the insurer's prior consent.

In all scenarios, the insured is generally required to get the insurer's written consent before incurring defence costs, and those costs must be reasonable.

5.2 Likely Changes in the Future

Traditional insurance products are unlikely to change significantly, but evolving risks will drive the development of new solutions and impact existing coverage. Within the UAE, examples include addressing emerging threats related to technology, environmental factors and global politics.

5.3 Trends in the Cost or Complexity of Litigation

Legal costs and the complexity of litigation in the UAE have increased in recent years due to several key factors, including:

- Inflation in claim values – the overall value of claims has increased, leading to higher financial stakes in disputes. This, in turn, can increase litigation costs as parties invest more resources in the proceedings. A recent ruling by the Dubai Court of Cassation has also signalled a shift (albeit it is still very early days and could be subject to various conditions) towards allowing for the recovery of actual, and not just symbolic, legal fees, which may further drive up the cost of litigation.
- Jurisdictional challenges – the parallel existence of the UAE's onshore courts and the common law courts in financial free zones (the DIFC and ADGM) often leads to jurisdictional disputes. These conflicts can result in concurrent proceedings, causing significant delays and driving up costs.
- Evolving arbitration landscape – the UAE has become increasingly pro-arbitration, especially following the implementation of the Arbitration Law and recent amendments. While arbitration is often seen as a flexible and efficient alternative to litigation, the process itself can become complex. Jurisdictional challenges related to enforcing awards or disputes over the arbitration clause can add layers of complexity and cost.
- New technologies and expertise – the emergence of new technologies and business models, such as those related to AI and innovative architecture, has introduced novel legal issues. Resolving these disputes often requires the involvement of specialised, and often expensive, technical experts, which contributes to the overall increase in litigation costs.

5.4 Protection Against Costs Risks

Claimants in the UAE can obtain protection against the risk of paying costs, but (i) such cover is not widely available; and (ii) the availability and type of protection can vary significantly depending on the court.

Onshore Courts

Onshore UAE courts, which follow a civil law system, generally award only nominal legal costs. This has made third-party litigation funding rare. However, a recent ruling by the Dubai Court of Cassation allows for the recovery of actual legal fees if the contract explicitly permits it. This development could increase confidence in litigation funding for onshore disputes.

Free Zone Courts

In contrast, the DIFC and ADGM common law courts have more developed frameworks. They follow the "loser pays" principle, where a winning party can recover a significant portion of their legal costs. These free zones also have formal rules governing litigation funding, providing claimants with a structured way to finance their cases and protect against adverse cost orders.

Arbitration

Arbitration is also a favourable option for claimants, as most major arbitration rules grant tribunals the discretion to award costs, including legal fees, to the successful party.

6. Insurers' Recovery Rights

6.1 Right of Action to Recover Sums From Third Parties

Under both onshore and offshore UAE legal frameworks, insurers are generally entitled to exercise rights of subrogation, meaning they have a legal right to recover sums from third parties responsible for causing an insured loss.

Through subrogation, the insurer effectively "steps into the shoes" of the insured and can pursue a recovery action against the liable third party. For subrogation to apply, the insurer must have paid out a valid insurance claim, and the insured must have had a viable cause of action against the third party. The insurer cannot recover more than it paid in indemnity.

Insurance policies commonly include contractual waivers of subrogation. Under onshore UAE civil law, subrogation is expressly excluded in respect of certain categories of persons, including the insured, their ascendants or descendants, spouse, co-habitants, and those for whose acts the insured is responsible. Beyond these limited exclusions, the enforceability of

broader contractual waivers of subrogation in onshore UAE policies remains uncertain. By contrast, such waivers are generally considered enforceable in the offshore jurisdictions of the DIFC and ADGM, where common law principles apply and contractual freedom is more robustly upheld.

6.2 Legal Provisions Setting Out Insurers' Rights to Pursue Third Parties

Under onshore UAE civil law, the insurer's right of subrogation is codified in Article 1030 of the UAE Civil Code (Federal Law No 5 of 1985). This provision establishes that once the insurer has indemnified the insured for a loss, it is subrogated to the insured's rights against any third party responsible for that loss, to the extent of the amount paid. Subrogated recovery proceedings in the onshore courts are typically brought in the name of the insurer.

In the offshore jurisdictions of the DIFC and ADGM, the right of subrogation is not codified in a specific statute. However, the right is available under the common law principles that apply in both jurisdictions. Under those principles, recovery actions by insurers are generally pursued in the name of the insured.

7. Impact of Macroeconomic Factors

7.1 Type and Amount of Litigation

The volume and type of insurance-related claims and litigation in the UAE continue to be shaped by macroeconomic factors and external shock events.

The COVID-19 pandemic resulted in a surge of business interruption claims, particularly in the hospitality and retail sectors, while simultaneously contributing to a drop in claims under classes such as motor and aviation, where activity was reduced.

The pattern of single events dramatically shifting claims activity has broadly continued. The April 2024 floods triggered a significant volume of claims across property, motor and construction policies, with many now progressing to formal disputes. These events have underlined the increasing underwriting and litigation exposure associated with extreme weather, and have added urgency to the regional conversation around climate-related insurance risk. While not directly linked to those floods, the publicised practice of cloud seeding in the UAE has come increasingly under the spotlight since then, with some questioning whether it might have any effect on the likelihood or severity of heavy rainfall events, and what that could mean for insurers.

In parallel, economic volatility, rising interest rates and inflationary pressures have heightened the potential for disputes in property and construction, particularly where project delays or cost escalations have occurred.

The impact of more recent macroeconomic developments, such as the imposition of international tariffs by the United States, the widespread integration of AI into society, and the continued development of the UAE's regulatory and taxation framework, is yet to be seen.

7.2 Forecast for the Next 12 Months

Despite geopolitical instability and regional conflict, 2025 has not been a particularly heavy year for traditional insurance claims in the UAE. The volume of disputes has remained largely event-driven, reflecting the pattern that single shocks can have a disproportionate impact on claims activity. The outlook for the next 12 months will similarly depend on the incidence of such individual events, whether climate-related, geopolitical or economic.

What is more predictable is the effect of claims inflation. Ongoing inflationary pressures are increasing the cost of property reinstatement, construction projects and liability exposure. At the same time, international trade tariffs and supply chain disruptions are expected to drive up costs for materials and equipment, adding to the quantum of claims in property, construction and related classes.

Accordingly, while the frequency of disputes is likely to remain contingent on unpredictable external events, the severity of claims is expected to rise.

7.3 Coverage Issues and Test Cases

One of the key coverage issues that has arisen in the UAE is the impact of claims inflation. Where the

cost of reinstatement or repair increases significantly between the date of loss and the adjustment of the claim, a question arises as to whether the insured or the insurer should bear those additional costs. In practice, the answer mostly depends on the policy wording and on the cause of delay in progressing the adjustment.

Increasingly, these matters are resolved through negotiation on a case-by-case basis, rather than by reference to established judicial authority.

The onshore UAE courts do not operate under a binding precedent system, and there is no concept of a "test case" to settle such issues for the wider market. As a result, each dispute is determined on its own facts, and outcomes can vary. The offshore courts in the DIFC and ADGM apply a common law system and publish judgments that may have persuasive value, but their insurance case law remains limited.

Accordingly, questions of allocation of increased costs arising from claims inflation, and other novel coverage issues, will need to be addressed individually in the UAE.

7.4 Scope of Insurance Cover and Appetite for Risk

Large loss events such as the April 2024 floods have had a noticeable impact on certain classes of business, particularly motor and property. However, the effect has been felt more in the form of premium inflation than in any restriction of the availability of cover. Insurers are adjusting pricing to reflect their higher loss experience and the rising cost of claims, but capacity has not been materially withdrawn from the market.

At the same time, the UAE insurance sector is experiencing a cycle of new entrants and increased capacity, which is driving competition and exerting deflationary pressure on premium levels across a number of lines. The combination of new market participants and strong regulatory oversight has helped maintain a broad appetite for risk.

Accordingly, while there has been some repricing following recent catastrophic events, there has been no significant reduction in the availability of cover in the UAE. Overall, the appetite for underwriting risk remains stable, and the market continues to offer wide cover options across commercial and consumer lines.

8. Emerging Risks

8.1 Impact of ESG on Underwriting and Litigating Insurance Risks

Environmental, social and governance (ESG) factors are increasingly shaping insurers' portfolios and influencing the litigation landscape in the UAE, as the country advances toward its "Net Zero by 2050 Strategy" and broader sustainability commitments.

In underwriting, insurers are placing greater emphasis on climate-related exposures, particularly in high-impact sectors such as construction, real estate and energy. Projects that fall short of environmental standards or demonstrate weak sustainability practices may face elevated premiums or restricted coverage, while those with strong ESG credentials are often rewarded with more favourable terms. Social factors, such as labour welfare, workforce diversity and human rights compliance, are also gaining prominence, especially in workers' compensation and liability lines. Governance considerations, including transparency, ethical conduct and regulatory compliance, are now central to underwriting D&O and PI insurance.

On the litigation front, ESG-related claims, such as greenwashing, regulatory violations and environmental harm, are beginning to surface, prompting insurers to reassess and tighten policy language to mitigate exposure. New ESG reporting requirements from UAE regulators like the Securities and Commodities Authority and ADGM are also encouraging insured entities to strengthen their ESG practices or risk legal and financial consequences.

8.2 Data Protection Laws

The data protection landscape in the UAE is evolving rapidly, significantly influencing how insurers approach both underwriting and litigation. This shift has been accelerated by the introduction of Federal Decree-Law No 45 of 2021 on the Protection of Personal Data ("UAE DPL"), which came into effect in January 2022.

Insurers must now closely evaluate the data protection compliance of insured entities across both onshore UAE and free zones when underwriting cyber, professional indemnity, and D&O policies. Weak data governance or inadequate cybersecurity measures, particularly in data-intensive sectors such as healthcare, education and retail, can lead to higher premiums, coverage limitations, or even denial of coverage.

On the litigation front, the UAE DPL has heightened the risk of claims stemming from data breaches, improper handling of personal data, and violations of data subject rights. This has increased insurers' exposure to third-party liability claims, regulatory penalties, and the early signs of "class-action style" lawsuits (though these are still rare in the region). This has led to more cautious policy drafting, particularly in cyber and liability insurance, with tighter terms and exclusions related to unlawful data processing.

Regulators are actively enforcing compliance, increasing legal risk. As data protection enforcement strengthens, insurers must continually adapt underwriting frameworks and policy wordings to manage emerging data privacy risks.

9. Significant Legislative and Regulatory Developments

9.1 Developments Affecting Insurance Coverage and Insurance Litigation

The following legislative and regulatory developments have significantly affected insurance coverage and insurance litigation in the UAE.

New Insurance Authority Law

In force since 30 November 2023, Federal Decree-Law No 48 of 2023 is now the principal onshore framework for UAE insurance. It consolidates prior rules, places the CBUAE at the centre of regulatory supervision, and licenses the full insurance value chain: insurers, brokers, agents, TPAs and loss adjusters. The law divides business into (i) persons/fund accumulation; and (ii) property/liability, which cannot be combined unless CBUAE approval is obtained. UAE-situated risks should be insured by a UAE-licensed insurer (there is an exception for reinsurance). Policy form rules have been tightened. Arabic policy wording prevails over any other policy translations, key exclusions must be prominent, and electronic issuance of policies is allowed. The power to establish a policyholder protection fund adds a future safeguard, particularly in insolvency scenarios.

New Insurance Ombudsman

Sanadak is the UAE's first financial and insurance ombudsman for consumer policyholder complaints after the insurer's internal process. Following a complaint, Sanadak undertakes a structured, time-bound dispute resolution process (in Arabic or English) and may request information before upholding, partially upholding, rejecting, or escalating a complaint. Following escalation, adjudication of insurance disputes proceeds through a judge-led committee called the IDSRC before limited appeals to the court. Filings before the IDSRC are in Arabic. The IDSRC may appoint experts, and decisions are enforceable unless appealed within a 30-day window to the Court of Appeal. Insurers cannot appeal decisions worth AED50,000 or less (but policyholders can). The new combined ombudsman and committee structure encourages earlier resolution and tighter procedural discipline in coverage and claims disputes.

New Broker Regulations

The Insurance Brokers' Regulation 2024 (effective 15 February 2025) has reshaped distribution and payment flows in the insurance market. Claim payments and premium refunds must be paid directly by insurers to policyholders. Premium collection is now an insurer-only function unless a broker obtains specific authorisation. Any authorised-broker collection must use a segregated insurance account (not a general business account). Commissions/remuneration to brokers cannot be taken from premiums and must be paid within ten business days of receipt (pro-rated for instalments). Only insurers may issue policies or endorsements (with a limited exception for motor certificates). Importantly, brokers cannot act in dual capacities (broker and agent) in the same transaction. The regulation strengthens governance and transparency, reducing settlement handling risks and aligning broker incentives with policyholder protection.

Trends and Developments

Contributed by:
Peter Ellingham, Mehdi Seadon, Rishi Sengupta and Daniel Bunoza
Kennedys

Kennedys is a global law firm specialising in dispute resolution, insurance and advisory services. The firm helps clients mitigate risks and maximise opportunities proactively by adopting an entrepreneurial, realistic and tailored approach. If required, clients have access to a global network of 76 offices, associated offices and co-operations across 36 countries around the world. Kennedys has been established in the Gulf region since 2006, with offices in Oman and the UAE. Its market-leading lawyers have expertise in the relevant local laws as well as extensive practical experience of local market conditions. Kennedys' vision is to be the go-to firm for straightforward expert legal advice, no matter how complex the issue, wherever in the world clients require it.

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Introduction

The UAE insurance market is undergoing a period of rapid legal and operational change. A new federal insurance law has come into effect, and the market is adapting to legal reforms amid continued and rapid economic and population growth. While these new developments remain untested in practice, their direction is clear: more centralised control, stronger accountability and enhanced policyholder protection.

Meanwhile, the April 2024 floods triggered an unprecedented volume of property and motor claims, raising complex issues around coverage, quantification and subrogation. There have been additional developments, including new broker regulations, clearer rules on policy language and form, and court decisions on arbitration and jurisdictional conflicts. Together, these changes are reshaping the way claims are notified, adjusted and resolved in the UAE.

This chapter highlights seven key developments and trends shaping the UAE insurance market. It focuses on the consolidation of insurance laws, evolving regulatory requirements (including broker reforms), and the legal, market and socioeconomic factors influencing how insurance claims and litigation are managed in the region.

1. New Insurance Law

Consolidation of insurance laws

Federal Decree-Law No 48 of 2023 Regulating Insurance Activities (the "Insurance Law") came into effect on 30 November 2023. It now provides the main framework for onshore insurance law in the UAE, consolidating previous legislation and directions relating to insurance.

The Insurance Law does not apply to insurers operating in the financial free zones, the Dubai International Financial Centre (DIFC) and the Abu Dhabi Global Market (ADGM), which are governed by their own regimes. Free-zone insurers are not permitted to insure risks located in the UAE directly, but may participate through reinsurance arrangements.

The Insurance Law brings a more structured and centralised regime, with the Central Bank of the UAE (CBUAE) playing the lead role in regulating insurance companies and related insurance professionals across the insurance value chain.

The Insurance Law addresses not only insurers, but also brokers, agents, third-party administrators (TPAs) and loss adjusters. These roles are now subject to a licensing regime administered by the CBUAE, signalling a firm move towards centralised onshore regulation.

A particularly helpful feature of the Insurance Law is the use of clearly defined terms, which improves how roles, responsibilities and liabilities are understood across the insurance value chain.

Insurance concept

The Insurance Law confirms that insurance is a contract under which the insurer, in return for a premium, undertakes to compensate the insured for a covered risk or to pay an agreed sum, depending on the outcome. This aligns with international practice and reinforces that an insurance policy is not merely a commercial contract but a risk-transfer mechanism with public-interest considerations.

Insurance types

Under Article 4 of the Insurance Law, insurance is divided into two broad categories:

- insurance of persons and fund accumulation operations (eg, life insurance); and
- property and liability insurance (eg, motor, home and commercial lines).

As a general rule, insurers cannot combine life with property/liability business without prior CBUAE approval. This supports clearer market segmentation, solvency discipline and governance.

The roles of insurance professionals

The Insurance Law defines specific players in the insurance market:

- insurance companies – insurers licensed in the UAE, either as a locally incorporated public joint stock company or a branch of a foreign insurer;
- insurance agents who are authorised to act for the insurer to market and conclude contracts – these agents must be licensed and act under the insurer's name and authority; and
- insurance brokers who act in the interest of the policyholder, not the insurer – this distinction is critical; brokers must remain independent and avoid conflicts (eg, they cannot also act as an agent in the same transaction).

Practical takeaways

This formal separation affects duties of care, disclosure responsibilities and potential liability for mis-selling. Intermediaries should now clearly state their role in every transaction, and insurers should verify that agents and distribution partners are properly licensed and not operating in dual or conflicting capacities.

From a compliance and claims perspective, clear role definitions also assist in the event of insurance disputes. Where there is a wording issue, misrepresentation claim or coverage denial, understanding whether the intermediary acted for the insured or the insurer can materially affect how liability is assessed.

More generally, the Insurance Law means insurance professionals should now revisit placement practices, confirm licensing compliance, and be cautious with offshore arrangements or free-zone structures that touch on onshore risks.

Prohibitions on insurance professionals

There are a few important "can't do's" under the Insurance Law:

- Insurers generally cannot combine insurance activities (eg, be an insurer and a broker, or mix life and general business) unless specific approval is obtained.
- UAE-situated property, liabilities or personnel must be insured with a CBUAE-licensed insurer. A narrow exception applies where the local market lacks capacity or expertise and this must be evidenced and properly documented.
- Insurers may reinsure exposures with onshore or offshore reinsurers.

Practical takeaway

Insurers should expect closer regulatory scrutiny of offshore placements and fronting arrangements. They should therefore be clear about when offshore placement is permitted and keep a record explaining any exception used.

Insurance policy form and language

Article 13 of the Insurance Law directly addresses policy form and language:

- Arabic is the default policy language and accurate translations into any other language may be attached. However, in the event of a discrepancy in the interpretation of a policy, the Arabic text will prevail over any other translation.
- Certain classes are exempt from the Arabic-language requirement under Administrative Decision No 140 of 2019, including marine hull, aviation, space, oil/energy, and other international policies required to be issued in English.
- Exclusions that exempt the insurer from liability must be prominent (written in bold and in a different colour) and must be endorsed by the policyholder.
- Onshore policies may be issued electronically.

Practical takeaway
To avoid disputes, it is important to review the Arabic text (particularly for locally drafted contracts and contracts of adhesion), even where an English translation or version is also provided.

Policyholder protection fund
Article 7 of the Insurance Law empowers the CBUAE to establish a policyholder protection fund. If implemented, this could provide additional safeguards for policyholders, particularly in cases of insurer insolvency, with insurers likely to be required to contribute to its financing.

2. New Broker Regulations
The Insurance Brokers' Regulation 2024 took effect on 15 February 2025, replacing the 2013 framework. It significantly reshapes how insurance brokers operate in the UAE. The new regulation aims to improve transparency, reduce the risk of claim payment misdirection, and balance broker incentives and governance with policyholder protection.

The key changes under the regulation include:

- Claim payments and premium refunds – these must be paid directly by the insurer to the policyholder (reinsurance arrangements aside). This is aimed at reducing the perception and risk of any conflict of interest and avoiding delays in remittance.
- Premium collection – this is the insurer's responsibility. Brokers are prohibited from collecting premiums unless they have specific authorisation to do so. Even where authorised, brokers are required to route the funds through a dedicated insurance account system, not a general business account. This is to ensure that premiums are segregated, traceable, and passed on to insurers without delay.
- Commissions/remuneration – these must not be deducted from premiums and must be paid by insurers to brokers within ten business days of the insurer receiving the premium (pro-rated for instalments).
- Policies and endorsements – only insurers may issue these (limited exception for motor certificates if agreed)
- Acting in multiple capacities – brokers cannot act as both broker and agent in the same transaction.

Practical takeaway
The CBUAE is sending a clear message that brokers are advisers and intermediaries, not handlers of client money or decision-makers. Brokers must operate transparently, act solely in the interest of the client, and keep financial and advisory roles strictly separate.

3. New Insurance Ombudsman
Sanadak
Sanadak has been established as the UAE's first financial and insurance ombudsman. It provides a structured, free-of-charge route for policyholders once they have completed the insurer's internal complaint process. Previously, insurance complaints were handled by the Insurance Authority's Insurance Disputes Committee (IDC), which operated as an administrative body within the regulator. Sanadak replaces this system with a more consumer-focused framework.

Under the new regime, most onshore insurance disputes must be referred in the first instance to Sanadak before any proceedings can be commenced in the UAE courts. Sanadak has two levels of dispute resolution:

- first level of review – which is more administrative in nature; and
- escalated cases – cases that cannot be resolved quickly are escalated to the Insurance Disputes Settlement and Resolution Committee (IDSRC) which is more judicial in nature.

Sanadak dispute resolution procedure
The policyholder must first file a complaint with the insurer (the insurer typically has 30 days to respond). This is a strict requirement. Failure on the part of the policyholder to first complete this step can result in dismissal of the complaint by Sanadak.

If the policyholder's complaint with the insurer is unresolved, the complaint can be filed with Sanadak. This can be done in Arabic or English. Sanadak undertakes a preliminary review (usually within ten business days). Sanadak may seek an explanation or further information from the insurer (usually within five days). These

timelines are strict and extensions of time may not be granted.

If the policyholder remains dissatisfied (or where the matter is not within Sanadak's scope) the policyholder can ask for the complaint to be escalated to the IDSRC, even before any determination is made by Sanadak.

Sanadak may otherwise decide within five business days to:

- uphold the complaint;
- partially uphold the complaint;
- reject the complaint; or
- refer the case to the IDSRC.

IDSRC proceedings

When escalated, there is a filing fee and the committee will attempt an amicable settlement before progressing with dispute resolution. This can involve hearings, requests for documents, and the appointment of experts. The IDSRC has the power to appoint experts from the list of professionals registered with the CBUAE.

IDSRC proceedings are in Arabic and can be appealed to the Court of Appeal within 30 days. Previously, IDC decisions were appealed to the competent court of first instance, but this level has now been removed. Insurers cannot appeal awards below AED50,000, but insureds can. Unless appealed, Sanadak and IDSRC decisions are final and enforceable.

4. Jurisdiction Challenge Reforms: New Judicial Authority for Resolving Jurisdictional Conflicts

The UAE operates a dual-court system (onshore courts and DIFC/ADGM courts) with clear geographical jurisdictions. However, in insurance disputes, those lines can blur. For example, an onshore insurer with a DIFC-registered policyholder, or a policy that selects a DIFC forum while the risk and parties are largely onshore. This can drive parallel proceedings, conflicting judgments and forum shopping.

To address this, a new Dubai-based Judicial Authority for Resolving Jurisdictional Conflicts (the "Judicial Authority") was established in April 2024 (replacing the former Joint Judicial Committee). The Judicial Authority is empowered to resolve jurisdictional disputes involving any Dubai judicial body, not just the DIFC and onshore courts. Its mandate is broader and its decisions are final. Once a conflict is referred, proceedings are generally stayed and limitation periods are put on hold until a determination is made. This has a real impact on how and when disputes progress.

Practical takeaway

Given these reforms, insurers and policyholders should review jurisdiction clauses, flag potential crossovers between onshore and DIFC jurisdiction early, and consider procedural strategy carefully.

5. April 2024 Floods: Coverage, Quantification and Subrogation

On 16 April 2024, the UAE faced severe rainfall and strong winds. The rainstorm brought the heaviest rainfall the UAE has recorded in around 75 years, triggering widespread flooding and a surge of property and motor claims. Airports, malls and residential buildings were affected, with follow-on business interruption across the economy. The relevant authorities have announced plans to develop further stormwater drainage infrastructure, but legacy claims and recovery actions continue through adjustment and litigation.

Insured losses were estimated to range between USD1.5 billion and USD2.5 billion. Unsurprisingly, loss quantification became a central theme. The claims also gave rise to a number of coverage issues, including:

- the application of exclusions for "flood, storm or natural peril" or "catastrophe" risks, and the scope of relevant definitions;
- the requirement for material damage to trigger business interruption cover (the "Material Damage Proviso");
- the operation of time-based business interruption deductibles;
- the extent of cover available under "Denial of Access" extension clauses; and
- the application of sub-limits across multiple insured locations.

6. Arbitration Clauses, Authority and Costs: the Current Onshore Picture

Arbitration remains widely used in UAE policies, but signatory authority is a common issue. UAE law requires that the policyholder's representative has specific authority to agree to arbitration and this must be "separately agreed" in writing. The courts are also more hesitant to uphold unilateral option clauses that allow only one party to choose arbitration.

In 2024, the Dubai Court of Cassation partially set aside an award's legal-fees component under the ICC Rules. This has prompted parties to draft clearer cost-allocation clauses in arbitration agreements and to consider institutional rules that expressly empower tribunals to award party costs. Parties seated in the DIFC/ADGM financial free zones also continue to use those courts' tools (including anti-suit injunctions) to protect arbitration agreements and stays. The forum and rules chosen at placement can materially affect enforcement risk later.

7. Warranty & Indemnity (W&I) Insurance in the UAE

W&I adoption continues to rise across Middle East deals, including in the UAE, as sellers seek clean exits and buyers demand recourse for warranty breaches. International insurers and brokers have increased capacity and awareness in the region.

Most UAE deals that use W&I insurance are governed by English law or DIFC law, with disputes routed through to international arbitration or the DIFC courts. This keeps policy construction and claim handling within a common law framework familiar to international insurers in the W&I market. What remains untested is how an onshore UAE court would approach a W&I coverage dispute if a policyholder tried to commence proceedings onshore. For example, because the policyholder is onshore, the loss is manifested onshore, or the insurer/placement involves an onshore element. Potential issues could arise in light of:

- the rule that UAE risks must usually be insured by a UAE-licensed insurer;
- Arabic language requirements (with Arabic text prevailing);
- the mandatory Sanadak dispute resolution process and the availability of experts with W&I experience; and
- a W&I coverage dispute arising in onshore courts.

Practical takeaway

Insurers and policyholders should consider forum/seat selection at policy placement, ensure key transaction documents and policy terms are consistent (including between Arabic and English translations). These efforts will likely reduce the risk of parallel proceedings and procedural challenge.

USA

Law and Practice

Contributed by:
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Contents

Thompson, Coe, Cousins & Irons, LLP (Thompson Coe) has been providing legal services to clients both regionally and nationally for more than 70 years. It has more than 270 attorneys across offices in Austin, Dallas, Denver, Houston, San Antonio, New Orleans, St Paul, New York and Honolulu. The firm is highly recognised for its civil litigation capabilities, and its diverse group of attorneys has the experience, resources and capacity to respond to the multi-service demands of clients across multiple states and industries. Thompson Coe offers comprehensive legal services in the areas of insurance litigation and coverage; products liability; mass torts; property and casualty litigation; labour and employment; business and commercial litigation; professional liability; appellate law; insurance regulation; state legislation; and business transactions, among others. Thompson Coe is recognised as a Band 1 law firm for insurance in Texas in the Chambers and Partners USA 2025 guide.

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Rhonda Thompson focuses on trial work at Thompson Coe on behalf of insurance carriers and on behalf of their policyholders as first chair trial counsel. She represents insurance carriers, both commercial and personal lines, in a variety of coverage-related litigation, declaratory judgment actions, bad faith cases, and carrier-to-carrier disputes. She is sought after to advise on complex coverage-related issues, including business interruption and civil authority matters along with additional insurance issues, shared defence and indemnity obligations, and contractual indemnity. Rhonda is licensed in Texas and New Mexico. She is certified in insurance law by the Texas Board of Legal Specialization.

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1. Rules Governing Insurer Disputes

1.1 Statutory and Procedural Regime

Insurance law in the USA is mainly governed at the state level.

State Legislatures

In the first instance, this involves the state legislature, which promulgates laws related to insurance. These laws form legal frameworks within the state, regulating the development and sale of insurance products, and the conduct of people and businesses in the insurance industry. This body of laws is often referred to and compiled in "codes".

State Agencies

Typically, the legislated code delegates significant authority to state executive officials to develop the regulatory framework in the state. This authority is usually located in an agency, or insurance department, the head of which is often titled the insurance commissioner. The commissioner and regulators flesh out the legislative framework, enacting more detailed policies regarding, for example, the creation and sale of insurance products in the state. A state insurance department also plays a significant role in governing brokers, agents, adjusters, and rating organisations, along with insurers themselves.

The regulation of insurance companies is focused on licensed companies, sometimes referred to as authorised or admitted companies, and can include domestic companies, foreign insurers, or alien insurers. Alien insurers are companies organised under the laws of a foreign jurisdiction. They may be able to obtain a certificate of insurance as a licensed insurer subject to certain trusteed asset and surplus requirements. Surplus lines insurers must typically be authorised in a domiciliary state or country and meet certain capital surplus requirements. A risk retention group is another form of potentially regulated entity. This is a type of captive insurer subject to limited regulation under state law. Finally, some specific types of insurers may not be subject to all types of regulation, such as rate and policy form regulation, and exemptions would be identified in specific statutes in a state exempting such insurers from some laws. These may include farm mutual, county mutual, Lloyd's, reciprocal exchanges, and fraternal benefit societies.

The Courts and Common Law Precedent

In addition to legislative and executive actions, insurance law in the USA is heavily impacted by the judiciary, both state and federal, and the common law precedents they set that can control particular insurance issues and disputes. These include the mechanics of a state's regulatory scheme (the validity and scope of state legislation and regulatory actions), the validity and interpretation of particular policies, and the application of policies to the universe of factual disputes. It is important to note that from state to state, jurisdictions vary greatly in the amount and depth of developed case law available.

Federal Role

Finally, the federal government also influences many aspects of insurance law nationally. For example, in addition to the regulation of US entities generally (particularly securities regulations and disclosure requirements), unique federal insurance issues may arise in relation to certain interstate transportation or maritime operations.

As discussed above, the primary regulation of the business of insurance is by a state department of insurance. The commissioner of that department may be elected or appointed by the governor and the appointment may be subject to confirmation by the state legislature. The state department of insurance regulates forms, rates and the solvency of most types of policies in the state, including most types of property, casualty, life, accident and health, and long-term care insurance.

The state department is typically subject to the input of state legislative committees with jurisdiction over insurance issues. These may include insurance committees and business and industry committees. Of course, the legislature also appropriates funds for the activities of these agencies.

Reinsurance credit and accounting for domestic insurers may be governed by separate legislation and regulations. This includes reinsurance assumed for reinsurers that meet accreditation and certification

requirements, including certain standards adopted by the National Association of Insurance Commissioners (NAIC) and reciprocal jurisdictions in the case of a covered agreement between the United States and European Union.

In some states, the state law enforcement official (eg, the attorney general) may have authority to enforce deceptive and unfair trade practices, as well as the authority to enforce actions against unauthorised insurance. Usually, the state's comptroller is responsible for the reporting and collection and auditing of all insurance taxes.

Writing of Insurance and Reinsurance

In many states, an authorised or licensed insurer must obtain a certificate of authority identifying the lines and types of insurance they are authorised to write. An applicant for a licence will need to demonstrate the competence, fitness and reputation of its officers, directors and other persons having control of the insurer, and officers or directors may not be qualified if they have been convicted of a felony involving moral turpitude or breach of fiduciary duty.

Those applying for a licence or to form a new company must typically demonstrate that the proposed officers, directors or attorney have, in fact, a good record and sufficient insurance experience, ability and standing to make a success of the proposed company.

Minimum capital and surplus requirements are necessary and these may vary by type of insurer (property/casualty, life and health, etc). A state's commissioner may also require larger amounts of capital and surplus depending on the nature of the risks being underwritten or reinsured.

Premium Taxation

Insurance companies must pay taxes on premiums written on risks located in a given state, which can vary widely. Surplus lines taxes may be required to be collected and reported by licensed surplus lines agents, and independently procured insurance obtained by a business must be reported for tax purposes. In addition to premium taxes, a state may impose maintenance taxes, which will vary by line and type of insurance. Foreign insurers are commonly subject to retaliatory taxes for business written in the state based on the tax rate in their state of domicile.

Overseas Firms Doing Business in the Jurisdiction

Alien insurers are able to provide reinsurance as accredited or certified reinsurers in most circumstances and may also qualify as eligible surplus lines insurers. Overseas insurers may qualify for a licence to write business directly, typically by meeting trusteed asset and surplus requirements with assets in the United States. An exception to unauthorised insurance is often made for an insurance contract independently obtained from an unlicensed insurer such as an overseas-based insurer, provided that all the negotiations for such insurance occur outside of the state and the applicable independent, procured premium taxes are paid.

Fronting

Fronting (in 100% quota share reinsurance agreements) is commonly allowed as a type of reinsurance with domestic or licensed insurers. The reinsurer must be solvent and licensed, or meet any accreditation or certification requirements in a given state. Approval for total assumption reinsurance agreements varies across the USA.

Transaction Activity

Approval for the acquisition of a domestic insurer will pay particular attention to any person who will own 10% or more of the stock or have control of a domestic insurer, because of a presumption of control at that level. Investors in publicly held companies that acquire more than 5% of the stock of the publicly held company may be required to file notices with the Securities and Exchange Commission, stating whether their investment is intended to be used for control. Passive investors who file a Schedule 13G filing and reference Rule 13d-1 (b) may be able to overcome a presumption of control without filing a separate disclaimer.

1.2 Litigation Process and Rules on Limitation

Insurance disputes of all kinds are usually resolved through litigation or arbitration. However, since most reinsurance contracts or treaties contain mandatory arbitration provisions, litigation of a reinsurance dispute is unusual in most jurisdictions.

Litigation is commenced when either party to the policy files a complaint or petition in a court of competent jurisdiction and the other party is formally served with a copy of the pleading.

The party that is being sued then has a relatively short time to file a written answer to the other party's allegations. The lawsuit must be filed within a specified time after the dispute arose. That time varies between states from as little as two years to as much as ten years. Statutes of limitations are enforced very strictly. Some policies include a contractual provision identifying the time in which a suit must be brought and the courts will generally enforce these provisions if the contractual time period is not unreasonably short.

Any entity that is either a named insured or an additional insured (either expressly named or identified by group or class) can initiate a lawsuit to enforce its rights under an insurance policy. In most states, a party asserting a claim against an insured cannot file a lawsuit against the wrongdoer's insurer until after the claimant has been awarded a judgment against the insured. However, Alabama, Arkansas, Louisiana, Minnesota, New York, Pennsylvania, Rhode Island and Wisconsin all recognise a claimant's right to file a direct action against the wrongdoer's insurer in some circumstances, with those circumstances varying between the states.

1.3 Alternative Dispute Resolution (ADR)

Mediation has been an integral part of litigation in the United States for several decades, including in insurance disputes. Most courts will either order mediation or strongly suggest the parties consider mediation. Federal courts will sometimes make a magistrate judge available to serve as a mediator at no cost to the parties. In state court, mediation is usually available through a mediation service or a lawyer or retired judge. The cost, which can range from a few hundred to several thousand US dollars a day, is divided among the parties.

2. Jurisdiction and Choice of Law

2.1 Rules Governing Insurance Disputes

Jurisdiction in American courts is composed of two elements: subject matter jurisdiction and personal jurisdiction.

Subject matter jurisdiction is created by the constitutional and statutory provisions of each individual jurisdiction. Since subject matter jurisdiction is a matter of state law, the courts will not allow parties to a contract, including an insurance policy, to create jurisdiction in a court. Personal jurisdiction, which addresses a party's amenability to being sued in a particular location, is not as strict and therefore a party may consent to being sued in a jurisdiction as a matter of private agreement. Therefore, the courts will typically enforce a forum selection clause to which the parties have agreed if the court has subject matter jurisdiction.

The decision of what substantive law will govern an insurance dispute varies between jurisdictions. Some states have statutes concerning what substantive law will apply to certain types of disputes. In the absence of a statute, if an insurance policy contains a choice-of-law provision, a court will usually enforce that provision, although there may be limited situations in which the law of the chosen jurisdiction is so opposed to the public policy of the forum state that one or more provisions of the other state's law will not be applied. If there is no statute or contractual provision, the decision of what substantive law to use is a matter for the court to resolve.

In the past, many courts applied the law of the jurisdiction where the insurance policy was negotiated and delivered, but as state lines have become less important in insurance transactions, most courts have adopted more flexible tests. The most prevalent is the "most significant relationship", in which the court considers various public and private interest factors involving the parties, the location where the claim arose, the nature of the claim, the interest that the states with some connection to the dispute have in the application of their respective laws, and other systems.

These factors are derived primarily from the Restatement (Second) of Conflicts of Laws which identifies the factors a court must consider and includes a specific provision for choice of law in insurance disputes. The test is very subjective and can result in inconsistent decisions between jurisdictions and even between courts in a single jurisdiction. Decisions on jurisdiction, court selection and choice of law all involve legal matters that are resolved by the court.

2.2 Enforcement of Foreign Judgments

Every jurisdiction has its own statutes and rules for the enforcement of judgments. Judgments from another jurisdiction in the United States are entitled to enforcement under the Full Faith and Credit clause in the United States Constitution. To satisfy this obligation, most states (California and Vermont being the exceptions) have adopted all or part of the Uniform Enforcement of Foreign Judgments Act, under which a judgment from another state court or federal court can be "domesticated" in the forum state and then enforced in that jurisdiction. In some states this is as simple as filing an authentic copy of the out-of-state judgment in a state court of competent jurisdiction, providing notice to the judgment debtor.

If the judgment debtor does not file an objection within 30 days, the judgment creditor can enforce the judgment in the state where it has become domesticated. The exact method of filing, giving notice and allowing the judgment debtor to object vary from one state to another. If the judgment debtor does object, it is usually not allowed to attempt to re-litigate the merits of the dispute and is limited to arguing that there was some procedural or judicial irregularity that would make enforcement of the judgment fundamentally unfair. There is no federal treaty for the enforcement of a judgment entered outside the United States but many of the individual states have adopted a variation of either the 1962 Uniform Foreign Money-Judgments Recognition Act or the 2005 Uniform Foreign-Country Money Judgments Recognition Act. In the few states that have not adopted either of these treaties, there are common law methods for enforcement of a non-US judgment, although these may be less efficient or effective.

2.3 Unique Features of Litigation Procedure

One notable feature of the American litigation system is the rampant use of expert witnesses on a wide variety of subjects. Although experts are supposed to be used only when they have special training, expertise or experience on matters that are beyond the knowledge or understanding of a typical juror, parties to an insurance suit may often try to gain a tactical advantage through the use of experts who are known to be especially friendly towards the insureds or insurers.

3. Arbitration and Insurance Disputes

3.1 Enforcement of Arbitration Provisions in Commercial Contracts

Both the federal court system and all state court systems favour arbitration in commercial disputes and the enforcement of arbitral awards. Under the Federal Arbitration Act, which applies to the majority of arbitral awards, a party seeking to enforce an arbitral award must seek confirmation of the award in a court of competent jurisdiction within a year of the arbitral award being made. A court can vacate an arbitral award only if the court determines that:

- the award was procured by corruption, fraud or undue means;
- there was evident partiality or corruption on the part of the arbitrators;
- the arbitrators were guilty of prejudicial misconduct during the course of the hearing; and/or
- the arbitrators exceeded their powers or so imperfectly executed them that a mutual, final and definite award upon the subject matter submitted was not made.

Some states have begun to prohibit or limit mandatory arbitration clauses in some types of consumer insurance policies.

3.2 The New York Convention

The USA has joined the UN Convention on the Recognition and Enforcement of Foreign Arbitral Awards (the "New York Convention") on the enforcement of foreign arbitral awards.

3.3 The Use of Arbitration for Insurance Dispute Resolution

Arbitral awards are routinely enforced in courts throughout the United States in commercial and reinsurance arrangements, but some states are starting to limit the enforcement of mandatory arbitration clauses in certain consumer transactions or statutory causes of action available to individuals. The United States is a signatory to both the New York Convention and the Inter-American Convention on International Commercial Arbitration (the "Panama Convention"), and American courts are very receptive to the enforcement of arbitral awards from outside the United States.

4. Coverage Disputes

4.1 Implied Terms

The interpretation of an insurance policy is normally a question of law for the court to resolve. Insurance contracts are interpreted the same way as other contracts, with two exceptions.

First Exception: Interpretation of a Policy Giving Effect to Provisions

In the first exception, a reviewing court must try to give effect to the intent of the parties as expressed in the contractual language. A court should examine the entire contract and try to interpret the policy in such a way that all the policy provisions are given effect and no policy provision becomes meaningless. The policy language is to be given its ordinary and generally accepted meaning, unless the policy shows that the words were meant to be used in a technical or specialised sense. Courts will sometimes rely on industry custom and practice in interpreting a word that has an established meaning in a certain industry or profession.

A court should not interpret a policy in a way that rewrites the policy by imposing an additional duty or obligation on either the insured or the insurer and the policy. Extrinsic evidence is not allowed to interpret or change clear and unambiguous policy terms. Despite these rules, many courts show a tendency to interpret a policy in a way that is more favourable towards the insured, under the theory that the insurer was the author of the document and should not benefit from any imprecision or inconsistency in the policy language.

A few jurisdictions require that a court interpret the policy with consideration for the reasonable expectations of the insured. One exception arises when there is ambiguity in the policy language. If the insured can offer a reasonable interpretation of the ambiguous language, a court will generally adopt that interpretation even if the insurer can offer a more reasonable interpretation. Extrinsic evidence can be used to help resolve ambiguous language.

Second Exception: When a Policy Provision Is Against State Public Policy

A second exception arises when a policy provision is against the public policy of the state, where the substantive law controls the interpretation of a policy. As an example, some states will not allow an insured who is found liable for punitive damages to escape liability by passing the economic loss to the insurer, and will therefore not enforce a policy term purporting to cover punitive damage claims.

In liability claims, which form a substantial portion of insurance disputes in litigation, the applicable substantive law usually distinguishes between an insurer's duty to defend its insured and its duty to indemnify its insured. The duty to defend is considered a broader duty and is based on analysing the factual allegations in the insured's petition or complaint against the applicable policy terms and conditions. Traditionally, extrinsic evidence was not allowed and an insurer's duty to defend was often resolved on a summary basis without trial. More recently, some jurisdictions have gone outside the language of the documents and have required an insurer to consider facts known to the insurer which would support the existence of a duty to defend. Specific jurisdictions may allow other extrinsic evidence in some circumstances.

The insurer's duty to defend is based upon the actual facts, regardless of the insured's allegations, and a determination of the duty to defend usually cannot be made until the underlying litigation between the insured and the third-party claimant has been resolved.

4.2 Rights of Insurers

An insurer will normally require the insured to complete an application requesting all information the insurer believes it will need to evaluate and underwrite the risk. The insured has an obligation to provide full and complete answers to all the requests from the insurer. It is common for the application to be incorporated into and made a part of the insurance policy. An insurer generally has no affirmative duty to proactively seek information but, in most instances, an insurer will have no ability to avoid coverage based on information in the possession of the insured but not requested by the insurer. This process applies to both consumer insurance contracts and commercial insurance contracts.

If the insured fails to disclose information requested by the insurer during the negotiation of the policy, the insurer can simply decide not to offer a policy to the insured. If the non-disclosure by the insured of information requested by the insurer is not discovered until after the issuance of a policy, the insurer can seek to rescind the policy through a judicial proceeding but, in most jurisdictions, an insurer must show that the non-disclosure was material to the underwriting decision and that the insured intended to defraud the insurer. If the insurer does not become aware of the withheld information until after a claim is made against the insured and the withheld information is material to the risk that resulted in the claim, the insurer can seek rescission but must usually show intent to defraud on the part of the insured. If the withheld information is not relevant to the claim, rescission is usually not available. Since the insurer's scope of coverage is defined by the terms of the policy, any conditions, limitations or exclusions not set forth in the written policy cannot be enforced by the insurer.

Rights Regarding Warranties

American courts have traditionally treated a warranty as a promise in the insurance policy by the insured to either represent that a fact is true or that the insured has agreed it will or will not do a specified act. Whether an obligation in a policy constitutes a warranty is determined by reading the policy as a whole and the obligation does not have to be denominated as a warranty to be treated as a warranty. Instead, the focus is on whether the policy language as a whole shows that one party intended to rely upon the truth of a representation made by the other party.

The consequences of a breach of warranty vary depending on the materiality of the representation to the loss or claim. The effect of a misrepresentation by an insured must be material to the claim or loss at issue. In extreme cases, breach of a warranty by an insured can relieve the insurer of any obligation under the policy.

To alleviate the especially harsh consequences that may result from some types of breach of warranty, many states, either by statute or by judicial precedent, will not allow a breach of warranty by the insured to relieve the insurer of its duties unless the misrepresentation expanded the risk covered by the policy, or the insurer can establish fraud on the part of the insured.

Historically there has been some lack of consensus as to whether a policy provision should be treated as a warranty, a condition, or a coverage term. The growing trend in American courts is to give greater weight to the substance of a policy term than its title. Therefore, although a policy provision may be placed in the conditions section, a court may interpret the provision as a warranty, a coverage term or an exclusion. Despite the label, implied warranties are disfavoured and are seldom recognised.

Duties Imposed on an Insurer

In consumer policies and some commercial policies, state statutes or state court judicial duties may impose duties on an insurer (such as a duty to perform a thorough investigation before making a claims decision or an obligation to pay within a certain time once coverage becomes reasonably clear) that act much like a warranty. The consequences of the breach of a condition vary due to a variety of factors. In many jurisdictions, an insurer's breach of what may be considered a condition precedent, such as a duty to give timely notice or to co-operate with the insurer's investigation, may be excused if the insurer has not been prejudiced by the breach. Generally, conditions are enforced more strictly against an insurer than against an insured.

4.3 Significant Trends in Policy Coverage Disputes

See **5.3 Trends in the Cost or Complexity of Litigation**.

4.4 Resolution of Insurance Coverage Disputes

Federal or State Court?

The American court system is complex and often confusing. There is a federal court system consisting of federal district courts, a limited number of appellate courts, and a single Supreme Court. The federal courts have limited jurisdiction and this is generally over:

- claims involving a federal statute or right; and
- disputes between citizens of different states or between a United States citizen and a foreign entity or person where the amount in controversy is in excess of USD75,000.

There is a general feeling that a federal judge (who is appointed for life) may be less protective of local interests than a state judge (most of whom are elected), so insurers generally prefer federal court to state court.

It is quite common for an insurer to file a claim in a federal court seeking a declaration of rights and obligations under the policy when a disputed claim arises. If an insured files a suit in state court, the insurer has 30 days in which it can remove the case to federal court if the amount in controversy and the citizenship of the parties satisfy the minimum jurisdictional requirements of the federal court. As a result, the petition or complaint filed in smaller consumer claims will include statements about the citizenship of the parties or the amount in controversy in an attempt to prevent the case from being removed to federal court.

The Litigation Process

Each of the 50 states, plus the District of Columbia and American territories and dependencies, has its own judicial system and the litigation processes can vary substantially. In broad strokes, once an insurance suit is filed, there will be an initial period where the defendant, either the insurer or insured, can challenge the court's jurisdiction or the legal sufficiency of the plaintiff's pleading. If the case survives this phase, the parties will begin taking discovery. Many states now require the parties to exchange certain relevant information before additional discovery beings.

Discovery can consist of:

- depositions of witnesses (either orally or in written questions);
- interrogatories served upon the opposing party asking about facts known to the party and legal positions taken by the party;
- requests that the opposing party produce documents in its possession, custody or control that are relevant to the dispute;
- requests that the opposing party admit or deny certain facts;
- site inspections of property; and
- physical or mental examinations of a party if the party's physical or mental health is in issue.

Additional discovery methods may be allowed in some jurisdictions. The discovery process often becomes very contentious in litigation and the parties may seek judicial intervention to resolve the dispute, although must judges expect the parties to resolve these types of disputes amicably. The ability and the intention of judges to intervene in these disputes varies greatly across the country.

At any time during the case, although usually after substantial discovery, a party may seek dismissal of the case through a procedure known as summary judgment, in which the party can try to convince the court that there are no material facts in dispute, that the applicable law is in favour of the moving party, and that the case should therefore be terminated. If the case is not resolved on summary judgment, the case will proceed to trial on the merits.

In most jurisdictions, either party can request that the factual disputes in the case be presented to a jury for resolution. Insureds often request a jury on the assumption (sometimes well founded) that the average jury will not be favourable to an insurer. After the trial, the parties will submit proposed judgments to the court and the court will prepare and sign the court's judgment. The losing party will usually have the right to appeal the judgment to the first-level appellate

court as a matter of right but any higher appellate review is discretionary with the higher court. It is worth bearing in mind that procedures will vary substantially between the various states.

4.5 Position If Insured Party Is Viewed as a Consumer

If a state considers insureds as "consumers" – typically under "bad faith" or extra-contractual statutes such as "deceptive trade practices" – an insurer may be liable for penalty sums for certain actions. See **4.7 The Concept of Bad Faith**.

Consumer policies tend to be more highly regulated than commercial contracts or reinsurance contracts and many of the forms and provisions in a consumer policy are either mandated by or must be approved by the appropriate state regulatory party. Despite this, there is no appreciable difference between the rules applicable to additional beneficiaries under a consumer policy and the rules applicable to a commercial policy. There is insufficient precedent on additional beneficiaries under a reinsurance contract to draw general rules.

4.6 Third-Party Enforcement of Insurance Contracts

There are multiple ways in which someone other than an original insured can obtain rights under an insurance policy. Firstly, either at the time of the negotiation of the policy or after the policy is issued, an insurer may agree to add additional persons or entities as named insureds under the policy. These named insureds generally have the same policy rights as the original insured. Secondly, a policy may allow for the protection of additional insureds, either by specifically naming the additional insureds or by describing a class or group of additional insureds (such as an endorsement in a policy issued to a contractor extending coverage to all parties the insured is contractually obliged to name as additional insureds, or a renter's policy that provides additional coverage to the owner). These additional insureds may not have the same scope of coverage as the named insured, depending on the scope of coverage contained in the policy naming or identifying the additional insured. (As an example, a renter's policy may limit the additional coverage to damage caused by the tenant but not to damage caused by the owner.) In homeowner, property, or similar policies, a lender, mortgagor, or lienholder may be protected through a loss payable clause that directs payment to the protected party instead of the named insured in some instances. In all these situations, the insurer may request information from the insured about the intended beneficiaries and the insured is obliged to give full and complete answers. Implied beneficiaries tend to be disfavoured and are not often allowed. An insured who wants to protect additional parties through a policy should make that intention clear to the insurer, and make sure that intent is reflected in the policy language.

4.7 The Concept of Bad Faith

An insured often attempts to impose extra-contractual liability ("bad-faith" liability) upon an insurer for alleged irregularities in claims handling. Most jurisdictions now have comprehensive statutory schemes imposing certain obligations on an insurer in handling and resolving a claim. A successful insured can recover amounts beyond the policy limits in some situations, but there is great variation between the states on what extra-contractual penalties can be imposed.

4.8 Penalties for Late Payment of Claims

Most jurisdictions have statutory or regulatory timelines dictating when an insurer must make a claims decision and make payment to the insured. The amount of the penalty varies between states but can be as much as 18% per annum on the amount that was wrongfully withheld or was delayed in payment.

4.9 Representations Made by Brokers

In the consumer market (also known as the personal lines market and primarily involving home, auto, health, and life insurance), an insurer may use an exclusive agent who is acting on behalf of the insurer but the agent may also have duties of honesty and disclosure to the insured. In other consumer policies, the insured may use the services of an independent agent who may be acting on behalf of the insurer in performing some duties, but be acting on behalf of the insured in performing other duties.

The duties of an agent vary from state to state but generally include duties of honesty and an obligation to obtain the insurance requested by the insured or to

explain to the insured why the coverage is not available. An agent for the insured usually does not have a duty to recommend coverage or explain policy terms to an insured. If an agent assumes those duties, the agent is obliged to perform them as a reasonably prudent agent would do.

4.10 Delegated Underwriting or Claims Handling Authority Arrangements

In commercial policies, especially those involving non-admitted surplus lines carriers or London market entities, the common practice is for the insured to retain the services of a retail broker to act on its behalf and for the insurer to retain a wholesale broker to act on its behalf. In commercial policy negotiations, there is little direct contact between the insurer and the insured or its retail broker, or between the insured and the insurer or its wholesale broker.

5. Claims Against Insureds

5.1 Main Areas of Claims Where Insurers Fund the Defence of Insureds

Insurer funding for defence of an insured naturally arises most commonly in the context of liability policies, such as commercial general liability, D&O, and certain package policies. It is important to note that in some instances the defence costs may reduce or "erode" the overall policy limits, leaving few funds for indemnification.

5.2 Likely Changes in the Future

These contractual defence obligations are standard and unlikely to change in the near future.

5.3 Trends in the Cost or Complexity of Litigation

The US has seen an uptick in wrap-up (or wrap) policies in the construction industry, which allow general contractors, for a higher premium of course, to "wrap" all their subcontractors under the general contractor's policy. With fewer parties actively involved in the litigation, the general contractor and its insurer then have greater control over the costs and resolution of the case.

5.4 Protection Against Costs Risks

Litigation Funding

Litigation funding (LF) has caught the eye of legislatures and courts alike. LF is used frequently by plaintiffs' attorneys, is on the rise, and is often not known about by defendants. Conservative estimates put the LF industry at USD2.3 billion, although the Swiss Re Institute suggests it is much higher. The loans can be provided to litigants or attorneys. The Government Administration Office defines LF as "an arrangement in which a funder that is not a party to a lawsuit agrees to provide nonrecourse funding to a litigant or law firm in exchange for an interest in the potential recovery of the lawsuit". Telltale signs of LF include unusually high medical specials (especially in soft tissue injuries); medical treatment for seemingly unrelated conditions; treatment by providers outside of their specialisms; accelerated medical treatment; and location of medical treatment.

The LF investors include a range of parties, from private equity groups to individuals. The non-recourse nature of the funding is what distinguishes LF from a traditional loan. Interest, not surprisingly, is attached to recovery. LF exists in commercial/corporate contexts (IP, antitrust, asset recovery, fraud, and class actions on behalf of large corporations) and is used by large law firms, as well as in the large personal injury/mass tort arena. LF also exists in the consumer arena, but the loans are typically small and used by plaintiffs to fund living expenses or medical treatment, as opposed to funding litigation. Consumer recipients have drawn the most attention from state legislatures due to the greater potential for abuse.

Downsides to LF

The downsides to LF include:

- with no personal stake in a case, the "money down" makes the funding deal similar to a bet at a casino;
- LF could put plaintiffs in a position that a reasonable offer to settle cannot be accepted because the financial obligations of the loan cannot be met;
- accidents should not be investment opportunities because this perverts the justice system;
- LF can promote and prolong litigation because defence counsel is forced to divert additional time

and money away from productive defence of the case;
- if the funder holds the purse strings, the funder may exert control over litigation strategy to the plaintiffs' disadvantage;
- a defendant should be entitled to know whether unnecessary medical procedures are being promoted by a funder to increase case value; and
- a defendant wants to know whether a lien exists to be satisfied.

Upsides to LF

Not surprisingly, the proponents of LF contend:

- disclosure of LF is unnecessary and irrelevant;
- LF shifts the risk of adverse litigation outcomes and because it is non-recourse, the funder's and plaintiff's interests are aligned;
- LF to a law firm benefits the client by providing the resources necessary to provide the best experts, etc, needed for the case; and
- a plaintiff could benefit by not settling early because the attorney could not afford a lengthy, expensive lawsuit.

Other issues of concern are the potential conflict of interest between a client and their attorney if the attorney puts the funder's interest ahead of the client's interest. The attorney's ability to maintain independent professional judgment is an additional consideration.

On the federal level, the Litigation Funding Transparency Act was presented to Congress in both 2018 and 2021, and was not passed on both occasions. Under the proposed act, disclosure of LF and the agreement itself were required in federal class actions and multidistrict litigation.

Response From the Legislature

Nevertheless, some federal courts have taken notice and require disclosure of LF (but not the agreement itself) by local rule. These are: District of Arizona; Central District and Northern District of California; Middle District of Florida; Northern District and Southern District of Georgia; Northern District and Southern District of Iowa; District of Maryland; Eastern District and Western District of Michigan; District of Nebraska; District of Nevada; Eastern District, Middle District and Western District of North Carolina; Eastern District, Western District and Northern District of Oklahoma; Middle District of Tennessee; Northern District and Western District of Texas; Western District of Virginia; and Western District of Wisconsin. The Third, Fourth, Fifth, Tenth and Eleventh Circuits of the federal appellate courts have also adopted local rules.

While state legislatures primarily seek to protect consumers, the courts have a differing perspective. The existence of LF alerts the court to:

- issues best addressed in pre-trial conferences;
- aids in compliance in the matter of financial disclosures and recusal obligations;
- potential conflicts of interest; and
- who should participate in settlement conferences due to potential resolution issues.

As mentioned above, some states have addressed LF by statute or common law with mixed results, including: Delaware, Illinois, Kentucky, Maryland, Minnesota, New Jersey, North Carolina, Ohio, Pennsylvania, Texas, Utah, West Virginia and Wisconsin. Even the United States tax court has jumped in, holding that although LF payments are structured as loans, including the non-recourse payments makes them "income" rather than a "loan" for tax purposes. Therefore, it is a good idea for attorneys to consider tax and accounting implications for their clients.

Insurers should expect LF to continue in one form or another. Some states may refrain from legislation, but the courts will likely start implementing their own local rules to address issues surrounding the disclosure of LF and possibly even the LF agreement itself. Additionally, the courts may issue opinions where statutes or the existence of LF at least raises issues of fairness for defendants, to understand what factors may be at play in order to further resolution.

The Alternative Risk Transfer (ART) Market

The USA insurance market also includes the alternative risk transfer (ART) market. In this market, companies purchase coverage and transfer risk outside traditional commercial insurance mechanisms. This may include the following:

- risk retention groups (RRGs);
- insurance pools;
- captive insurers;
- risk mitigation provided by wholly owned subsidiaries of a company;
- contingent capital;
- derivatives; and
- insurance-linked securities.

The ART market is primarily delineated between risk transfer through alternative products and risk transfer through alternative carriers.

6. Insurers' Recovery Rights

6.1 Right of Action to Recover Sums From Third Parties

Most consumer and commercial policies expressly recognise an insurer's right of subrogation against the wrongdoer once a claim is paid. Some jurisdictions also recognise common law subrogation rights in favour of the insurer, but those rights may be based on equitable or other considerations, so a contractual subrogation right is preferred.

6.2 Legal Provisions Setting Out Insurers' Rights to Pursue Third Parties

There are two important limitations on an insurer's subrogation rights. Firstly, in the absence of an express contractual provision, an insurer usually cannot exercise that right against its own insured because to do so would undercut the exact risk transfer which is the purpose of insurance. Secondly, in many types of policies, such as construction liability policies, an insurer will be asked to waive its subrogation rights and a provision to that effect will be included in the policy, either as a term of the original policy or as an endorsement. The insurer may charge a higher provision for waiving subrogation.

7. Impact of Macroeconomic Factors

7.1 Type and Amount of Litigation

Regarding climate and natural disaster risks, insurers and related institutions appear to be experimenting with a variety of responses:

- reorganising, or at least re-thinking the way they see themselves as many policyholders do – ie, as "financial safety nets";
- increasing reliance on technology for better evaluation of climate-related issues on classification, underwriting and rating of risks; and
- reorientating customer-facing services to take a more active role in risk prevention (additionally, such risks may push a new demand for and increase in industry consolidation).

7.2 Forecast for the Next 12 Months

Climate change and the attendant insurance risk are likely to continue to be a focus in the near future.

7.3 Coverage Issues and Test Cases

No truly seminal cases in this area have taken root at this time.

7.4 Scope of Insurance Cover and Appetite for Risk

These factors have also led some carriers to pull out of certain markets, especially coastal regions like California, Texas and Florida.

8. Emerging Risks

8.1 Impact of ESG on Underwriting and Litigating Insurance Risks

There has been a slight potential for pull-back by the insurance industry on some ESG considerations in the past year. However, insurtech, or "the innovative use of technology in connection with insurance", unsurprisingly continues to be a topic at the forefront of the insurance industry's attention. Issues to monitor include:

- innovations in improved customer experiences, particularly among established insurance businesses;
- consolidation and the blending of automation and analytics technologies; and
- data-driven ESG analysis and risk exposure.

These are in addition to trends such as embedded insurance, accelerated learning and artificial intelli-

gence, which will continue to play an important role going forward.

Regulators nationwide are naturally keeping a close eye on insurtech developments. These include traditional concerns regarding consumer protection, capital and reserve requirements, and solvency evaluations. But this will also push regulatory bodies further into new territories of digital data privacy, cybersecurity and AI. For certain states, ESG considerations will also play an increasingly important role.

8.2 Data Protection Laws

Data use and security, and climate and natural disaster risk have continued to be the leading risks and areas for concern in 2025. While many states, and the federal government in some cases, are taking an active role in guiding and developing protections or guard rails for these issues, many other jurisdictions are allowing more experimentation. The use of AI in the classification, underwriting and rating of risks is one such area.

9. Significant Legislative and Regulatory Developments

9.1 Developments Affecting Insurance Coverage and Insurance Litigation

Florida Tort Reform

Perhaps one of the most notable changes affecting insurers writing policies in Florida moving forward will be the significant tort reform enacted by the Florida legislature in 2023. Florida is one of the most litigious jurisdictions in the US, and the tort reform was intended to quell some of that litigation by giving businesses and insurers greater protection against lawsuits. The legislation was directed at tort claims, and some enactments were directed at bad faith in insurance. The legislation applies to causes of action accruing on or after 23 March 2023. Some of the changes are enumerated below.

One major change was to Florida's comparative fault scheme. While Florida had been a traditional, "pure" comparative negligence state, the legislation aligns Florida with the majority of other states having a "modified" scheme. Under the old scheme, a plaintiff was entitled to recover a percentage of the damages proportionate to the degree of fault of the defendant. Now, if a plaintiff's percentage of fault is more than the defendant's percentage of fault, the plaintiff cannot recover. The change, however, does not apply to medical negligence.

Another noteworthy change is that the legislation reduced the limitations period for general negligence claims. The limitations period for general negligence is now two years instead of four years.

Possibly looking to the Texas statutory model, Florida modified the admissible evidence available to prove past and future medical expenses. Previously, a plaintiff could board the entire amount of the medical bills charged for the services rendered. Evidence of adjustments or reductions by healthcare insurers was prohibited. Now, generally, evidence presented to prove past damages for medical expenses is limited to the amounts actually paid, regardless of the source of payment. Admissible evidence varies with the existence of healthcare coverage, Medicare, or Medicaid. Importantly, if past medical care was obtained under a letter of protection, evidence of what health insurance would have paid for the necessary treatment, plus a plaintiff's share of the expenses, is now admissible. Moreover, a letter of protection must be disclosed, overruling *Worley v Central Florida YMCA, Inc*, 228 So. 2d 18 (Fla. 2017).

Premises liability claims involving negligent security also received attention. Under the new legislation, a jury can now consider the fault of all persons contributing to an injury, including a non-party who injured the plaintiff by committing a crime on the defendant's property.

Florida legislation also addressed insurer bad faith. Significantly, a claimant, an insured, or their representatives have the duty to act in good faith in providing information to insurers, making demands, setting deadlines and making settlement attempts, and a fact finder may consider it bad faith to reduce the damages awarded. Also, the legislation clarified that mere negligence cannot support a finding of bad faith against an insurer. An insured's statutory entitlement to recover attorneys' fees upon prevailing against an

insurer has been eliminated, except in declaratory judgment actions to determine coverage. The use of non-contingency multipliers to calculate attorneys' fees is now prohibited.

While the impact of these enactments must make their way through the Florida courts, the number of baseless lawsuits in the bodily injury arena should decrease. For those suits that go forward, insurers and defendants should have a more level playing field.

The Illinois Supreme Court Turned the Tables for Construction Defect Coverage

Illinois courts for over 20 years have interpreted the standard commercial general liability (CGL) definitions of "occurrence" and "property damage" to refuse coverage for faulty construction. However, a new day has arrived for contractors, owners and developers, to the detriment of insurers – see *Acuity v M/I Homes of Chicago, LLC*, No 129087, N.E.2d (Ill. 30 November, 2023). Previously, Illinois courts generally found coverage only in the event of damage to other real property or the personal property of owners.

The underlying lawsuit was filed by a townhouse owners' association for breaches of contract and the implied warranty of habitability against the general contractor/successor developer/seller of the townhouses. The association generally alleged that the general contractor's subcontractors used defective materials, caused faulty workmanship, and failed to comply with building codes. The damage alleged was uncontrolled water leakage and moisture in locations of the buildings where it was not "intended or expected" and causing resulting property damage to the townhouses and other property – such as windows and patio doors, as well as damage to the interior of the units.

The general contractor tendered its defence as an additional insured under a subcontractor's policy, which denied and filed a declaratory judgment action. The general contractor argued that the association merely alleged "the natural and ordinary consequence of defectively performed work", which was not an accident, and therefore, not an "occurrence". The insurer further urged that the association only sought economic loss – the cost of repairing and replacing the defective construction work, which was not "property damage". The association countered that damage to "other property" was alleged beyond the repair and replacement of the faulty work, meaning "property damage" caused by an "occurrence" existed, implicating the insurer's duty to defend.

The trial court found in favour of the insurer, concluding that property damage resulting from faulty work was not an "occurrence" because it was a natural and ordinary consequence of the construction project and not an accident as required under the policy. While the trial court agreed that damage to other property was sufficient to implicate coverage, it found that was not the case before it, which focused on recovering damages to the townhouses and not damage to other property.

On appeal, the parties agreed that Illinois law found coverage only in the event of damage to other real property or personal property of owners. The appellate court agreed with the parties' interpretation of Illinois law but criticised and questioned that approach because it focused on the courts' analyses driven by broad policy considerations and not by policy language. Nevertheless, the appellate court was duty bound by precedent, but reversed the trial court conclusion that the association had sufficiently pleaded damage to other property, triggering a duty to defend.

The Illinois Supreme Court granted leave to appeal. The Supreme Court noted upfront that it had "not yet analysed the specific coverage provisions at issue here in the context of a construction defect case, but the issue has been the subject of much litigation in the appellate court". Like the intermediate court, the Supreme Court recognised the multitude of opinions in which the issues of "occurrence" and "property damage" were decided and the various reasons for their holdings, while acknowledging that the opinions were based on policy considerations rather than contract construction. Accordingly, the court reasoned that it would not begin by analysing the parties' premises but would first return to legal principles to bring clarity and provide a disciplined legal framework.

Following a discussion of Illinois law on the duty to defend and the construction of policy language, the

court turned to the insurance agreement. The court gave little discussion to the meaning of "property damage" pointing out that tangible property suffers a "physical injury" if the property is "altered in appearance, shape, color or in other material dimension". Since the allegations against the general contractor sufficiently alleged "property damage" to the interior of the units by leaks and moisture damage, the requirement was met.

With respect to an "accident", the court indicated that no opinions had interpreted its meaning in the context of construction defects. In accordance with contract construction law, the first court reviewed "accident" interpretation by courts in other contexts, followed by the dictionary definition. The court then held that "the term 'accident' in the policies at issue reasonably encompasses the unintended and unexpected harm caused by negligent conduct".

Applying that definition to the construction defect allegations before it, the Supreme Court noted that the association did not allege intentionally performed substandard work. Instead, according to the court, the allegations reflected inadvertent construction defects. The court concluded this despite the insurer's assertion that any portion of a completed project caused by faulty work can never be an accident because it is always the natural and probable risk of doing business. The court addressed that assertion by pointing out that the notions of business risk were specifically expressed in the exclusions of the policy. Therefore, the court held that the duty to defend was implicated and remanded the case to the trial court to address the effect of the exclusions on the duty to defend.

The importance of this new opinion to insurers writing general liability coverage in Illinois is that it is likely to increase the number of construction defect lawsuits in which the insurers must defend. What should be surprising to insurers is that in a state like Illinois, no Supreme Court precedent existed in such a commonplace claim until now.

Trends and Developments

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Thompson, Coe, Cousins & Irons, LLP (Thompson Coe) has been providing legal services to clients both regionally and nationally for more than 70 years. It has more than 270 attorneys across offices in Austin, Dallas, Denver, Houston, San Antonio, New Orleans, St Paul, New York and Honolulu. The firm is highly recognised for its civil litigation capabilities, and its diverse group of attorneys has the experience, resources and capacity to respond to the multi-service demands of clients across multiple states and industries. Thompson Coe offers comprehensive legal services in the areas of insurance litigation and coverage; products liability; mass torts; property and casualty litigation; labour and employment; business and commercial litigation; professional liability; appellate law; insurance regulation; state legislation; and business transactions, among others. Thompson Coe is recognised as a Band 1 law firm for insurance in Texas in the Chambers and Partners USA 2025 guide.

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Artificial Intelligence (AI)

AI presents both huge upsides and downsides to the insurance industry. The benefits are obvious: reduced operating costs after recovery of investment, more precise underwriting and profitability, more efficient claims handling – including the ability to identify high-risk claims earlier in the process – improved investment analytics, and streamlined compliance reporting. While most insurers are positive about a dramatic increase in the use of AI technology, the industry has been somewhat slow in transferring to a more AI-centric business model. The reasons include uncertainty about what regulations will be put in place, concern that the technology is improving so rapidly that such a major investment should be postponed until technological development slows, difficulty in integrating AI elements into existing IT systems, concerns about data privacy and security, and the reluctance of some older executives to embrace the new technology.

Lack of access to sufficient data is also offered as a justification for the delay in transition, but tools such as blockchain technology and the Internet of Things may provide substantial help in gathering and ordering data.

For now, most companies seem willing to slowly adopt AI, and will probably not make major investments until the technology is better established.

Climate Change and Natural Catastrophes

Between 1980 and 2010, the United States experienced an average of five severe natural catastrophic events a year. That annual average grew to 15 between 2011 and 2022 and reached 28 events in 2023. The impact of those events on underwriting profitability, reserve adequacy, and funds available for investment has been immense. Many carriers are no longer writing coverage in areas such as Florida and California. Their departure leaves some risks uninsured and others covered by non-admitted carriers, with resulting higher premium costs.

The number of severe weather events is universally expected to continue this upward trend and the pressure on property, health, and live insurers will continue to increase. Both investors and regulators are demanding that carriers gain a greater understanding of their climate risk exposures and develop business models to prepare for sudden and unanticipated changes in climate patterns.

Personalised Insurance and Customer Service

As consumers' daily lives become more digitally controlled, insurance consumers want the purchase of insurance and the resolution of claims to be as simple as ordering a shared ride or having dinner delivered to their door. The insurance industry was forced to move in this direction by the pandemic and the digital focus on customer interaction will continue.

One of the consequences of greater access to consumer data is what some insurers are calling "personalised insurance": a fully automated process that begins with a more individualised analysis of an insured's needs, includes more comprehensive risk-management advice, advances to a policy that is more customised to the individual insurer, and provides a data-driven claims process.

Insurtech

The combination of increased AI capability and greater consumer individuality has led to a new type of insurer known as an insurtech company. Insurtech is premised on the belief that the insurance industry is ripe for innovation and disruption through technology innovations designed to make the current insurance model more efficient and priced more competitively. According to Grand View Research, the total global insurtech industry value in 2022 was USD5.45 billion. The revenue forecast for 2030 is USD152 billion. Insurtech insurers are facing some resistance from established insurers and from some regulators, but most observers agree that the insurtech market will continue to grow dramatically over the next few years.

Embedded Insurance

Embedded insurance is coverage that is directly related to the purchase of an item, such as having the option to buy cellphone insurance as part of the purchase of a mobile phone or having travel insurance added when an airline ticket is purchased. In a 2023 survey by Chubb, a global insurer, 81% of financial executives involved in purchasing insurance products expressed the opinion that embedded insurance will

move from a "nice-to-have" option to a "must-have" necessity.

Nuclear Verdicts

Nuclear verdicts – awards that are much higher than expected based on the facts of the case – continue to grow at an alarming rate. A survey by Marathon Strategies found nuclear verdicts, which totalled USD4.9 billion in 2020, grew to USD18.3 billion by 2024, an increase of 370%. The median nuclear verdict increased by 92%, from USD21.5 million to USD41.1 million, over that same period.

There is some suggestion that this dramatic rise in verdicts is fuelled by successful plaintiffs' attorneys whose use of AI and other analytic tools identifies particular cases and venues where the possibility of a substantial verdict is more likely. Whatever the source, the carriers' response is an increased effort to determine cases with the potential for a nuclear verdict at an early stage in the claim handling or litigation process.

Litigation Funding

Litigation funding, in which a third party such as a private investor, a partnership, or a hedge fund, provides money to a plaintiff or plaintiff's counsel to finance the costs of litigation. The funder receives an agreed percentage of the recovery, whether through trial or settlement, but receives nothing if the litigation is unsuccessful. One study found that the amount of litigation funding grew by more than 400% from 2012 to 2017 and the practice has continued to grow since then. The Institute for Legal Reform estimates that there is USD15.2 billion in commercial litigation investments in the United States alone.

The practice is highly controversial. Its proponents assert that litigation funding provides better resources to claimants and makes justice more accessible to litigants. Opponents liken the practice to bankrolling a gambler at a casino and creating multiple conflicts between claimant, lender and attorney. Some legal scholars have raised concerns that the practice is a form of champerty, an English law doctrine that prohibits third parties from providing financial assistance to a claimant in return for a piece of the recovery. That is still the law in England and in many American jurisdictions, although in a more relaxed form in some states. The use of litigation funding is largely unregulated and its legality and ethical propriety remain undetermined.

Cybersecurity

Cybersecurity issues present both an opportunity and a risk for the insurance industry. The opportunity lies in the potential to prevent adverse consequences from cybersecurity attacks and data breaches. This is a risk that can be quantified and insured against and that continues to grow. Ransomware attacks increased by 77% in the first quarter of 2023 and the entire cybersecurity market is expected to triple in size between 2022 and 2027. That growth could be even greater as the level of geopolitical strife continues and one or both of the contentious parties seeks a financial or an information advantage.

The other side of the coin is the risk of loss to an insurer who is the victim of a cybersecurity breach. For many of the same reasons that the increased use of AI will reshape how insurance companies do business, the risk of a data breach or other security invasion will increase for insurers and other businesses.

Attorney-Client Privilege

The attorney-client privilege is designed to protect from disclosure certain confidential communications between an attorney and their client relating to legal advice. The privilege is a concept of the law of evidence and is derived from statutory and common law in all 50 states. It is the oldest recognised privilege in US jurisprudence and traces its origins back to the reign of Queen Elizabeth I in 16th century England. However, not all communications between an attorney and a client are protected by the privilege. Generally, the communication must be (1) seeking legal advice; (2) from a legal professional in their capacity as such; (3) related to that legal purpose; (4) made in confidence; and (5) by the client.

Despite the central importance of the privilege, recent years have seen erosion. A few representative cases are discussed below.

In-house counsel

Travelers Prop. Cas. Co. of Am. v 100 Renaissance, LLC, 308 So. 3d 847, 857 (Miss. 2020), reh'g denied (14 January 2021)

In *Travelers*, the Supreme Court of Mississippi addressed whether the attorney-client privilege was waived when a disclaimer letter was drafted by the insurer's in-house counsel and sent under the adjuster's signature. The court said "yes". After denial of a claim, the insured sued Travelers for bad faith and deposed the adjuster. In the transcript, the adjuster disclaimed any knowledge of the statute, saying:

"I'm not an attorney. I don't know anything about statutes. That's what we have General Counsel for. I deal with policy language, what's in the policy."

Ultimately, the Supreme Court of Mississippi held that the adjuster's testimony put the attorney-client privilege at issue, waiving the privilege. Her testimony was bereft of any knowledge or information as to why the claim was denied. The decision was based primarily on the fact that the second denial letter was written after in-house counsel's involvement and was signed by the adjuster. The court noted that, "Generally, it may be expected that the person who signs the letter has personal knowledge of the matters set forth in the letter." Furthermore, the court found that the adjuster lacked the necessary personal knowledge:

"Travelers sent the denial letter to Renaissance in an effort to explain its arguable and legitimate basis to deny the claim. The letter was signed by [the adjuster]; but based on her deposition testimony, it clearly was prepared by someone other than [the adjuster], most likely [in-house counsel]. If so, [in-house counsel] did not act as legal counsel and give advice to [the adjuster] to include in the denial letter. Instead, the denial letter contained [in-house counsel's] reasons to deny the claim. [The adjuster's] signature was simply an effort to hide the fact that [in-house] counsel, not [the adjuster] had the personal knowledge of Travelers' reasons to deny the claim and to use the attorney-client privilege as a sword to prevent Renaissance from discovering the reasons from the person who had personal knowledge of the basis to deny the claim.

"Because the claims handler relied substantially, if not wholly, on in-house counsel to prepare the denial letter, then the reasoning of in-house counsel should be discoverable."

Anderson v Trustees of Dartmouth College 2020 WL 5031910 (D. New Hampshire 25 August 2020)

In this case, an expelled pro se college student obtained discovery of numerous documents the college withheld as privileged. The plaintiff asserted a variety of claims against Dartmouth College after he was expelled. In discovery, he filed a motion to compel hundreds of documents Dartmouth withheld on the grounds of attorney-client privilege. Rather than mechanically protect the documents as a default, the court delved into them and, after dividing them into four groups, found some documents discoverable despite the privilege.

- Group 1 were emails in which an attorney in General Counsel's office provided legal advice to another Dartmouth employee outside of the General Counsel's office. To the extent these emails contained curtained threads of forwarded emails between the plaintiff and the college, these emails were discoverable.
- Group 2 were emails between an attorney in the General Counsel's office and a staff member of that office. Again, unless any actual legal advice was provided, these communications were discoverable.
- Group 3 were emails between two or more employees that an attorney in the General Counsel's office was later copied into. Emails between non-lawyers merely forwarded to the college attorneys were discoverable along with emails sent to groups of college recipients, including both lawyers and non-lawyers.
- Group 4 emails between non-attorneys that discussed legal advice given by an attorney were discoverable, although not the actual legal advice.

Saran v Chelsea GCA Realty Partnership, 174 A.D.3d 759 (Supreme Court NY 2019)

In this litigation, the defendants inadvertently disclosed to the plaintiff certain confidential and allegedly privileged emails, including emails between the defendant's CEO and in-house counsel. In the discov-

ery dispute, the court noted, "because the attorney-client privilege obstructs the truth-finding process, its scope is limited to what is necessary to achieve its purposes" and "because in-house counsel may serve other company roles, with mixed business and legal responsibility, and their involvement in the company may blur the lines between legal and nonlegal communications, there is a heightened need to apply the privilege cautiously and narrowly in the case of in-house counsel, lest the mere participation of an attorney be used to seal off disclosure". With this harsh view of the privilege, the court ruled that the communications related more to the business of the defendants than legal issues and therefore the privilege did not apply.

Counsel Actions During Claim Investigations

*Curtis Park Group, LLC v Allied World Specialty Ins. Co., 20-CV-00552-CMA-NRN, 2021 WL 4438037, at *7 (D. Colo. 28 September 2021)*

In *Curtis Park Group*, the court held that an insurer's outside counsel could be deposed, as the court concluded that he had been "a key person in the claims investigation process". In a Colorado coverage action, the deposition of Allied World's coverage counsel was sought. Because the coverage counsel was also Allied World's defence counsel, the court considered a three-part test: "where the party seeking to take the deposition has shown that: (1) no other means exist to obtain the information other than to depose opposing counsel; (2) the information sought is relevant and nonprivileged; and (3) the information is crucial to the preparation of the case". Applying these factors, the court ultimately allowed the deposition despite the attorney-client privilege. As to the first element, other available means, the engineer's oral report and communication between coverage counsel and Allied World regarding the reservation of rights was not completely contained in prior discovery and depositions. As to the second and third elements, the information sought was crucial because "what the insurer knew and when it knew it is crucial to resolving" an insurance bad-faith claim. Allied World needed to explain how it concluded that a construction defect caused the deflection, and how the engineer's evidence, conclusions and communications informed the denial letter. The Colorado authority therefore held that when an attorney acts as a claims adjuster, the communication is not protected by either attorney-client privilege or work product doctrine.

*Canyon Estates Condo. Ass'n v Atain Specialty Ins. Co., No. 2:18-CV-1761-RAJ, 2020 WL 363379, at *1 (W.D. Wash. 22 January 2020)*

In *Canyon Estates* (W.D. Wash. 20 November 2019), the court held that Great Lakes Insurance Company, SE, did not rebut the Washington state presumption that "there is no attorney-client privilege relevant between the insured and the insurer in the claims adjusting process". In the coverage action after a denial, the magistrate held that Great Lakes did not rebut the presumption to attorney-client privilege or work-product doctrine because claims counsel was retained long before litigation and drafted the initial and subsequent denial letters. The magistrate held that the claim file up to and including the date of the second denial was not protected and discoverable. Great Lakes maintained that its outside counsel was kept separate from the claim investigation and did not participate in the claims-handling functions. The court disagreed. The disclaimer letter had been drafted by the insurer's outside counsel, and the district court found that "assisting an adjustor in writing a denial letter is not a privileged task". The court also held that work-product protection did not apply because Great Lakes was not added to the lawsuit until after the letters were drafted. Thus, after an in-camera review, the district court held that information related to the drafting of the declination letters and the deposition of the drafting counsel was permitted under the statutory presumption.

*Otsuka America, Inc. v Crum & Forster Specialty Ins. Co., 2019 WL 4137024, at *2 (Sup. Ct. N.Y. 30 August 2019)*

In *Otsuka America, Inc.*, communications between Crum & Forster and its outside counsel (including the attorney's coverage opinion letter) were not privileged because determining whether a claim is covered is "part of the regular business of an insurance company" and happened prior to the date Crum & Forster disclaimed coverage. The documents were also not work product because "attorney work product only applies to documents prepared by counsel acting as such, and to materials uniquely the product of a lawyer's learning and professional skills, such as those

reflecting an attorney's legal research, analysis, conclusions, legal theory or strategy", and which have a supporting attorney affidavit. It was therefore concluded that in determining coverage, counsel categorically acted as investigators not attorneys.

Tort Reform

State-by-state tort reform also continues to alter the risk and exposure landscape. Florida provides the most recent example. One major change was to Florida's comparative fault scheme. While Florida had been a traditional "pure" comparative negligence state, the legislation aligns Florida with the majority of other states having a "modified" scheme. Under the old scheme, a plaintiff was entitled to recover a percentage of damages proportionate to the degree of fault of the defendant. Now, if a plaintiff's percentage of fault is more than the defendant's percentage of fault, the plaintiff cannot recover. The change, however, does not apply to medical negligence.

Another noteworthy change is that the legislation reduced the limitations period for general negligence claims. The limitations period for general negligence is now two years instead of four years.

The Florida legislation also addressed insurer bad faith. Significantly, a claimant, an insured, or their representatives have the duty to act in good faith in providing information to insurers, making demands, setting deadlines, and settlement attempts, and a fact finder may consider evidence of bad faith to reduce the damages awarded. Also, the legislation clarified that mere negligence cannot support a finding of bad faith against an insurer. An insured's statutory entitlement to recover attorneys' fees upon prevailing against an insurer has been eliminated except in declaratory judgment actions to determine coverage. The use of non-contingency multipliers to calculate attorneys' fees is now prohibited.

Multiple Claims – Multiple Insureds – Bankruptcy

The Fifth Circuit's opinion last year in *Law Office of Rogelio Solis, PLLC v Curtis*, 83 F.4th 409 (Fifth Circuit 2023) and its procedural aftermath and appeal will likely affect the way insurers in Texas have long understood their potential Stowers obligations and exposure in liability claims in which there are multiple plaintiffs (typically with multiple counsel representation) and not enough liability insurance.

Following an appeal from the bankruptcy court's decision against the insurer, the federal district court certified a question to the Fifth Circuit: was "Whether the pre-petition payment of insurance proceeds to a tort claimant creditor of a debtor constitutes a 'transfer of an interest of the debtor in property' under 11 U.S.C. § 547 when such payment is made by an insurer of the debtor pursuant to a valid Stowers settlement demand under Texas law." The Fifth Circuit answered the question affirmatively, but left unanswered, for claimants and insurers alike, the dilemmas presented by finding that liability policy proceeds paid to avoid Stowers exposure under *Texas Farmers Ins. Co. v Soriano*, 881 S.W.2d 312 (Texas 1994) belong to a policyholder's bankruptcy estate.

The *Solis* facts are straightforward. The insured, Josiah's Trucking LLC ("Josiah's"), owned a tractor-trailer that collided with a vehicle in which Carlos Tellez ("Tellez") and Anna Isabel Ortiz ("Ortiz") were riding. Both were killed in the accident. Tellez and Ortiz were each survived by wrongful death beneficiaries, the Tellez family and the Ortiz family.

Josiah's was insured for USD1 million by Brooklyn Specialty Insurance Company RRG, Inc. ("Brooklyn"). Both families engaged counsel and began the claims process, with the Ortiz family engaging the Law Firm of Rogelio Solis, PLLC ("Solis") and the Tellez family engaging Escobar & Cardenas, LLP. The Tellez family engaged in settlement discussions with Brooklyn and filed suit. The Ortiz family, however, made a Stowers demand to Brooklyn for the policy limits, which Brooklyn accepted and then transferred the proceeds to the Solis IOLTA account. On the same day, Brooklyn informed the Tellez family that the policy limit had been exhausted. Approximately one week later, the proceeds were distributed to the Ortiz family and Solis.

The following week, the Tellez family commenced an involuntary bankruptcy against Josiah's. The trustee then commenced an adversary proceeding against the Ortiz family and Solis seeking to avoid and recover the transfer of the Brooklyn policy proceeds under the Bankruptcy Code. Solis and the Ortiz family moved

to dismiss the adversary proceeding contending that the trustee failed to allege a transfer of the debtor's property because Josiah's had neither legal title or a contractual right to receive the policy proceeds, and otherwise lacked control over their disbursement.

The bankruptcy court denied the motion, first concluding that the trustee's complaint, alleging over USD8 million of potential claims from the accident in light of the USD1 million policy limit, satisfied the "limited circumstances" in which a debtor may have an equitable interest in liability insurance proceeds such that they can be classified as property of the estate, citing *In re OGA Charters, LLC*, 901 F.3d 599 (Fifth Circuit 2018). The bankruptcy court then considered whether the pre-petition payment affected the debtor's equitable interest in the proceeds, concluding it did not.

In the Fifth Circuit, Solis argued that the district court's conclusion that the debtor held an equitable interest in the policy proceeds was incorrect because the debtor had no legal or equitable rights to the policy proceeds under Texas law, disputing *OGA*. The Ortiz family and Solis went so far as to argue that *OGA* must have been incorrectly decided based upon Texas law regarding an insured's right to liability policy proceeds. The Fifth Circuit, however, emphasised that it was bound by the "well-recognized rule of orderliness", and therefore, must follow circuit precedent. The Fifth Circuit emphasised that the *OGA* opinion did not bestow a debtor the right to pocket the proceeds but served to reduce claims and permit a more equitable distribution of available assets in the liquidation of the estate.

While the Fifth Circuit did not address *Soriano*, the court was forced to admit that in *OGA* the policy proceeds had not been disbursed, and the court had not answered the question of whether the transfer of proceeds could be avoided under Section 547 of the Bankruptcy Code. Nevertheless, the court reasoned that Section 547 (b)'s use of "an interest of the debtor in property" means "property that would have been part of the estate had it not been transferred before the commencement of bankruptcy proceedings". The court found that the policy proceeds would have been the property of the estate at the time the petition was filed if they had not been transferred. Accordingly, the court affirmed the opinion of the bankruptcy court.

Notably, following the Fifth Circuit's refusal to rehear the matter en banc, the *Solis* parties requested a direct appeal and filed a Petition for Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit on 14 May 2024. The trustee waived a response, but the Supreme Court nevertheless requested a response on 11 July 2024, which was filed on 12 August 2024. It was distributed for conference at the court for 30 September 2024.

The Supreme Court has been addressing insurance issues that end up in the bankruptcy courts in its opinions this year. This may signal the potential for the court to solve not just the *Soriano* issue, but also when, if ever, liability policy proceeds will be considered part of the bankruptcy estate.

The Louisiana legislature passed tort reform legislature targeting the state's insurance crisis on 28 May 2025 when Louisiana Governor Jeff Landry signed a package of bills constituting substantial tort reform, particularly with respect to automotive claims. In a press conference announcing the reforms, Governor Landry cited both increasing insurance profits and "a cultural problem of frivolous litigation" as drivers of reform. The measures signed include the following:

HB 148: Insurance Commissioner Authority

This grants the insurance commissioner greater authority to regulate insurance rates.

HB 431: Comparative Fault

This bars drivers responsible for at least 51% of an accident from receiving a damage award to cover their injuries. This is a departure from Louisiana's current comparative fault scheme.

HB 434: No Pay No Play

This increases the threshold for uninsured motorists to collect damages, from USD15,000 to USD100,000.

HB 436: Undocumented Immigrants

This prohibits undocumented immigrants who are injured in car accidents from collecting general damage awards.

HB 450: Housley Presumption

This requires plaintiffs in car accident claims to show that the injuries actually occurred during the accident.

Louisiana's legislature significantly revised the Direct-Action Statute, which impacts how insurers may be sued directly in the state.

In 2024, Governor Landry signed into law a bill that limits the situations in which a plaintiff can assert a direct claim against a defendant's insurer under Louisiana's Direct Action Statute, LSA – R.S. 22:1269. It also included new provisions relating to joinder of an insurer after settlement or final judgment. It includes specific provisions of notice to an insurer of an action and outlines the procedures and timelines for how insurers assert reservation of rights or denial of coverage.

Under the prior version of the law, a tort plaintiff could bring suit against an insurer jointly and in solido with its insured. The new law provides that a tort plaintiff "shall have no right of direct action against the insurer" unless at least one of the following exceptions applies:

- the insured files for bankruptcy in a court of competent jurisdiction or when proceedings to adjudge an insured bankrupt have been commenced before a court of competent jurisdiction;
- the insured is insolvent;
- service of citation or other process has been attempted without success, or the insured defendant refuses to answer or otherwise defend the action within 180 days of service;
- when the cause of action is for damages as a result of an offence or quasi-offence between children and their parents or between married persons;
- when the insurer is an uninsured motorist carrier;
- when the insured is deceased; or
- when the insurer is defending the lawsuit under a reservation of rights, or the insurer denies coverage to the insured, but only for the purpose of establishing coverage.

With respect to an insurer's obligations, the new law provides that an insurer that denies coverage is required to provide written notice of reservation of rights to assert a coverage defence to the named insured at their last known address by US postal mail or other similar tracking method, commercial courier, or by hand delivery, within 90 days after the liability insurer makes a determination of the existence of a coverage defence, but not later than 30 days before trial.

The Act also includes new provisions that allow for the joinder of an insurer after settlement or in connection with a final judgment. The new law does not prevent a plaintiff from resolving a claim of coverage against one insurer while preserving a claim against another insurer of the same defendant in the cause of action. It provides that the filing of an action against an insured interrupts prescription for all insurers whose policies provide coverage for the claims asserted in the action.

Also of note, the new law prohibits inclusion of the name of an insurer in the caption of the suit, and prohibits the court from disclosing the existence of insurance coverage to the jury or mentioning coverage in the jury's presence unless required by Louisiana Code of Evidence Article 411.

Colorado Bad Faith Law Allows Reasonable Reliance on Expert Opinions

El Dueno, LLC v Mid-Century Ins. Co., No. 24-1000 (Tenth Circuit Ct App, 30 May 2025)

On 30 May 2025, the Tenth Circuit Court of Appeals affirmed summary judgment in favour of the insurance carrier, holding that Mid-Century's reliance on an independent engineering report – despite conflicting internal estimates – did not constitute unreasonable conduct under Colorado's bad faith statutes.

The court believed that the policyholder, El Dueno, failed to present sufficient evidence that Mid-Century's denial was objectively unreasonable, particularly given that the engineering report provided a legitimate basis for denying further payment, and dismissing the claims.

This commercial property dispute arose from a hail damage claim made by El Dueno, LLC after a storm allegedly damaged the roof of its property. Mid-Century initially estimated the replacement cost value at USD22,372.44 and issued a payment of USD12,384.54 after applying depreciation and the deductible. Later,

El Dueno submitted a significantly higher contractor estimate of over USD343,000, including code compliance upgrades. In response, Mid-Century obtained a report from an engineering firm concluding that no hail damage had occurred. Based on that report, the insurance company denied coverage for any additional roofing repairs.

El Dueno filed suit under Colorado's statutory bad faith law, asserting that Mid-Century's denial was unreasonable and relied on a flawed investigation. This matter focuses on the carrier's use of conflicting internal and external reports and raises important issues regarding the reasonableness standard for claim denials under Colorado law.

Cosmetic Damage Endorsement Battles Continue

Rajiv Ivenagar v Liberty Insurance Corp., 5:21-cv-01091-FB (W.D. TX – San Antonio Div) December 2024

The wordings and scope of cosmetic damage endorsements and exclusions continue to foster battles over ambiguity and the scope of these limitations in the arena of metal roofing cases. Generally, these endorsements exclude coverage for "cosmetic loss or damage" to metal roof materials but the devil is in the policy language and claim details.

In *Ivenagar*, the endorsement in question excludes coverage when the cosmetic loss or damage altered the physical appearance of "metal materials" but did not result in penetration of water through all "metal materials" or there was no evidence of failure of all the "metal materials" to perform their intended function. "Metal materials" were defined as "all metal roofing materials that are part of the dwelling; or all metal materials that are part of an other structure". In response to the carriers' motion for summary judgment, *Ivenagars* relied upon two experts, a materials engineer and a structural engineer. Both were of the opinion that hailstones impacted the metal materials causing functional damage because the water penetrated through the zinc coating into the steel substrate of the roof panels. One expert opined that 40% of the zinc coating's life was lost. The court found this was insufficient to show all metal roofing materials failed. However, the court then analysed whether there was any evidence of hailstorm-caused leaks. Based upon fact witness testimony, the court found a fact question regarding whether there was a leak to the metal roof and if so, whether the leak was caused by hail damage. Ultimately, the court denied the carriers' motion as to breach of contract and extra-contractual claims after a thorough review of each word of the cosmetic damage endorsement and whether the expert and fact witness testimony created a genuine issue of material fact as to the endorsement's application.

Proving Federal Court Jurisdiction – a Step at a Time

Federal courts have become more demanding in maintaining their jurisdiction based upon diversity of citizenship and the amount in controversy. The focus is turning on the proof of each element of diversity jurisdiction and at each phase of the litigation. In the past, parties have relied upon the allegations contained in pleadings as binding judicial admissions sufficient to support the federal court's diversity jurisdiction. This practice is, however, being tested. In *Ivan Nunez v Prime Ins. Co.*, the court considered whether the summary judgment record contained evidence to support diversity jurisdiction. The court reminded the parties that under 28 U.S.C.§ 1332 and Fifth Circuit Court of Appeals authority, allegations at the pleading stage and evidence at the summary judgment and trial stages to support the citizenship of each party is required – see *Megalomedia Inc. v Philadelphia Indemn. Ins. Co.,*115 F.4th 657 (Fifth Circuit 2024). The *Nunez* court provided guidance on the type of evidence demonstrating a litigant's intention to establish domicile, that is, place of voting, paying taxes, owning property, location of bank accounts, club memberships and churches, along with places of employment and residence.

The *Nunez* court eventually allowed the party invoking the court's jurisdiction a brief period to supplement its summary judgment briefing and the record with evidence of diversity of the parties.

USA – FLORIDA

Trends and Developments

Contributed by:
Maria Elena Abate, Matthew C Scarfone and Fernando J Valle
Colodny Fass

Colodny Fass is a boutique law firm with offices in Tallahassee and Sunrise, Florida representing admitted and non-admitted insurance companies, reinsurers, managing general agents, premium finance companies, surplus lines brokers, claim adjusting firms, investors and self-insured entities in complex legal, legislative, transactional and regulatory matters. The firm is intimately involved with the insurance industry, and its 12 attorneys and government consulting division keep their fingers on the pulse of Florida's insurance market. Its regulatory and transactional practice serves as a critical partner for insurance start-ups and seasoned players alike, seeking to enter the market or expand their offerings and jurisdictional footprint. The firm's complex litigation division routinely handles class actions, declaratory judgment actions, bad faith claims, fraud claims, administrative hearings and broker and agent E&O matters. Representative clients include Chaucer Syndicates Limited, J.S. Held and GEICO.

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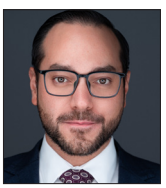
Matthew C Scarfone is a shareholder in the litigation division at Colodny Fass and handles all types of civil litigation, with a special focus on insurance matters, including property insurance disputes, liability coverage opinions, bad faith actions, fraud investigations, complex commercial disputes and class actions. He also advises clients on compliance and best practices. He frequently presents at conferences, webinars and other engagements on emerging issues affecting the insurance industry. As a certified continuing education instructor with the Florida Division of Insurance Agent and Agency Services, he provides continuing education on coverage, statutory compliance, best practices, bad faith and fraud prevention and detection.



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"I Can See Clearly Now" – Analysing Florida Insurers' Good Faith Obligations in the Face of "Clear" Liability Post Tort Reform

Bad faith in the insurance context arises when a carrier fails to act with the same degree of care and diligence as a person of ordinary care and prudence would exercise in the management of their own business, when handling claims brought by a third party against an insured. For a third-party bad faith claim, a liability insurer's bad faith exposure is triggered when:

- damages are likely to exceed policy limits; and
- the insured's liability is "clear".

Under such circumstances, the carrier is obligated to attempt to settle the matter within policy limits or to proffer policy limits to the claimant. But what is the definition of "clear", and when does an insurer have to make the determination?

When does a determination need to be made?

The 2023 amendments to Section 624.155, Florida Statutes, state that a third-party bad faith action may not lie if the insurer tenders the lesser of policy limits or the amount demanded within 90 days of "receiving actual notice of a claim which is accompanied by sufficient evidence to support the amount of the claim". This amendment was enacted in response to case law that required an insurer to initiate settlement in the absence of a demand in some cases. The question of whether or not payment of limits is required, once a demand is received, still turns on whether liability is "clear" when notice is received and the amount in question is above limits.

Prior to tort reforms enacted by Florida Legislature in 2023, the "when" could be as early as a few weeks after an insurer was notified of a potentially covered incident, even when no demand for limits (or otherwise) had been made. Rather, the insurer had an affirmative duty, upon receipt of the notice, to investigate possibilities of settlement and initiate settlement discussions. The 2023 amendments to section 624.155, Florida Statutes, sought to alleviate the potential for a bad faith set up. That statutory provision now states that a third-party bad faith action shall not lie if the insurer tenders the lesser of policy limits or the amount demanded within 90 days of "receiving actual notice of a claim which is accompanied by sufficient evidence to support the amount of the claim".

The legislative reforms were intended to allow for a more meaningful analysis, by providing a "safe harbour" period of 90 days after an insurer received "actual notice of a claim that is accompanied by sufficient evidence to support the amount of the claim". See Florida Statutes Section 624.155 (4)(a)(2023). During that 90-day period, no bad faith action, whether brought pursuant to Section 624.155 or under the common law, will lie for causes of actions filed after 24 March 2023.

Is it clear enough?

As to what constitutes "clear" liability, Florida courts had, on a case-by-case basis, held that clear liability meant something more than "possibly" being liable; and generally entailed circumstances where the insured's responsibility for the loss was evident and uncontroverted, or so well established that a reasona-

ble insurer, when viewing all the evidence know to the insurer at the time in question, would conclude that liability was inevitable if the case proceeded to trial. Think, for example, of an inebriated driver proceeding the wrong way on a highway and colliding into another vehicle, causing catastrophic injuries. In such a situation, most reasonable persons would understand that liability for the accident was "clear". Further, in such a situation, the claimant's injuries would likely exceed the policy limits, triggering the duty to proffer limits. Importantly, the existence of "clear" liability, as defined in Florida jurisprudence, stripped an insurer's ability to delay or negotiate a settlement for something less than policy limits, if the damages were known to exceed or would likely exceed policy limits, as doing so would put the insurer's financial interest ahead of the insurer's obligation to act in the best interest of its insured.

A decision to watch

The Eleventh Circuit's recent decision in *Kinsale v Pride of St. Lucie Lodge 1189, Inc.* introduces new language around what constitutes "clear" liability in the bad faith context. Whereas earlier Florida precedent focused on whether liability was evident based on facts known to the insurer at the time, *Kinsale* suggests that a jury may consider whether liability was a "likely possibility" based on information the insurer knew – or should have known – through further investigation. Thus, plaintiffs' attorneys will likely rely on *Kinsale* to argue that carriers are obligated to act on information not actually provided during claim handling, potentially shifting how "clear" liability is argued in future cases. This retroactive approach has the effect of diluting the clear liability threshold set by *Powell* and invites jury speculation about an insurer's mindset based on information acquired only after litigation began. As Judge Lagoa warned in her dissent, the *Kinsale* decision has imposed liability "based on information that was not and could not have been known to the insurer at the time". Going forward, the trial bar will likely cite *Kinsale* in support of broader bad faith theories.

While the full effect of *Kinsale* remains to be seen, the decision is already drawing attention from practitioners and commentators because it gives plaintiffs' attorneys new ground to argue that liability can be deemed "clear" even where factual disputes or defences exist. In practice, this means *Kinsale* may be cited in bad faith cases outside of the negligent security context, as claimants attempt to broaden its logic to automobile, premises and products liability claims. At a minimum, the opinion underscores the importance of insurers carefully documenting their investigative efforts during the safe harbour period and beyond, so that the record reflects both what was known and what steps were taken to obtain additional information. By doing so, carriers can place themselves in the best possible position to rebut arguments that they "should have known" more than they actually did at the time.

At the same time, *Kinsale* highlights an unresolved tension in Florida bad faith law: how far an insurer's obligations extend when liability is not obvious, but instead depends on developing facts, intervening actors or contested legal theories. By framing "clear liability" in terms of what the insurer might have uncovered with additional investigation, the decision blurs the line between hindsight and contemporaneous judgment. That uncertainty is why plaintiffs' attorneys are likely to test *Kinsale's* reasoning in a variety of contexts, particularly those involving complex causation questions.

Expanding consequences

Another potential consequence of *Kinsale* is that the plaintiffs' Bar will cite the case to expand the "foreseeable zone of risk" in negligent security cases beyond what presently exists under Florida law. Before *Kinsale*, a property owner's duty to guard against third-party criminal acts arose only when the risk was known or reasonably foreseeable – see, eg, *McCain v Florida Power Corp.*, 593 So. 2d 500, 503 (Fla. 1992). *Kinsale* muddies the risks insurers and their policyholders must manage by introducing a retrospective "should have known" standard. This has the potential to invite litigation over whether every missed fact or unpursued lead could transform a case into "clear" liability in retrospect.

But the Eleventh Circuit's holding in *Kinsale* conflicts with Florida case law. For example, in *Brownlee v 22nd Avenue Apartments, LLC*, 389 So. 3d 695, 699 (Fla. 3d DCA 2024), the court rejected liability for a

shooting in an adjacent alley, holding the owner neither created the hazard nor had notice of it. *Brownlee* affirmed that foreseeability must be judged based on facts known beforehand – not in hindsight. *Kinsale's* departure from that principle by delving into what the carrier "should have known" invites plaintiffs' attorneys to encourage juries to impose bad faith without actual knowledge of clear liability, and could expand exposure for insurers and premises liability defendants alike.

Kinsale also conflicts with *Demelus v King Motor Co. of Fort Lauderdale*, 24 So. 3d 759, 762 (Fla. 4th DCA 2009), where the court declined to impose liability on a dealership whose locked vehicle was stolen and crashed. The court held no duty existed because the defendant had not created a foreseeable zone of risk and rejected expert testimony about additional security. Foreseeability alone, it emphasised, is not enough – liability cannot rest on hindsight or speculation. Plaintiffs' attorneys will likely rely on *Kinsale* to invite juries to infer bad faith from the absence of clairvoyance.

The Florida Supreme Court has long cautioned against evaluating insurer conduct with hindsight. In *Harvey v GEICO General Insurance Co.*, 259 So. 3d 1, 7 (Fla. 2018) the Florida Supreme Court reiterated that "[t]he question of whether an insurer acted in bad faith… must be determined under the 'totality of the circumstances'", but emphasised that this inquiry must be based on facts actually known to the insurer during claim handling, not those discovered later in litigation. *Kinsale's* approach – shifting attention to information uncovered only after litigation began – complicates that framework. Going forward, plaintiffs may seize on *Kinsale* to argue for broader duties in both negligent security and bad faith cases, while insurers will need to consider how this evolving standard could shape claims investigations in factually complex cases.

Insurers should consider proffering policy limits in situations in which liability is not just a "given" but in which liability may be likely foreseeable. This means that adjusters, who are trained to rely on formulas, actuarial tools and documentation to estimate the "value" of a claim, must be extra-vigilant not to undervalue the total exposure, particularly in cases involving pain and suffering, mental anguish or permanent injury. These subjective damages must be closely analysed through evaluation of prior judgments and verdicts in similar cases. Further, the inquiry into what constitutes "clear liability" cannot be stagnant. Rather, facts must be reassessed consistently, and the need to proffer readdressed, as the claims investigation continues.

One step forward, two steps back

Kinsale's broadening of bad faith exposure comes against the backdrop of the Legislature's 2023 reforms, which were designed to curb gamesmanship and provide greater predictability. In fact, the in 2023 tort reforms where specifically designed to curb the misuse of bad faith claims as a litigation strategy. The statutes introduced meaningful guardrails such as reciprocal good faith obligations, a 90-day safe harbour period and a clarification that bad faith cannot arise from mere negligence. The real-world consequences of bad faith litigation abuse – precisely what the 2023 reforms aimed to address – are well-documented. A 2024 report by the Insurance Information Institute noted that although Florida accounts for just 8% of national insurance claims, it generated over 75% of all insurance-related litigation in the years preceding the reform. Nine insurers became insolvent over a two-year period, and Citizens Property Insurance Corporation's policy count more than doubled between 2018 and 2022. During that time, the average Florida homeowner's premium climbed to USD4,231 – nearly triple the national average.

The reforms enacted in H.B. 837 and S.B. 2A were intended to reverse these trends. Early results suggest they are working: Florida's defence and cost containment expense (DCCE) ratio – a key indicator of litigation burden – declined from 8.4% to 3.1% following passage of the reforms. See Section 624.155 (4)(a), Florida Statutes (2023). These outcomes underscore the Legislature's intent to impose balance and predictability in the claims process.

Florida's bad faith framework has always walked a fine line between holding insurers accountable for unreasonable claims handling and avoiding hindsight-driven liability that distorts the claims process. The Legislature's 2023 reforms were a deliberate recali-

bration – creating a defined safe harbour, clarifying reciprocal good faith duties and aiming to reduce gamesmanship. Kinsale, however, points in a different direction. By allowing liability to be framed around what an insurer "should have known", it departs from the traditional focus under Florida law on the facts known to the insurer at the time. While the majority's opinion leaves many questions unanswered, it may encourage plaintiffs to argue that insurers must go further and act faster than before – even in the absence of a demand.

How far *Kinsale* will reach remains to be seen. The opinion has already drawn attention because it may invite greater jury scrutiny of insurers' investigative decisions, and plaintiffs' counsel are likely to cite it in support of expanded theories of bad faith. At the same time, Florida precedent has long cautioned against hindsight-based liability, and courts will have to reconcile *Kinsale* with those principles.

That tension – between *Kinsale's* hindsight-inflected standard and Florida's long-standing guardrails – will likely frame the next wave of litigation. It can be expected that plaintiffs will test the decision aggressively, citing it in contexts far removed from the facts of the case, while insurers will seek to cabin its reach by pointing to earlier authority such as *Powell*, *Harvey* and *Farina* s. Florida's appellate court's will ultimately be called upon to clarify whether *Kinsale* represents a true doctrinal shift or a fact-specific, federal outlier. Until then, the case sits at the intersection of evolving statutory reform and common-law precedent, raising as many questions as it answers.

In short, *Kinsale* adds a new wrinkle to Florida's already complex bad faith landscape. For now, insurers should treat it as a decision to watch closely: one that may be tested in future cases, but whose long-term impact will depend on how Florida courts interpret and apply it in practice.

Looking ahead

The *Kinsale* decision underscores the unsettled and evolving nature of Florida's bad faith jurisdprudence. By shifting attention towards what an insurer "should have known", the opinion introduces uncertainty into an area that legislative reform sought to stabilise. While plaintiffs' attorneys will likely seize on *Kinsale* to broaden bad faith theories, Florida courts still have a deep body of precedent emphasising that liability must be judged based on facts actually known during the claim investigation, not with the benefit of hindsight.

For insurers, the key takeaway is vigilance. Claims investigations should be thorough, well-documented and continuously reassessed as new information emerges. At the same time, carriers should not assume *Kinsale* has rewritten the rules across the board. Its ultimate impact will depend on whether Florida courts adopt its reasoning or distinguish it as an outlier.

In the end, *Kinsale* adds another wrinkle to an already complex area of law. As Florida courts continue to reconcile recent statutory reforms with longstanding common-law principles, insurers and their counsel should follow these developments closely. The balance between fair claim resolution and hindsight-driven liability remains delicate, and how courts strike that balance in the wake of *Kinsale* will shape the state's insurance market for years to come.

USA – MARYLAND

Trends and Developments

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Funk & Bolton, PA is a Maryland-based law firm that focuses extensively on the representation of the insurance industry in legislative, regulatory and litigation matters. This comprehensive approach to the insurance industry provides the firm with a unique perspective on Maryland insurance law. The firm's commitment to the insurance industry is supported by several significant Maryland Supreme Court decisions influencing the direction and scope of Maryland insurance law.

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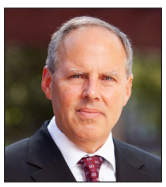

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Identifying and Avoiding the Perils of Maryland Insurance Law

The Insurance Commissioner and the People's Insurance Counsel Division (PICD)

Maryland insurance litigation is different from that of most states due to the impact of the regulatory environment on administrative insurance litigation. The Maryland Insurance Commissioner (the "Insurance Commissioner") is charged with the authority and duty to enforce the Maryland Insurance Article. The Insurance Commissioner is authorised to conduct the examinations and investigations necessary to fulfil that purpose.

In addition to direct regulation by the Insurance Commissioner, the Maryland General Assembly created the People's Insurance Counsel Division (PICD) in the Office of the Attorney General. The PICD exists to protect the interest of persons insured under policies of medical professional liability insurance and homeowner's insurance issued or delivered in Maryland. The General Assembly charged the PICD with responsibility for reviewing and evaluating each medical professional liability insurance and homeowner's insurance matter pending before the Insurance Commissioner to determine whether the interests of insurance consumers are affected. The General Assembly further mandated that the PICD review any rate increase of 10% or more by any medical professional liability insurer or homeowner's insurer. The General Assembly authorised the PICD to appear before the Insurance Commissioner on behalf of insurance consumers.

The PICD's right to request a hearing before the Insurance Commissioner and file a petition for judicial review of an adverse decision by the Insurance Commissioner are not entirely clear from the statutory language, but the Supreme Court of Maryland determined the PICD has standing to request a hearing and file a petition for judicial review. Although opposition to a professional liability or homeowner's filing by the PICD can present additional challenges for insurers, the Supreme Court of Maryland has demonstrated a willingness to correctly apply the law and reject misguided arguments from the PICD.

The Maryland Insurance Administration (MIA) and the Maryland Insurance Article

The PICD's authority to appear before the Insurance Commissioner is significant because the Maryland Insurance Administration (MIA), acting under the direction of the Insurance Commissioner, has an entire process set up for processing administrative complaints alleging a violation of the Maryland Insurance Article. Regardless of whether a complaint is initiated by the PICD, a consumer, a professional concerned about professional liability insurance, or an agent, the MIA investigates complaints and makes an initial determination as to whether a violation of the Maryland Insurance Article occurred. Anyone "aggrieved" by that initial investigatory decision, has the right to request a hearing. This will be a quasi-judicial hearing and limited discovery is permitted.

A hearing request, whether filed by the PICD, a consumer, or even an insurer, must set forth "[t]he action or non-action of the Commissioner causing the per-

son requesting the hearing to be aggrieved" and "[t]he ultimate relief requested". A defective hearing request should result in the denial of a hearing, but this rarely occurs unless an insurer raises the issue in a timely fashion.

The Insurance Article grants the Insurance Commissioner broad remedial powers including the power to (i) impose a fine for each violation that is arbitrary and capricious based on all available information; and (ii) impose penalties for violations committed with a frequency that indicates a general business practice. A party dissatisfied with a final order of the Insurance Commissioner, after a quasi-judicial hearing, can seek judicial review in the Circuit Court.

Although the administrative litigation process can be burdensome and costly, a person claiming to be aggrieved by an insurer's alleged violation of the Insurance Article cannot invoke the original jurisdiction of a trial court. Rather, they must pursue and exhaust the administrative remedies expressly provided in the Insurance Article. Where the General Assembly has provided a special form of remedy and has established a statutory procedure before an administrative agency for a special kind of case, a litigant must ordinarily pursue that form of remedy and not bypass the administrative official.

The Supreme Court of Maryland has confirmed Maryland's strong public policy requiring the pursuit and exhaustion of administrative remedies before a litigant can pursue a judicial action:

"[W]hen the Legislature enacts a comprehensive remedial scheme in which a claim is to be determined by an administrative agency and reviewed in an administrative appeal before judicial review is available, it establishes, as public policy, that such a procedure produces the most efficient and effective results. In order to effectuate this public policy, trial courts generally should not act until there has been compliance with the statutory comprehensive remedial scheme."

A private party cannot circumvent the comprehensive remedial scheme established under the Insurance Article by pursuing a private cause of action for damages. If a statute provides a special form of remedy, then a plaintiff must use that form rather than any other. In other words, when a statutory remedy is provided, that remedy is exclusive. An individual cannot, therefore, in addition to the statutory remedy, pursue a tort action for damages in court based on the same issues advanced or that should have been advanced in the administrative proceedings. The Supreme Court of Maryland has referred to state insurance laws regulating claims practices as "in the nature of governmental regulations... [that do] not create private rights of action."

Common law claims independent of the Insurance Article

The Supreme Court of Maryland, however, has recognised that common law claims for fraud, negligent misrepresentation, and negligence arising out of the sale of insurance, that are independent of the Insurance Article, are not subject to the requirement of pursuit and exhaustion of administrative remedies. The point is that common law claims are not subject to the doctrine of pursuit and exhaustion of administrative remedies.

Although the complex administrative litigation environment can sometimes be challenging, Maryland does not recognise an action against an insurer for bad faith failure to pay a first-party insurance claim. Maryland has made a considered decision not to recognise a tort action for bad faith failure to settle with an insured in the first-party context. Even a bad faith negligence claim against an insurer by a third-party beneficiary is considered a "first party" claim because the beneficiary "stands in the shoes of the insured". This is important, again, because Maryland does not recognise a tort action against an insurer for bad faith failure to pay an insurance claim.

The Supreme Court of Maryland has further recognised that the duty owed by an insurer who "mistakenly denies coverage... to the insured" is "entirely contractual". An insurer's mistaken failure to provide a defence based on the belief that there is no insurance contract or no insurance coverage exists does not give rise to a tort claim for bad faith. Any such claim is contractual, and limited to the coverage policy limits and defence costs.

Maryland law further holds that the insured-insurer relationship is not fiduciary in nature. Moreover, in the absence of a special (fiduciary) relationship between the parties, Maryland courts have not ordinarily been willing to impose an affirmative duty to protect the interests of another.

Claims for lack of good faith

Property and casualty insurance policies and individual disability insurance policies issued, sold or delivered in Maryland, however, can be the subject of a statutory claim for lack of good faith. Good faith is defined by statute to mean: "an informed judgment based on honesty and diligence supported by evidence the insurer knew or should have known at the time the insurer made a decision on a claim". As a matter of law, however, an insurer cannot be found to have failed to act in good faith based on any delay in determining coverage or payment, if the insurer acted within the time specified by statute or regulation.

In a lack of good faith action, an insured can recover "actual damages", up to the policy limits, along with attorneys' fees, expenses, litigation costs, and interest. This claim is again subject to an administrative exhaustion requirement. For this reason, a Circuit Court action cannot be commenced until after a final decision by the MIA. Any appeal of the MIA decision to the Circuit Court is de novo. A party also has the option to elect to have the case tried by a jury in the Circuit Court.

Bad faith claims

Maryland recognises a tort claim for bad faith in connection with third-party liability insurance. An automobile liability insurer, for example, may be subject to a claim of bad faith if it fails to resolve a claim within policy limits. Maryland has not, however, allowed premature filing of bad faith claims where there has been no excess judgment and the insurer is continuing to provide a defence. Maryland also recognises that an insurer's offer to settle for the policy limits before entry of an excess verdict will generally insulate an insurer from a bad faith claim.

The insurance producer protection law

Maryland's unique legal landscape creates additional barriers to property and casualty insurers' ability to place restrictions on underperforming insurance producers both directly through laws protecting insurance producers and indirectly through laws preventing discrimination in underwriting. Maryland's insurance producer protection law restricts a property and casualty insurer's ability to cancel or amend a written agreement with an insurance producer because of an adverse loss ratio. Maryland's insurance producer protection law also prohibits insurers from cancelling or amending an agreement with an insurance producer, or refusing to accept business from an insurance producer, for arbitrary, capricious, unfair or discriminatory reasons.

Obligations of insurers with underwriting guidelines and a filed rating plan

Maryland laws aimed at preventing underwriting discrimination prohibit insurers from cancelling or refusing to underwrite or renew particular insurance risks or classes of risk except by application of standards reasonably related to the insurers' economic and business purposes. The MIA has interpreted the "economic and business purposes" standard to prohibit an insurer from refusing to write a risk if the insurer has a filed rate applicable to that risk. In other words, if an insurer's rating rules provide a rate for a risk, then the insurer cannot reject the risk. Similarly, an insurer may not apply underwriting guidelines, whether directly or through its agents, that would result in declination or non-renewal of a risk for which the insurer has a rating factor.

The MIA has sanctioned insurers for restricting an agent's ability to place business with the insurer when the restriction results in the agent not placing business with the insurer that qualifies under the insurer's underwriting guidelines and for which the insurer has a filed rate. This is true regardless of whether the insurer characterises the restrictions as profitability initiatives, adjustments to underwriting parameters to account for loss ratios, and/or placing policy volume constraints on selected agencies. Still further, insurers cannot encourage appointed agents to adopt agency underwriting guidelines that are inconsistent with the insurer's general underwriting guidelines and filed rates, or apply agency-specific underwriting requirements, underwriting scores, loss ratio benchmark requirements, or agency disciplinary programmes that

might result in an agency not placing business with the insurer that qualifies under the insurer's company-wide underwriting guidelines and filed rating plan.

Insurers seeking to take agency-specific actions, whether formal or informal, must be careful not to run afoul of Maryland's prohibition on the application of loss-ratio standards and avoid taking action that requires or encourages agencies not to place business with the insurer that qualifies under the insurer's underwriting guidelines and filed rating plan. If an agency files a complaint with the MIA, then the same administrative litigation process discussed above applies.

Supreme Court decisions

From a traditional judicial litigation perspective, the Supreme Court of Maryland has long followed the law of objective interpretation of contracts. The Supreme Court of Maryland's recent insurance decisions continue to reflect the court's contract-focused perspective.

In the *Matter of Featherfall Restoration, LLC*, 419 Md. 586 (2025), for example, the Supreme Court of Maryland examined an anti-assignment clause in a homeowner's insurance policy issued by Travelers Home and Marine Insurance Company ("Travelers"). The policy's anti-assignment clause provided that "assignment of this policy will not be valid unless we give our written consent". The insured notified the insurer of damages to a roof and claimed the damages were the result of a windstorm. The same day, the insured hired Featherfall Restoration, LLC ("Featherfall") to repair the roof. Travelers' representative found no signs of storm damage to the roof, and instead observed wear, tear and deterioration. As a result, the insurer denied the claim.

Featherfall provided Travelers with an "Assignment of Claim" form executed by the insured, purporting to "irrevocably transfer, assign, and set over onto [Featherfall] any and all insurance rights, benefits, proceeds, and any causes of action under applicable insurance policies". Travelers refused to recognise the assignment, citing the anti-assignment clause in the policy. Featherfall then filed an administrative complaint with the MIA. Featherfall did not challenge the merits of the denial of the claim, but instead asked the MIA to compel Travelers to honour the assignment and Featherfall's right to act in place of the insureds. Featherfall asserted that Travelers had violated Maryland's prohibition on unfair claim settlement practices.

The Insurance Commissioner ruled the assignment was void under the anti-assignment clause, and that Travelers' handling of the claim complied with Maryland law. The Maryland Circuit Court affirmed the Insurance Commissioner's decision and the Maryland Appellate Court also affirmed this. Since Featherfall's assignment was not valid, the Appellate Court held Featherfall was not an "aggrieved person" and lacked standing to challenge Travelers' actions with respect to the claim denial.

The Supreme Court of Maryland disagreed. Noting that Maryland law distinguishes between a contract and a claim arising under a contract, the Supreme Court held the insured's post-loss claim for money payments under the policy was a "chose in action" distinct from the contract instrument from which it arose. The court reasoned that "notwithstanding the Assignment, the Policyholders still had coverage under the policy for other losses" and that the assignment to Featherfall was limited to the rights with respect to the specific claim at issue. Therefore, the anti-assignment clause prohibiting assignment of "this policy" did not bar the assignment to Featherfall of a single post-loss claim under the policy. Since Featherfall was a valid assignee, it had standing as an aggrieved party to request a hearing to challenge the MIA's determination. As a result, the Supreme Court reversed the Insurance Commissioner's ruling and remanded the matter for pursuit and exhaustion of the administrative proceedings.

The Supreme Court of Maryland's contract-focused perspective is further borne out by the court's recent decision in *Government Employees Insurance Company, et al v MAO-MSO Recovery II, LLC, Series PMPI, et al*, 491 Md. 221 (2025). In that case, the Supreme Court was called upon to respond to a certified legal question from two consolidated federal court class action lawsuits. The certified question focused on the validity of an assignment of the right to seek reimbursements from the Government Employees Insur-

ance Company (GEICO) and its affiliates, as primary payers, for conditional payments made by Medicare Advantage Organizations (MAOs) for medical expenses incurred by MAO members.

As a general rule, under the Federal Medicare Secondary Payer Act, Medicare is a secondary payer of medical expenses when a Medicare beneficiary has coverage from an insurer other than Medicare. As a secondary payer, Medicare is only responsible for any remaining costs of care in excess of those covered by a primary payer. MAOs, operating under Medicare Part C, provide Medicare coverage to beneficiaries under contracts with the Centers for Medicare and Medicaid Services ("CMS") and are considered secondary payers. Like Medicare, they can make conditional payments and seek reimbursement from primary payers.

The plaintiff entities were established in an effort to recover, through litigation or otherwise, unpaid reimbursements for MAOs and other secondary payers. To recover such funds, plaintiffs effectuated "Claims Cost Recovery Agreements" (the "Assignments") under which their secondary-payer clients (the "Assignors") assigned to plaintiffs their rights to seek and receive reimbursement from the primary payers, and granted the plaintiffs control over any litigation conducted. The Assignments did not purport to assign claims against a specific identified party, and the Assignors were either not aware of whether they had claims or how many claims they had at the time of the Assignments.

In the consolidated federal class action, plaintiffs sought to recover thousands of conditional payments made by MAOs – and assigned to plaintiffs through the Assignments – for medical expenses that plaintiffs alleged GEICO was legally obliged to reimburse as a primary payer. The defendants argued the Assignments were void as they went against Maryland public policy.

The Supreme Court focused on the language in the barratry statute, noting that the plaintiffs did not solicit any secondary payer to file a lawsuit, but rather obtained the right to bring suit against primary payers in the plaintiffs' own names based on the Assignments. Since the plaintiffs had not violated the barratry statute, the court held the Assignments were not barred by public policy.

The Supreme Court further rejected GEICO's argument that the Assignments were void as being against general Maryland public policy. The court explained that "Maryland public policy does not prevent sophisticated parties like Plaintiffs and the assignors from striking a bargain they both deem valuable. Put another way, Plaintiffs' assignments are not sufficiently 'officious' as to warrant invalidation. And it certainly is not the case that litigation designed to recover reimbursement of Medicare payments is useless". The court explained "to the extent Maryland retains a policy under common law that prohibits a scheme 'to stir up and promote litigation for the benefit of the promoter rather than for the benefit of the real party in interest... that policy, at least in general, does not apply to litigation conducted by an assignee.'"

Conclusion

Maryland insurance litigation can present complex choice of forum questions. In addition, many of the regulatory and statutory deadlines are jurisdictional and failure to strictly adhere can be fatal. Engaging experienced insurance counsel is therefore critical to identifying and avoiding the perils that are a part of Maryland insurance law.

USA – NEW JERSEY

Trends and Developments

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Pollock Law LLC has represented policyholders in the United States and internationally for over 35 years. Although the CGL has been in existence since 1935, both its coverage and the risks it addresses are constantly changing – as are the exclusions limiting coverage. In addition to commercial general liability, the lawyers at Pollock Law have litigated claims arising from product liability, products-completed operations coverage and of course the constantly evolving environmental insurance claims, ranging from nuisance, trespass and hazardous substances to more recent claims for natural resource damages as well as PFAS/PFOA. Jeff Pollock is an elected member of the American College of Coverage Counsel (ACCC), the American Law Institute (ALI, where he served as a commentator on the Principles of Insurance Project) and the American College of Environmental Lawyers (ACOEL).

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Auto and Commercial Vehicle Insurance

Clarification on minimum liability insurance for motor carriers

Effective 1 July 2024, the New Jersey Department of Banking and Insurance (NJDOBI) clarified that commercial motor vehicles garaged in New Jersey and travelling interstate must carry higher minimum liability coverage. Vehicles weighing 26,001 pounds or more require USD1.5 million for injury, death or property damage per accident, while those weighing between 10,001 and 26,000 pounds need USD300,000. This corrects earlier interpretations, limiting the liability to intrastate carriers and exceeding the federal minimum of USD750,000. Governor Phil Murphy signed the law on 16 January 2024.

Supreme Court ruling on low-speed electric scooters and PIP benefits

In a November 2024 decision (*Goyco v Progressive Insurance Company*), the New Jersey Supreme Court ruled that users of low-speed electric scooters do not qualify as "pedestrians" under the state's no-fault law. This means scooter riders injured in accidents may not be eligible for personal injury protection (PIP) benefits, as scooters are classified as motorised vehicles rather than as being akin to bicycles. The ruling emphasises the scooter's features (eg, electric motor, handlebars, lights) and upholds denials of such claims.

Health Insurance and Pharmacy Benefits

Pharmacy Benefit Managers (PBM) Act (Bulletin No 24-18)

Effective 1 January 2025, this bulletin implements New Jersey Statutes Annotated (NJSA) 17B:27F-1 et seq, which requires the licensing and oversight of PBMs. Key requirements include registration for pharmacy service administrative organisations (PSAOs) by 31 March 2025 (for retroactive effect to 1 January), contract provisions for pricing transparency (eg, updates every seven days, appeal mechanisms) and treating uncollected rebates as non-admitted assets in accounting. Penalties for violations can reach USD10,000 or aggregate receipts, with possible licence suspension.

Ensuring Transparency in Prior Authorization Act (ETPAA) (Bulletin No 24-17)

Also effective 1 January 2025, this Act replaces the prior Health Claims Authorization Act, mandating greater transparency in utilisation management. Carriers must post prior authorisation information online, adhere to strict response timelines, provide appeal processes (including arbitration) and ensure prompt payments with interest on overdue claims. The Act aims to reduce inefficiencies in healthcare delivery and applies to hospitals, physicians and insurers.

Rising health insurance costs for public workers

In 2025, public employees (especially educators) faced significant premium hikes due to cost overruns in the State Health Benefits Program (USD254 million for school employees in 2025). While not a new law, this stems from ongoing regulatory oversight and has sparked calls for state intervention to improve affordability.

Data Privacy and Consumer Protection

New Jersey Data Privacy Act (NJDPA)

Signed on 16 January 2024, and effective 15 January 2025, this comprehensive law (Senate Bill 332) regulates controllers processing the personal data of at least 100,000 New Jersey residents (or 25,000 if deriving revenue from data sales). Consumers have the right to access, correct, delete and opt out of data use for advertising or profiling purposes. Insurers must obtain express consent for sensitive data (eg, health or financial info), conduct impact assessments, limit collection to necessary purposes and support universal opt-out mechanisms by 15 July 2025. This increases compliance costs for insurers but provides no private right of action – enforcement is by the Attorney General, with a 30-day cure period (expiring after 18 months).

Exemption for insurance-support organisations (A5017)

Introduced in 2024 and engrossed in May 2025, this bill exempts certain personal information collected by insurance-support organisations from data notification and disclosure requirements under P.L.2023, c.266. It was referred to the Senate Commerce Committee, potentially easing burdens on insurers while maintaining privacy standards.

Annuities and Producer Standards

Adoption of the "best interest" standard for annuity transactions

Effective 21 April 2025, New Jersey became the 50th state to adopt this National Association of Insurance Commissioners (NAIC)-based standard, requiring producers to act in the best interests of consumers. It includes duties of care, disclosure of conflicts and documentation, aligning with SEC regulations to enhance protections for retirement products without overly restricting insurers.

Workers Compensation

Increase in attorney fee cap (S2822/A3986)

Signed 22 August 2024, this law raises the maximum attorney fee in workers' compensation cases from 20% to 25% of awards, effective immediately for pending claims. Judges retain discretion, but it applies to medical, temporary disability and permanency benefits.

Emerging Technologies

Bulletin on AI use in insurance (No 25-03)

Issued on 11 February 2025, this bulletin adopts the NAIC Model Act, which requires insurers to govern AI systems in a responsible manner. While specific requirements (eg, bias mitigation, transparency) align with the model, it emphasises ethical use in underwriting and claims.

Arbitration-Focused Mechanisms

New Jersey has seen significant judicial developments regarding the arbitrability of insurance-related claims, particularly under the Insurance Fraud Prevention Act (IFPA; NJSA 17:33A-1 et seq) and in connection with PIP benefits. These rulings highlight the tensions between state and federal interpretations and aim to clarify the scope of arbitration versus court litigation in cases involving fraud. Additionally, new health insurance regulations incorporate arbitration mechanisms.

Disagreement on the arbitrability of IFPA claims

In April 2024, the US Court of Appeals for the Third Circuit ruled in *Gov't Emps. Ins. Co. v Mount Prospect Chiropractic Ctr., P.A.* (98 F.4th 463) that claims under the IFPA are subject to arbitration under New Jersey's Automobile Insurance Cost Reduction Act (AICRA). The court reasoned that nothing in the IFPA's text or history prohibits arbitration, and the claims involved efforts to recover PIP benefits, which fall under mandatory arbitration provisions in no-fault laws and insurers' decision point review plans. This decision made it challenging for insurers to litigate fraud claims in federal court.

However, on 9 January 2025, the New Jersey Appellate Division reversed course in *Allstate v Carteret Comprehensive Medical Care* (No A-0778-23), holding that IFPA and New Jersey Anti-Racketeering Act (RICO) claims are not subject to PIP arbitration. The case involved Allstate alleging a conspiracy to fraudulently obtain over USD1.7 million in PIP benefits through the submission of misleading claims. The Appellate Division emphasised that PIP arbitration is limited to disputes over medical expense payments and lacks the capacity for broad damages, discovery or third-party joinder available in court. It also noted that arbitration could hinder the New Jersey Commissioner of Banking and Insurance from intervening in the matter. The court explicitly disagreed with the Third Circuit's interpretation, prioritising legislative goals and the right to a jury trial for complex fraud claims, as affirmed in prior state precedent like *Allstate N.J. Ins. Co. v Lajara* (2015). This ruling allows insurers to pursue such claims in the Law Division, potentially leading to an appeal to the New Jersey Supreme Court for final resolution.

Arbitration in health insurance appeals (ETPAA)

As part of the ETPAA(Bulletin No 24-17), effective 1 January 2025, health carriers must provide robust appeal processes for prior authorisation denials, including arbitration options. This enhances transparency and efficiency in resolving disputes over utilisation management, applying to hospitals, physicians and insurers.

Ongoing No-Fault PIP Arbitration Program

Administered by Forthright under AICRA, this programme continues to handle PIP disputes, with no significant structural changes reported in 2024–25. It focuses on quick resolution of medical expense claims, though the above rulings clarify that broader fraud allegations may bypass it for court proceedings.

Cyber-Fraud

In the past year, New Jersey has advanced protections against cyber fraud in the insurance sector through enhanced data privacy regulations, enforcement actions by the Cyber Fraud Unit and court decisions clarifying cyber insurance coverage. Cyber fraud here encompasses fraudulent activities enabled by digital means (eg, data breaches leading to false claims) and insurance claims arising from cyber-attacks. While no major new statutes specifically target cyber insurance fraud, the focus has been on preventing data misuse that could facilitate fraud and resolving coverage disputes for cyber incidents. Key developments include the following.

Implementation of the NJDPA (Section 332)

Effective 15 January 2025, this comprehensive law regulates entities, including insurers, that process the personal data of New Jersey residents. It applies to businesses controlling or processing data for at least 100,000 consumers (or 25,000 if deriving revenue from data sales), requiring data minimisation, security practices, consent for sensitive data (eg, health or financial information common in insurance), privacy notices and data protection assessments for high-risk activities like profiling. This directly combats cyber fraud by limiting data exposure that could be exploited for fraudulent claims or identity theft in insurance contexts. Non-compliance can result in fines up to USD10,000 per violation (enforced by the Attorney General), with a 30-day cure period until 15 July 2026. The Division of Consumer Affairs' Cyber Fraud Unit released FAQs on 6 January 2025, clarifying applicability to non-profits and small businesses acting as data processors, which may include insurance entities. Proposed draft regulations were issued on 2 June 2025, to further implement consumer rights and consent mechanisms, with a comment period ending 1 August 2025.

Enforcement and initiatives by the Cyber Fraud Unit

The Cyber Fraud Unit, within the Division of Consumer Affairs, enforces laws like the Consumer Fraud Act, Identity Theft Protection Act, and Health Insurance Portability and Accountability Act (HIPAA), focusing on digital privacy violations that intersect with insurance (eg, health data breaches). In July 2024, it advised consumers impacted by the Change Healthcare data breach – a major incident affecting medical claims and insurance processing – to protect their information, highlighting risks of downstream fraud in health insurance claims. In August 2024, Attorney General Platkin secured a USD4.5 million multistate settlement with Enzo Biochem for inadequate health data safeguards, underscoring the importance of protections for data used in insurance underwriting and claims. These actions reinforce regulatory oversight to prevent cyber-enabled fraud in the insurance ecosystem.

Court rulings on cyber insurance coverage

Merck & Co. v ACE American Insurance Co. (App. Div., 2024)

In a November 2024 decision, the New Jersey Appellate Division ruled that a "hostile/warlike action" exclusion in property insurance policies does not apply to the 2017 NotPetya cyber-attack, attributed to Russian state actors. Merck sought USD1.4 billion in coverage for losses from malware that disrupted 40,000 computers. The court limited the exclusion to traditional armed conflicts, not cyber-attacks, potentially expanding coverage under "all-risks" property policies for similar incidents. The New Jersey Supreme Court initially granted certification but dismissed the appeal in 2024 after a settlement, leaving the appellate ruling intact. This development influences how insurers assess and cover cyber risks, encouraging more explicit policy language to address fraud or losses from state-sponsored hacks.

Amendments to the IFPA via Bill S2558

Introduced on 8 February 2024, this bill extends IFPA protections to self-insured entities and plans, allowing them to pursue damages for fraudulent claims and enabling the sharing of evidence with the Commissioner of Banking and Insurance. While not cyber-specific, it could apply to cyber-facilitated fraud (eg, digitally falsified claims under self-insured health plans). The bill's status as of August 2025 is unclear from available sources, but it represents ongoing efforts to broaden anti-fraud measures in insurance.

General trends in data breach and fraud litigation

While no standout court cases directly involved cyber fraud in insurance claims (eg, phishing for benefits), 2024 reviews of data breach litigation noted increased

scrutiny of standing in such cases, potentially affecting insurance recoveries for breach-related losses. Existing statutes like NJSA 2C:21-4.6 criminalise insurance fraud via false statements (including electronic submissions), but no 2024–25 amendments or cyber-specific rulings were identified.

USA – NEW YORK

Trends and Developments

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Cohen Ziffer Frenchman & McKenna LLP

Cohen Ziffer Frenchman & McKenna LLP is built on the reputations and experience of nationally recognised lawyers who have worked together and represented policyholders as a unified team for more than 20 years, recovering billions of dollars for their clients and securing landmark judicial rulings. The group has earned a national reputation as a fierce advocate for policyholders in high-profile, high-dollar disputes against insurance companies, and for obtaining precedent-setting decisions. The team represents a client base of Fortune 500 companies, hedge funds and private equity firms in matters involving insurance recovery and complex commercial litigation.

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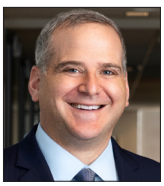

Andrew Bourne is a partner at Cohen Ziffer Frenchman & McKenna, where he represents policyholders in high-value insurance disputes. He has secured hundreds of millions of dollars and precedent-setting victories for his clients, including a multimillion-dollar claim for a cargo policyholder affirmed on appeal, a ground-breaking New York appellate decision clarifying bad faith standards and a California ruling finding that 180 Life Sciences Corp is entitled to advancement of defence costs under a D&O policy. With over two decades of experience, Andrew combines deep industry knowledge with strategic litigation skills to maximise client outcomes and ensure insurers honour their obligations.

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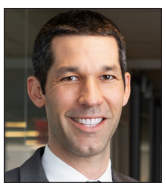

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Introduction

In a year marked by notable judicial activity, 2025 has seen several important legal decisions shape the landscape of insurance law in New York. These rulings have addressed a range of critical issues – from settlements that assign rights to insurance to disputes over relatedness of actions. This update summarises some of the most impactful decisions handed down by New York courts in 2025, offering insight into how these developments may influence insurers, policyholders and legal practitioners moving forward.

New York Courts Continue To Endorse Settlements Assigning Insurance Rights With Covenants Not To Execute

One recurring issue in insurance law is whether a policyholder may assign its coverage rights to a third party as part of a settlement in which the third party agrees not to execute a judgment, without defeating the policy's "legally obligated to pay" requirement. Jurisdictions are split: the minority view holds that a covenant not to execute negates the insured's legal obligation, barring coverage – see, eg, *Freeman v Schmidt Real Est. & Ins., Inc.*, 755 F.2d 135, 138–39 (8th Cir. 1985) (applying Iowa law).

Traditionally, New York courts have followed the majority rule. In *Westchester Fire Insurance Co. v Utica First Insurance Co*., 40 A.D.3d 978 (N.Y. App. Div. 2nd Dep't 2007), the court held that liability was fixed upon settlement, even though the claimant agreed not to execute against the insured. Federal courts in New York have applied the same principle – see, eg, *Intelligent Digital Sys., LLC v Beazley Ins. Co., Inc*., 207 F. Supp. 3d 242, 247 (E.D.N.Y. 2016); and *Illinois Union Ins. Co. v US Bus Charter & Limo Inc.*, 291 F. Supp. 3d 286, 292–93 (E.D.N.Y. 2018).

Most recently, in *Geiger v Hudson Excess Ins. Co.*, 2025 WL 2248666 (N.Y. App. Div. 1st Dep't Aug. 7, 2025), the First Department reaffirmed New York's adherence to the majority view. In *Geiger*, the underlying plaintiffs sued a nightclub alleging that the club "improperly and knowingly used their images and likenesses in advertising without their consent and without payment". Id. at *1. The underlying parties then entered into a settlement agreement and consent judgment with a covenant not to execute on the judgment, pursuant to which the club "assigned to plaintiffs its right to prosecute its coverage claims against [its insurers] to recover the amount of the judgment and defense costs". Id.

After discussing New York precedent and the majority and minority views, the First Department concluded that the "majority view represents the sounder position" and added: "It is not difficult to find justification for the prevailing view when we consider that any scenario wherein an insured is assigning its claims against its insurer to a plaintiff, in exchange for a covenant not to execute, necessarily takes place when the insured has been abandoned by its insurer. In New York, an insurer that breaches its duty to defend a claim for loss that is covered under its policy will be held liable for the insured's reasonable settlement of that claim, regardless of whether the insurer consented to such settlement". Id. at *5. Accordingly, the policyholder is "justified in taking affirmative steps to limit its own

liability by assigning its claims against its insurer to the plaintiff in exchange for a covenant not to execute on the consented to judgment, as long as the insured has acted reasonably and in good faith". Id. The court emphasised that such assignments typically arise when an insurer wrongfully refuses to defend. In those circumstances, it held, the insured may reasonably assign its rights in exchange for a covenant not to execute, without defeating coverage.

First Department Clarifies "Relatedness" in Employment Practices Claims

In *Zurich American Insurance Co. v Giorgio Armani Corp.*, 238 A.D.3d 81 (N.Y. App. Div. 1st Dep't Mar. 11, 2025), the First Department clarified the "relatedness" standard that should be used in connection with employment practices liability (EPL) policies.

Hiscox provided EPL coverage for the period covering August 2017 to August 2018, and Zurich provided EPL coverage from August 2018 to August 2019. Both policies contained standard language stating that "related" or "interrelated" wrongful acts – defined as acts sharing a common nexus or nucleus of facts – would be treated as a single claim first made when the earliest related claim was filed.

Giorgio Armani involved three employment-related claims tied to sexual misconduct allegations against an Armani employee, Javier Herrera, at its Seattle, Washington stores. Specifically, between 2018 and 2019, Armani reported these matters to its insurers; Armani reported the *Loreto-Hays* and *Oberloh* US Equal Employment Opportunity Commission (EEOC) charges to Hiscox, and it reported the later *Christin* lawsuit – brought by five female plaintiffs – to Zurich. Zurich denied coverage, asserting that *Christin* was interrelated with the earlier claims and thus deemed first made during the Hiscox policy period.

The trial court found the *Christin* allegations too factually distinct to be interrelated, holding Zurich liable. It emphasised that while all claims involved Mr Herrera and Armani's failure to act, the specific allegations in each case – different victims, timelines and workplace dynamics – lacked a sufficient causal connection.

On appeal, however, the First Department reversed. It held that all three claims arose from a "common nexus of facts": Mr Herrera's repeated misconduct and Armani's alleged inaction. The court rejected the lower court's reliance on *Roman Catholic Diocese of Brooklyn v National Union Fire Insurance Co. of Pittsburgh, PA*, 21 N.Y.3d 139 (2013), noting that that case addressed whether incidents were part of the same occurrence for policy limits purposes – not whether they were "related" under a claims-made framework. The court emphasised that the policies' relatedness language required only a shared factual nucleus or causal connection – not identical conduct, victims or harms.

Critically, the First Department clarified that under New York law, "arising out of" means originating from or having some connection with the alleged conduct. Because the *Christin* action stemmed from the same alleged misconduct and management failures as the earlier claims, it was both a Related Wrongful Act under the Hiscox policy and an Interrelated Wrongful Act under the Zurich policy. As a result, it was deemed first made during the Hiscox period, and Zurich owed no coverage.

The decision underscores the importance of policy language in relatedness analyses and affirms New York's broad interpretation of "common nexus" provisions in the EPL context.

Second Circuit Affirms That Declaratory Judgment Is Appropriate on the Duty To Indemnify Where There Is a Finding Of Proximate Cause

Insurers and policyholders often seek declaratory judgments to clarify their respective duties to defend and indemnify before liability in an underlying lawsuit has been fixed. However, a recent federal case highlights a significant divergence between New York's federal and state courts on when such declarations are appropriate.

In *Liberty Insurance Corp. v New York Marine & General Insurance Co.*, 2023 WL 2597053 (S.D.N.Y. Mar. 22, 2023), aff'd in part, rev'd in part sub nom. *Liberty Insurance Corp. v Hudson Excess Insurance Co.*, 2025 WL 2325902 (2nd Cir. Aug. 13, 2025), the federal district court held that a subcontractor's insurer (Hud-

son) was obligated to indemnify a property owner for injuries sustained by the subcontractor's employee – despite the fact that the subcontractor's liability had not yet been established in the underlying state court action.

The district court found that the subcontractor's acts were a proximate cause of the injury, satisfying the conditions of the additional insured endorsement in Hudson's policy. In August 2025, the Second Circuit affirmed, reasoning that a federal court may enter a declaratory judgment on indemnity if proximate cause is established, even if a subsequent state court ruling later undermines the contractual indemnity claim.

This approach contrasts with the refusals of various New York state courts to issue declaratory judgments on indemnification unless:

- the underlying action is resolved;
- the issue will not be addressed there; or
- the issue can be resolved purely as a matter of law – see, eg, *Ace Am. Ins. Co. v Consol. Edison Co.*, 228 A.D.3d 552 (N.Y. App. Div. 1st Dep't 2024); *Harleysville Ins. Co. v United Fire Prot., Inc*., 227 A.D.3d 499 (N.Y. App. Div. 1st Dep't 2024).

The case illustrates how federal courts applying New York law may take a more flexible approach in declaratory judgment actions, particularly in finding proximate cause to support indemnity obligations – even before underlying liability is determined. This distinction has important implications for litigants seeking early resolution of insurance coverage disputes to facilitate settlement.

Discovery in Bad Faith Cases

Policyholders and insurers often battle over the discoverability of reserve and reinsurance information and documentation and claims-handling documents withheld by insurers on the basis of privilege. In *Mandarin Oriental, Inc. v HDI Global Insurance Co.*, 2025 WL 1638071 (S.D.N.Y. June 10, 2025), the district court compelled production of reserve information, reinsurance communications and other claim file materials in a COVID-19 business interruption case, finding them relevant to the policyholder's bad faith claim and not protected by privilege.

Mandarin Oriental sought coverage under an all-risk policy for pandemic-related business interruption losses at its hotels. The insurers engaged adjusters, forensic accountants and outside counsel to assess the claims, but withheld seemingly key documents in discovery. Mandarin moved to compel, and the court conducted an in camera review of exemplar documents.

Following this review, the court ruled as follows.

- Reinsurance communications were discoverable, as they could reflect the insurers' internal coverage evaluations, which were central to the bad faith claim.
- Reserve information was likewise relevant. The court rejected the insurers' argument that reserves merely reflect litigation risk, indicating their potential to show how insurers assessed liability.
- The insurers' privilege objections failed. Most documents predated litigation by over one year and were created in the ordinary course of business. Routine claims handling – even when involving outside counsel – did not qualify for attorney-client or work product protection, especially where third-party information was involved.

The court offered specific guidance, as follows:

- emails forwarding non-confidential or third-party information to counsel are not privileged;
- claim evaluations and routine internal communications are not protected work product; and
- only documents genuinely reflecting legal advice qualify for privilege.

Mandarin Oriental reinforces that, under New York law, courts will compel production of claims materials in bad faith cases unless insurers can clearly establish that documents were created in anticipation of litigation or reflect actual legal advice.

Insured Directors and Officers Win an Arbitration Provision Dispute in Bankruptcy Proceedings

In *In re Orion HealthCorp, Inc.*, 2025 WL 1129201 (2nd Cir. Apr. 15, 2025) (summary order), the Second Circuit affirmed a judgment of the US District Court for the Eastern District of New York, which had affirmed

an order of the US Bankruptcy Court for the Eastern District of New York denying an insurer's motion to compel arbitration between the insurer and insured directors and officers (D&Os).

In 2018, Constellation Healthcare Technology, Inc (CHT) and Orion HealthCorp, Inc (Orion), a direct subsidiary of CHT, filed for Chapter 11 bankruptcy. The Bankruptcy Court subsequently approved a consolidated plan of liquidation and named a liquidating trustee. Together, CHT and the trustee then commenced adversary proceedings against certain CHT and Orion D&Os who, in a settlement agreement with the trustee, assigned their rights to insurance coverage to the trustee.

Allied World National Assurance Company issued the subject policy, an excess policy that adopted the underlying primary policy's arbitration provision as well as its definition of the "policyholder" as CHT. The arbitration provision stated that it governed disputes regarding the policy "between the insurer and the policyholder". Id. at *1.

After being assigned the insureds' rights, the trustee sued Allied World for defence costs and indemnification coverage owed to the D&Os under the Allied World policy for the earlier CHT and trustee proceeding against the D&Os. Allied World then filed a motion to compel, which the Bankruptcy Court denied, a denial upheld by the District Court and Second Circuit.

Applying New York law, the Second Circuit found that the underlying action was entirely against the D&Os. Id. at *2. Thus, because the D&Os were defined as "insureds" in the policy, whereas CHT was defined as the "policyholder", the arbitration provision did not apply to the D&Os or, by extension, the trustee who stood in their shoes as an assignee. Id. The court also held that the result is no different when considering the D&Os (and the trustee) as third-party beneficiaries because the obligation to arbitrate is a creature of contract, and the D&Os did not contract with Allied World to arbitrate their dispute – CHT did. Finally, the Second Circuit held that estoppel also did not apply because, "although the directors and officers seek benefits under the Allied World Policy, they have not 'assumed performance' of the Allied World Policy in the place of the policyholder". Id.

This case is noteworthy in that multiple issues affected the determination of potential coverage, including the interplay between primary and excess policies, the enforceability of arbitration provisions, the effect of settlement agreements assigning rights to insurance coverage, and the varying rights and obligations of insured entities and D&Os in bankruptcy proceedings.

USA – TEXAS

Trends and Developments

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Hall Maines Lugrin, PC (HML) is a leading energy-focused trial boutique based in Houston, Texas, with an outpost in London. HML's practice is substantively and geographically diverse. Its lawyers provide over 350 combined years of experience in complex matters including trials, appeals, and arbitration of insurance coverage, products liability, personal injury, professional liability, and commercial disputes. The firm handles legal matters across the US and internationally, such as in Latin America and Canada. Having deep roots in the insurance and energy industries and an appreciation for overall business implications, HML has the ability to understand each client's problems and provide solutions in the context of the client's business. While its lawyers often resolve disputes favourably at critical junctures without trial or suit even being filed, HML also has a notable track record of successfully trying cases and pursuing appeals throughout the US, which lends precedential guidance to the energy industry in underwriting and coverage decisions.

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George Lugrin of Hall Maines Lugrin, PC is recognised for his deep knowledge and adept handling of the legal aspects of oil and gas well blowouts, as well as product liability defects involving cutting-edge technologies in multibillion-dollar onshore and offshore construction projects. He frequently handles matters outside the USA, with the help of a network of correspondents, but is most often found in Texas, Louisiana, Wyoming, New Mexico and Oklahoma. In addition to being a renowned trial lawyer, George is also reputed for resolving sensitive matters outside of public courts, whether in private meetings between principals, using confidential arbitration agreements, or accessing jurisdictions where details of proceedings are not public.

Reece Rondon focuses his practice on a variety of commercial disputes – from subrogation and coverage litigation involving the energy insurance market to trade secret matters and legal malpractice defence. Prior to joining Hall Maines Lugrin, PC, Reece served as a Texas district court judge for nearly nine years, presiding over more than 125 jury trials. He frequently speaks at continuing legal education conferences and also taught trial advocacy at the University of Houston Law Center for over four years. He graduated from the University of Houston with honours in accounting and law, and served as an editor of the Houston Law Review while at law school.

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Does Texas Prompt Payment Penalty Interest Keep Accruing After a Final Judgment?

Overview of the TPPCA and its requirements

The Texas Prompt Payment of Claims Act (TPPCA) is codified in Chapter 542.051 of the Texas Insurance Code. The Texas legislature intended for the TPPCA to protect insureds by requiring insurance companies to promptly process and pay first-party claims. The Supreme Court of Texas has held that the TPPCA applies not only to first-party insurance claims, but also to an insurer's duty to defend in the context of third-party claims (*Lamar Homes, Inc. v Mid-Continent Cas. Co.*, 242 S.W.3d 1, 20 (Texas 2007)).

Among other obligations, the TPPCA sets certain deadlines by which most insurers are required to (i) acknowledge the receipt of an insured's claim; (ii) begin investigating the insured's claim; and (iii) request from the insured all necessary information reasonably required by the insurer to adjust the claim within 15 days. Surplus lines insurers, however, have 30 business days for these same milestones in the claim adjustment process.

Once an insurer receives all the information that they reasonably need to adjust the claim, they generally have 15 business days to accept or reject the claim in writing. However, if the insurer is unable for any reason to accept or reject the insured's claim within 15 business days after receiving the requested documentation, the TPPCA provides the insurer an opportunity to explain to the insured in writing why they need additional time to accept or reject the claim. In that instance, the insurer then has 45 days to accept or reject the claim. If the insurer rejects the insurance claim, it must do so in writing and explain the reasons for the denial. If the insurer decides to accept the insurance claim, the insurer must pay the claim within five business days. Surplus lines insurers, however, have 20 business days to make payment to the insured.

If an insurer violates any of the TPPCA's "promptness" deadlines described above, or otherwise wrongfully denies coverage for (and thereby wrongfully denies payment for) all or part of an insured's claim, the insurer is not only liable for the amount of the claim, but the insurer is also liable to the insured for 18% annual interest on the amount of the claim, as well as the insured's attorneys' fees (Texas Insurance Code § 542.060; see also *GuideOne Lloyds Ins. Co. v First Baptist Church of Bedford*, 268 S.W.3d 822, 830-31 (Texas Appeals Court – Fort Worth 2008, no petition), wherein the elements of a TPPCA claim are listed as: (i) a claim under an insurance policy; (ii) where the insurer is liable for the claim; and (iii) where the insurer has failed to follow one or more sections of the TPPCA with respect to the claim).

This 18% prompt payment penalty interest is in addition to normal statutory pre-judgment and post-judgment interest, providing policyholders with a costly

hammer to wield over their respective insurers. The TPPCA is also a strict liability statute, meaning a policyholder does not need to prove bad faith or wrongful conduct by the insurer to recover penalties (see, eg, *Angell v GEICO Advantage Ins. Co.*, 67 F.4th 727, 741 (Fifth Circuit 2023)). The insurer owes the insured this 18% prompt payment penalty interest merely by wrongfully denying a claim, even if the insurer denies the claim in good faith and/or in a reasonable manner.

When does prompt payment interest start to accrue?

On the issue of when prompt payment penalty interest starts to run, there is little debate. Texas courts generally hold that the prompt payment penalty interest begins to accrue from the date an insurer violated the TPPCA or wrongfully refused to pay the claim. The penalty is calculated on the amount of the claim ultimately determined to be owed (see *State Farm Life Ins. Co. v Martinez*, 216 S.W.3d 799, 806 (Texas 2007)). If partial payment is made by the insurer, then the insurer receives a credit towards the ultimate amount owed, and the 18% penalty is not calculated on the amount that has been partially paid.

When does prompt payment interest stop accruing?

However, on the issue of when prompt payment penalty interest stops running, there is less clarity and, at present, this is an open question under Texas jurisprudence.

A. Insurer's position – prompt payment interest stops running on the date of final judgment

Insurers argue that damages assessed as statutory penalty interest under Section 542.060 only accrue until the date of the final judgment, and do not continue to accrue post-judgment even if the insurer has not yet satisfied the judgment nor paid any money to the insured on the insurance claim. Insurers argue that once the court renders the judgment, standard post-judgment interest provides the insured the only compensation for any lost opportunity to invest the money awarded as damages in the judgment if those amounts remain unpaid while an appeal is pending. Arguably, the Supreme Court of Texas has supported the insurers' position regarding the non-accrual of post-judgment prompt payment penalty interest.

For example, in *Republic Underwriters Insurance Co. v Mex-Tex, Inc.*, which involved the predecessor of the current prompt payment statute, the Supreme Court of Texas stated that interest as "damages" awarded as a statutory penalty under Section 542.060 accrue "from the time [the amount of the claim] should have been paid until judgment" (150 S.W.3d 423, 427 (Texas 2004)). The United States Court of Appeals for the Fifth Circuit has likewise repeatedly declined to extend the potential accrual of penalty interest past the date of the judgment (see *Great Am. Ins. Co. v AFS/IBX Fin. Servs., Inc.*, 612 F.3d 800, 809 (Fifth Circuit 2010) – "While Section 542.060 does not expressly state when the 18% interest stops accruing, the Supreme Court of Texas has noted that such interest only accrues until the date judgment is rendered in the trial court", as well as *Lyda Sinerton Builders, Inc. v Ok. Sur. Co.*, 903 F.3d 435, 454-55 (Fifth Circuit 2018) where it says that regardless of "[c]ompelling reasons" that may support a different outcome, the policyholder that sought to extend accrual of penalty interest past the date of judgment did not "identify any such change in Texas Law" or distinguish precedent dictating that "damages" awarded as statutory penalty interest only accrue through date of judgment).

Moreover, as noted above, the statute expressly states that the statutory penalty is in addition to pre-judgment interest (see Texas Insurance Code § 542.060 (a) where it notes that "[n]othing in this subsection prevents the award of prejudgment interest on the amount of the claim, as provided by law"). Thus, the Texas legislature clearly intended to ensure that there was no confusion over which interest can be awarded pre-judgment. The Texas legislature made it clear that both standard pre-judgment interest and statutory prompt payment penalty interest can accrue before the date of judgment.

If the Texas legislature intended for both interests to accrue after a judgment, one would expect a similar clarification. However, that legislative clarification does not exist regarding post-judgment and penalty interests both accruing after a judgment. Thus, one can infer from that absence that the legislature intended to award only one type of interest post-judgment – that interest being standard and traditional post-judgment interest on all amounts owed.

In further support of the position that penalty interest runs only until the date of judgment and not after, the Supreme Court of Texas has declined to extend relief to an insurer beyond final judgment under similar Texas Insurance Code provisions. In particular, the Supreme Court of Texas in *Mid-Century Insurance Company of Texas v Boyte* held that a final judgment extinguished the relationship between insured and insurer and thus eliminated any further duties that the insurer owed to the insured under the Texas Insurance Code in connection with the claim (80 S.W.3d 546, 548-49 (Texas 2002)). Presumably, those extinguished duties would include the TPPCA and prompt payment obligations and related penalty interest. The Supreme Court explained that once a dispute over a claim has been "reduced to judgment", the relevant sections of the Texas Insurance Code are "no longer applicable" and cannot create additional liability post-judgment. While *Mid-Century* involved a different chapter of the Texas Insurance Code pertaining to an insurer's duty of good faith, the same reasoning holds that, after a judgment is rendered, the insured's "cause of action" under the Texas Insurance Code is "replaced by traditional judgment enforcement mechanisms" and "all judgment creditors stand in the same position relative to their judgment debtors upon appeal".

B. Insured's position – prompt payment interest continues to run past the date of final judgment until the claim is paid

Insureds argue that the penalty interest runs until the date the insurer actually pays the claim and, the insured's argument continues, a final judgment is not payment of a claim; payment of a claim is payment of a claim.

Supporters of this position often highlight that the purpose of the Prompt Payment of Claims Act – as the title of the statute emphasises – is to promote the actual payment of claims. Thus, from the insured's perspective, the TPPCA's purpose is not fulfilled until that payment is made and, accordingly, it makes sense that the statutory penalty interest would continue to run until the purpose is met via actual payment.

Moreover, the courts have noted that the TPPCA is to be "liberally construed to promote the prompt payment of insurance claims" (see, eg, *Hinojos v State Farm Lloyds*, 619 S.W.3d 651, 653 (Texas 2021)). Under the TPPCA, "the insurer shall pay damages and other items as provided by Section 542.060" (Texas Insurance Code § 542.058). Section 542.060 states only that the insurer is liable for "interest on the amount of the claim at the rate of 18 percent a year as damages". There is no mention of an early end to the penalty interest while the amount owed is still outstanding. Accordingly, a liberal construction indicates that the insurer continues to be liable for prompt payment penalty interest until payment is made to the insured.

The Fifth Circuit case *Lyda Swinerton Builders, Inc. v Oklahoma Surety Company* supports the insureds' reading of the statute despite holding otherwise (903 F.3d 435, 454 n.7 (Fifth Circuit 2018)). In that case, the court appears to have imposed the penalty interest only through the date of judgment due to what the court implied was a prior Fifth Circuit panel's incorrect – albeit binding – interpretation of Texas law. The court noted that there was "no rational basis nor any basis in the language of the statute for stopping the penalty on the date of judgment, when the violation is a failure to pay. The insured remains unpaid on the date of judgment. The insurer has been penalized during the time it may have been challenging the claim in good faith. Why does it make sense to stop the penalty once the insurer's liability is recognized by a judgment? It doesn't." Certainly, the insureds' position is not without logic.

Current trend

Some courts have agreed (or, at least, implied) that the 18% prompt payment penalty interest should continue to accrue until it is actually paid. See, for example, *Puente v State Farm Lloyds*, No CV B-15-190, 2016 WL 1729532, at *5 (S.D. Texas 28 March 2016), report and recommendation adopted under the name *Puente v Lloyds*, No CV B-15-190, 2016 WL 1733472 (S.D. Texas 29 April 2016), which notes that "the insurer is subject to a mandatory 18 percent interest penalty until it is paid";*Nautilus Ins. Co. v Int'l House of Pancakes, Inc.*, No CIV. A. H-03-2182, 2009 WL 5061767, at *5 (S.D. Texas 15 December 2009), which notes that "[f]or each day [...] that the [...] defense costs remain unpaid, the 18% interest penalty will continue to accrue [...]". Other courts have held otherwise – see,

for example, *United Nat. Ins. Co. v AMJ Investments*, LLC, 447 S.W.3d 1, 15 (Texas Appeals Court – Houston [14th District] 2014, petition dismissed).

However, while the federal courts still appear to be in conflict on this issue, the developing trend of cases in the state courts appears to favour the insurers' position. Ultimately, Republic Underwriters is still the Supreme Court of Texas' last word on the issue. And just recently, a Harris County, Texas, district court agreed via a final judgment that the penalty interest accrued only until the date of the judgment rather than until the day the insurer pays the claim. That Harris County case is bound for appeal, so there may in future be additional appellate guidance on this issue.

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