Insurance Litigation

Contributing editors
Mary Beth Forshaw and Elisa Alcabes

2018

GETTING THE DEAL THROUGH

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Insurance Litigation 2018

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Mary Beth Forshaw and Elisa Alcabes
Simpson Thacher & Bartlett LLP

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CONTENTS

Austria 5
Philipp Strasser and Jan Philipp Meyer
Vavrovsky Heine Marth Rechtsanwälte GmbH

Bermuda 10
Peter Dunlop
ASW Law Limited

Chile 13
Ricardo Rozas
Jorquiera & Rozas Abogados (JJR)

China 17
Zhan Hao, Wang Xuelei and Wan Jia
AnJie Law Firm

Colombia 22
Sergio Rojas
DLA Piper Martínez Beltrán

Germany 26
Fabian Herdter and Christian Drave
Wilhelm Rechtsanwälte

India 31
Neeraj Tuli and Rajat Taimni
Tuli & Co

Ireland 36
Sharon Daly and April McClements
Matheson

Italy 40
Alessandro P Giorgetti
Studio Legale Giorgetti

Japan 44
Keitaro Oshimo
Nagashima Ohno & Tsunematsu

Korea 48
Sung Keuk Cho and Dong-Hyun Kim
Cho & Lee

Malaysia 52
Loo Peh Fern and Khoo Wen Shan
Skrine

Norway 56
Atle-Erling Lunder
Arntzen de Besche Advokatfirma AS

Sweden 59
Johan Gregow
Wistrand

Switzerland 63
Dieter Hofmann and Daniel Staffelbach
Walder Wyss Ltd

Turkey 66
Pelin Baysal and Ilgaz Önder
Gün + Partners

United Arab Emirates 71
Sam Wakerley and John Barlow
HFW

United Kingdom 75
Hermes Marangos, Tom Rotherham and Lucy Alexander
Signature Litigation LLP

United States 80
Mary Beth Forshaw and Elisa Alcabes
Simpson Thacher & Bartlett LLP

Preface

Insurance Litigation 2018

Fifth edition

Getting the Deal Through is delighted to publish the fifth edition of *Insurance Litigation*, which is available in print, as an e-book and online at www.gettingthedealthrough.com.

Getting the Deal Through provides international expert analysis in key areas of law, practice and regulation for corporate counsel, cross-border legal practitioners, and company directors and officers.

Throughout this edition, and following the unique **Getting the Deal Through** format, the same key questions are answered by leading practitioners in each of the jurisdictions featured.

Getting the Deal Through titles are published annually in print. Please ensure you are referring to the latest edition or to the online version at www.gettingthedealthrough.com.

Every effort has been made to cover all matters of concern to readers. However, specific legal advice should always be sought from experienced local advisers.

Getting the Deal Through gratefully acknowledges the efforts of all the contributors to this volume, who were chosen for their recognised expertise. We also extend special thanks to the contributing editors, Mary Beth Forshaw and Elisa Alcabes of Simpson Thacher & Bartlett LLP, for their continued assistance with this volume.

GETTING THE DEAL THROUGH

London
February 2018

Malaysia

Loo Peh Fern and Khoo Wen Shan

Skrine

Preliminary and jurisdictional considerations in insurance litigation

1 In what fora are insurance disputes litigated?

Insurance disputes are litigated in the civil courts.

The choice of civil court depends on the value of a dispute, save for unlimited jurisdiction of Sessions Court in Motor Vehicle Accidents' cases:

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

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

Insurance contracts may include an arbitration clause, in which case a dispute should be referred to arbitration. The insurance contract itself should provide for the terms of a reference to arbitration. In Malaysia, the most common arbitration service provider is the Kuala Lumpur Regional Centre for Arbitration (KLRCA).

Alternatively, reference to mediation may be an option to resolve a dispute. The Financial Mediation Bureau will hear most types of insurance disputes valued up to 200,000 ringgit.

As of October 2016, the Ombudsman for Financial Services has been set up to assist financial consumers in resolving a claim valued at up to 250,000 ringgit.

2 When do insurance-related causes of action accrue?

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

For liability insurance (eg, a claim of professional negligence), time starts to run from the date that the injury or loss occurs, or can be reasonably discovered.

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

In a cause of action against the insurer on non-payment of money claimed under a policy, the time when that cause of action accrues depends on whether making of the claim is a pre-requisite to the insurer's liability. If the making of a claim is a pre-requisite to the insurer's liability, then presumably the cause of action accrues from the date the claim is received by the insurer and not from the date of the occurrence of the insured event. If the making of the claim is mandatory, then the cause of action accrues on the date of injury or loss, or the point of event insured under the policy, of which the limitation period will start to run.

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

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

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

- future relationship with the insurer: the insured may have several insurance policies with the insurer. Legal proceedings often have a detrimental effect on the relationship between the parties that could affect the efficacy of any possible future payout. Insurers have the discretion to give ex gratia payments, but an insurer may be unwilling to do so if the insured has been a difficult client; and
- other insurance: an insured may have multiple policies, and there could be some overlap in coverage. Consideration should be given to how the policies overlap and apply and interact with each other. A policy may require the insured to notify if litigation is pursued or for any other reason.

4 What remedies or damages may apply?

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

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

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

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

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

Interpretation of insurance contracts

6 What rules govern interpretation of insurance policies?

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

The Financial Services Act 2013 (FSA) governs the supervision of financial institutions, including insurance businesses, payment systems and other relevant entities; has oversight of the money market and foreign exchange market to promote financial stability; and is responsible for related, consequential or incidental matters. The FSA also provides generally for pre-contractual disclosure requirements and provisions for life insurance payments.

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

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

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

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

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

- the natural meaning of the words;
- by looking at the evidence of previous correspondence between parties, if the words were discussed;
- within a commercial contract, the court will try to give the words a meaning that promotes business efficacy. In particular, the court may consider whether there could be an implied term based on the actions of the parties or based on how the insurance industry normally operates, or both;
- by reference to the contra proferentum rule (a rule that requires a written document, where there is an ambiguity, to be read against the party drafted the document);
- by reference to rule favouring the insured;
- by giving priority to the policy over other documents; or
- by referring to annexures to policies if those annexures are supplementing and explaining the clauses in the policies.

Notice to insurance companies

8 What are the mechanics of providing notice?

Notice should be given by the insured to the insurance agent, or to the insurer directly. The insurer may sometimes provide an initial claims notification form wherein the insured only needs to provide basic information about the claim, such as the nature and date of the event. The insured should be aware that some insurance policies have a limitation period for the provision of notice, after which the insurer may validly refuse a claim or reduce the compensation given.

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

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

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

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

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

10 When is notice untimely?

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

11 What are the consequences of late notice?

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

Insurer's duty to defend

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

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

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

The insured should always be aware that, in any situation, the insured should not admit, negotiate or settle a claim against it if it intends to notify or claim under the insurance policy. A boilerplate clause in insurance policies is the exclusion of coverage if the insured admits liability or agrees to settle a claim without the insurer's prior approval.

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

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

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

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

Standard commercial general liability policies

14 What constitutes bodily injury under a standard CGL policy?

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

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

15 What constitutes property damage under a standard CGL policy?

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

16 What constitutes an occurrence under a standard CGL policy?

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

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

17 How is the number of covered occurrences determined?

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

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

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

18 What event or events trigger insurance coverage?

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

19 How is insurance coverage allocated across multiple insurance policies?

The allocation of which policy a particular claim falls under may be decided by an insurer (if there is only one) or between insurers.

If multiple policies are covered by multiple insurers, it could depend on the insured to decide which insurer it wishes to claim from for a particular loss, as claiming from difference insurances may grant different advantages. With a common exception of life policies, a policy normally excludes liability for compensation if another insurance policy is covering the loss.

Insurance policies normally include a clause setting out how it would interact with other polices.

First-party property insurance

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

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

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

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

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

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

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

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

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

22 Is insurance available in your jurisdiction for natural disasters and, if so, how does it generally operate?

Insurance for natural disasters is available and provided by selected insurers in Malaysia. However, a standard insurance policy will normally exclude insurance coverage for natural catastrophes such as earthquakes, tsunamis, landslides, storms, typhoons and floods. Therefore, a policy owner may need to insure against those 'special perils' to cover the contingencies of such natural catastrophes or calamities as an optional extension to his or her standard insurance policy, with an increased premium.

Directors' and officers' insurance

23 What is the scope of D&O coverage?

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

Coverage is excluded for loss arising from fraud or dishonesty.

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

D&O insurance may cover the expenses of defending extradition proceedings and criminal proceedings. The insurance may cover the cost of defending a criminal proceeding against directors and officers only if acquitted, it will not cover any fine imposed or any cost or loss incurred if found guilty.

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

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

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

Cyber insurance

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

Cyber insurance policies cover personal data liability, corporate data liability, outsourcing liability, data security liability and defence costs that may be optionally extended to cover media content, cyber extortion and network interruption.

26 What cyber insurance issues have been litigated?

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

Terrorism insurance

27 Is insurance available in your jurisdiction for injury or damage caused by acts of terrorism and, if so, how does it generally operate?

Property insurance against acts of terrorism and sabotage is available. Depending on the individual policy, it may operate as an excess of loss type of insurance.

Insurance protection against injury caused by acts of terrorism may be included under personal accident or life insurance. However, it is common for many policies in the market to exclude claims for injury caused by terrorism.

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