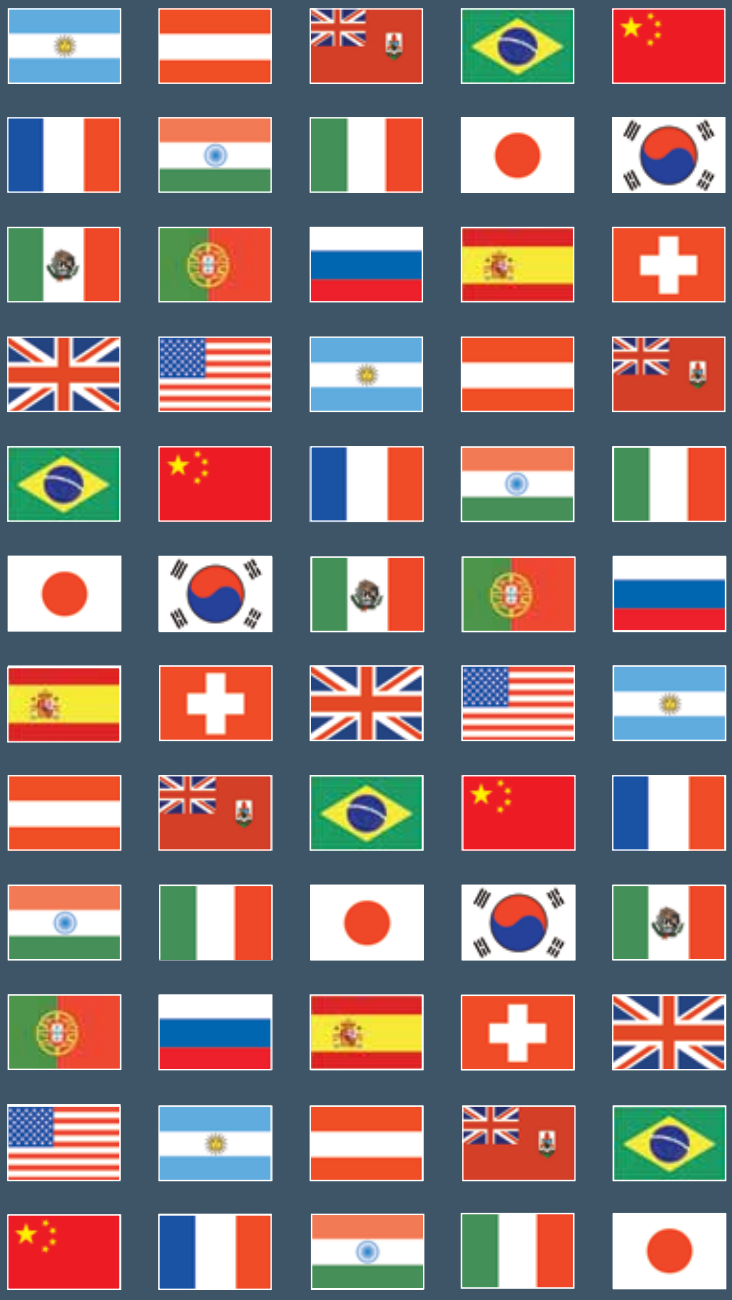
GETTING THE DEAL THROUGH

Insurance Litigation

in 17 jurisdictions worldwide

2014

Contributing editor: Barry R Ostrager



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Getting the Deal Through is delighted to publish the first edition of Insurance Litigation, a new volume in our series of annual reports, which provide international analysis in key areas of law and policy.

Following the format adopted throughout the series, the same key questions are answered by leading practitioners in each of the 17 jurisdictions featured.

Every effort has been made to ensure that matters of concern to readers are covered. However, specific legal advice should always be sought from experienced local advisers. *Getting the Deal Through* publications are updated annually in print. Please ensure you are always referring to the latest print edition or to the online version at www.GettingTheDealThrough.com.

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Preliminary and jurisdictional considerations in insurance litigation

1 In what fora are insurance disputes litigated?

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

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

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

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

2 When do insurance-related causes of action accrue?

In many insurance-related cases, the disputed issue is simply whether or not, or to what extent, the claimant is entitled to compensation under any class of insurance contract. In this type of case the claimant may be the insured, an injured third party in liability insurance, or a third-party beneficiary in personal insurance, the defendant being the insurer.

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

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

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

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

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

4 What remedies or damages may apply?

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

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

terminate the insurance contract must be exercised within 30 days from the date on which the policyholder received the documents that comprise the insurance policy.

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

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

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

Interpretation of insurance contracts

5 What rules govern interpretation of insurance policies?

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

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

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

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

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

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

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

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

Notice to insurance companies

7 What are the mechanics of providing notice?

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

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

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

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

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

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

9 When is notice untimely?

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

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

10 What are the consequences of late notice?

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

According to article 101 of the ICL, the consequences of late notice are: a reduction of the compensation payable by the insurer, taking into consideration the loss caused by late service of the notice; or preclusion of the right to compensation in the case of an intentionally late service of the notice that caused loss to the insurer. One should bear in mind that the relevant loss for this purpose is that which could have been avoided if the notice had been served in a timely manner. However, such adverse consequences should not occur if the insurer had knowledge of the claim by other means during the time set for the notice to be served or if the server of the notice is able to demonstrate that earlier notice could not have been served.

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

Insurer's duty to defend

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

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

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

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

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

Standard commercial general liability policies

13 What constitutes bodily injury under a standard CGL policy?

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

14 What constitutes property damage under a standard CGL policy?

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

15 What constitutes an occurrence under a standard CGL policy?

Again, there is no such thing as a standard CGL policy in Portugal. Some degree of diversity may be found among the standard terms used locally by insurers. Generally, an occurrence is a partially or totally developed factual event that is susceptible to triggering the insurance coverage. In some cases the wording will specify that the event must be sudden and unforeseen. In the context of a CGL policy, this event must be imputable to the insured. However, small wording differences may result in different interpretations, especially in the context of more complex successions of facts. Two or more factually separable events may be considered as a single occurrence if the cause from which they originated is one and the same (see question 16). It should be noted that in some cases the occurrence will be the insurance trigger, while in other cases, notably in claims-made policies, the occurrence itself will not give rise to any right to insurance compensation (see question 17).

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

16 How is the number of covered occurrences determined?

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

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

For example, if the insured's vehicle accidentally spilled oil on the road and as a consequence three other vehicles spun out of control, we may usually conclude that there is a single occurrence with

multiple adverse consequences. More complex situations may give rise to interpretation difficulties as to what a court of law would consider to be a single cause. The well-known discussion that arose after the events of 9/11 did not lead local insurers to clarify their wording significantly in this respect.

17 What event or events trigger insurance coverage?

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

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

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

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

18 How is insurance coverage allocated across multiple insurance policies?

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

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

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

Special rules may apply if different types of liability insurance are involved. For instance, a motor liability insurer will bear all the loss of an occurrence involving a motor accident with a company vehicle, even where the risk is also covered by the general liability insurer.

First-party property insurance

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

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

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

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

According to article 49 of the ICL, except as otherwise provided by law, it is for the policyholder to indicate to the insurer, either at the beginning or during the term of the contract, the value of the insured assets. As a general rule, the principle of freedom of contract applies to the determination of property value under first-party insurance policies, thus allowing for the inclusion of different clauses, it being possible to determine, for instance, that the relevant value will be

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that of a new asset with the characteristics of the insured asset, that the relevant value is that of the insured asset at the time of the occurrence, or that the relevant value is that which has been agreed by the parties, as is the case in valued policies. So as not to undermine the nature of this insurance, the parties may not agree on a value that is manifestly unfounded in view of the circumstances of the case.

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

Directors' and officers' insurance

21 What is the scope of D&O coverage?

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

Update and trends

2011–2013 was a period of recession. Particularly in the life insurance sector, which accounts for a share of more than 80 per cent of the investment portfolio managed by the industry, the premium turnovers fell significantly. The values relating to non-life insurance also decreased, but in a less significant manner.

In this scenario, very significant operations of concentration have been taking place in 2013 and 2014, most relevantly the sale and consequent privatisation of Caixa Seguros, the insurance arm of the state-owned banking and insurance group (Caixa Geral de Depósitos), which is being streamlined to increase the capital base of its core banking arm. This privatisation of the insurance group with the largest market share in Portugal (30 per cent) is part of the government's undertakings in the MoU entered into by Portugal and the International Monetary Fund, the European Commission and the European Central Bank. In January 2014 the Portuguese government announced that the selected buyer of Caixa Seguros was Fosun International, China's largest private conglomerate. This changing market matrix is bound to have an impact on insurance litigation.

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

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

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