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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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

India

Neeraj Tuli and Rajat Taimni
Tuli & Co

Preliminary and jurisdictional considerations in insurance litigation

1 In what fora are insurance disputes litigated?

In the absence of any reference to arbitration under the terms of a policy, insurance disputes can be litigated both before a civil court or consumer forum. If the insurer initiates the litigation, it has to be before the civil courts, and consumer fora cannot entertain such disputes.

Both the civil and consumer courts have territorial and pecuniary jurisdiction, and the civil court or consumer forum before which the matter is decided is dependent on the value of the dispute and the geographical limits of the head office of the defendant insurance company, within which the cause of action for the dispute arose.

The broad ascending hierarchy of the civil courts comprises roughly 600 district courts, 24 High Courts and the Supreme Court of India, which is the highest court of law in India. Four of the 24 High Courts – Delhi, Mumbai, Chennai and Calcutta – have original jurisdiction to hear matters over a certain pecuniary value, so the civil courts and judges under them do not hear matters involving values higher than that limit. In all other cases, district courts and the competent courts of first instance have an unlimited pecuniary jurisdiction to hear any insurance dispute. There is no right to a hearing before a jury, and cases are decided by judges.

The consumer courts follow a three-tier hierarchy – in ascending order, the district, state and National Consumer Disputes Redressal Commission (NCDRC). There are 626 district consumer disputes redressal commissions, which can accept claims up to a value of approximately US$29,500. There are 36 state consumer disputes redressal commissions, which can accept claims of up to approximately US$148,000 and appeals against the decisions of the district commissions. At the apex is the NCDRC, which accepts matters with a value of over US$148,000 and appeals against the decisions of the state commissions.

For quick resolution of commercial disputes, Commercial Courts were set up by the government in 2015 through the Commercial Division and Commercial Appellate Division of High Court Act, 2015 (Commercial Courts Act). The Commercial Courts Act defines 'commercial disputes' to include insurance and reinsurance disputes. Commercial courts can accept disputes of values that exceed US$148,000. Insurance and reinsurance disputes that exceed US$148,000, if not heard before the consumer fora, will now be heard and decided by the commercial courts.

2 When do insurance-related causes of action accrue?

Disputes between the insured and the insurer usually arise when the insured's claim is rejected (in part or in full) by the insurer and which the insured believes is covered under the policy. There can be disagreement between the insurer and the insured in relation to the scope of the insuring clauses, the quantum payable under the policy, the applicability of exclusions or compliance with the policy terms and conditions. Under the Indian Limitation Act of 1963, the cause of action for the purposes of calculating the limitation for filing a suit against the insurer will commence from the time that the claim is denied or the date of the occurrence causing the loss. The prescribed limitation period for filing a claim in the civil court or an arbitration is three years, whereas the limitation period for filing a claim in the consumer court is two years.

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

Procedural considerations include identification of the appropriate limitation period and jurisdiction for the institution of the litigation. In relation to strategy, it is important that the preliminary objections to any suit (such as expiry of limitation) are brought to the court's attention at an early stage to attain a dismissal on the basis of the preliminary objections. However, in India, it is very often the case that the preliminary objections are decided after the substantive pleadings are complete, as the courts are unwilling to decide without having had access to all the documentation on the matter.

4 What remedies or damages may apply?

The relief available in Indian litigation in cases of insurance disputes are specific performance and claims for damages. In a proceeding, the insured can either require the insurer to specifically perform its obligations under the policy or to pay the claim amount.

Indian courts and tribunals have discretion to award interest from the date when the cause of action arose until the enforcement of the judgment. Interest is usually awarded at a rate of 9 to 12 per cent and, in certain cases based on the conduct of the parties, interest of 18 per cent is also awarded.

The courts may also award the successful party its costs, but the award is at the court's discretion. It is common for cost awards to be made in favour of a successful party, but the level of costs awarded is rarely sufficient to cover the actual costs of litigation. Referring to a statutory upper limit of 4,000 rupees for costs awards in the case of vexatious litigation, the Supreme Court suggested that Parliament should consider raising the limit to 124,000 rupees. In view of the low level of costs awarded, there are, as yet, no material advantages in making a pretrial offer in civil litigation, so Calderbank letters are hardly (if ever) used.

Important changes have been introduced by the Commercial Courts Act, which remove the statutory limits for costs, thereby allowing costs to be awarded in accordance with the actual expenditure incurred by the winning party. However, awarding of costs is not compulsory and remains at the discretion of the court.

In relation to interim reliefs that are available in general, they include temporary injunctions and interlocutory orders that are provided for under the Civil Procedure Code of 1908. Parties also seek interim mandatory injunctions that are available under the Specific Relief Act of 1963. A court may issue a temporary injunction restraining any act or omission to act, or make an order for the purpose of staying and preventing the alienation, sale, removal or disposition of a property in appropriate cases. Interim relief also includes ordering the insurer to pay the insured the admitted sums payable under the policy so that only the disputed amount remains to be adjudicated upon. It is for the court to decide whether any interim relief should be granted, the terms on which it should be granted and the duration of the relief. The other option that is more applicable to insurance disputes is calling for deposits.

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

Indian contract law does not permit the awarding of extracontractual or punitive damages. In cases where no damages have been stipulated

in a contract, the courts award reasonable damages. Even in contracts where the damage amount is stipulated, courts will examine whether the amount stipulated is in the form of a penalty, and can reduce the amount if it is of the opinion that the stipulated sum is a penalty. The Supreme Court settled the law in this respect in *Fateh Chand v Balkishan Das* AIR 1963 SC 1405, and has reiterated the same in subsequent case law.

Under tort law, Indian courts are also slow to award any form of punitive damages, and compensatory damages are usually awarded. In some rare instances punitive damages have been awarded by the courts; these, however, relate to environmental damage cases and cases of negligence where loss of life is involved.

Interpretation of insurance contracts

6 What rules govern interpretation of insurance policies?

It is a settled legal proposition that while construing the terms of a contract of insurance, the words used therein must be given paramount importance, and it is not permitted for the court to add, delete or substitute any words. It is equally settled that, because upon issuance of an insurance policy the insurer undertakes to indemnify the loss suffered by the insured on account of risks covered by the policy, its terms have to be strictly construed in order to determine the extent of the liability of the insurer.

The general rule is that where the contract is expressed in writing, oral evidence is inadmissible to explain or vary the terms of a written contract. Although a contract must always be construed according to the intention of the parties, that intention can only be ascertained from the instrument itself and all other evidence of intention is excluded because, when an agreement is reduced to writing, the parties thereto are bound by the terms and conditions of it. One of the Supreme Court decisions laying down this principle is *United India Insurance Company Limited v M/s Orient Treasures Private Limited* Civil Appeal No. 2140 of 2007, which held that when the terms of the policy are clear, plain or unambiguous, and reasonably susceptible to one meaning, the courts are bound to give effect to that meaning irrespective of the consequences.

However, in the event that there is an ambiguity or doubt as to the provisions in the contract, the same is to be construed contra proferentem, that is, against the insurance company.

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

An insurance policy provision is ambiguous when there is uncertainty as to the meaning or intention of that provision. It can also arise when the same words are capable of two different meanings. When such an ambiguity appears in an insurance policy then it is to be construed contra proferentem, as the terms of an insurance policy are drafted by the insurer in most cases. However, the Supreme Court of India has recently held in the case of *Export Credit Guarantee Corporation of India Ltd v Garg Sons International* (2014) 1 SCC 686 that the rule of contra proferentem does not apply in cases of commercial contracts, because the terms are bilateral and have been mutually agreed upon.

Notice to insurance companies

8 What are the mechanics of providing notice?

The mechanism for the provision of notice to insurers is generally provided in the policy and differs from one policy to the other. Notice can be required to be given by way of post, email or facsimile, and the name and address of the person to whom notice should be given are also mentioned in the policy. We have seen policies where claims or circumstances are required to be reported on a periodic basis by way of a bordereau.

In relation to the contents of the notice, this is also usually governed by the terms of the policy, but generally should contain a summary of the matter including the details of its inception and estimated quantum, along with the supporting relevant information and documentation that would be required by the insurer to assess coverage under the policy. Irrespective of the time period within which notice is required to be given under the policy, insurers always prefer early notification (as soon as the claim or circumstance of the same arises) as they then have the opportunity to effectively participate in the handling of the claim or assume a defence, depending on the policy wording.

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

In a claims-made policy, the insured is required to give notice to the insurer as and when the claim is made against the insured. The trigger point for this sort of policy is a claim or the circumstances of a claim made against the insured. It is advisable that the notice is given immediately when the insured becomes aware of the claim or circumstance, but the outer limit is usually mentioned in the policy. This can be within a specified number of days or 'as soon as reasonably practicable'. The notice is required to carry all the information in respect of the claim or circumstance that will be required by the insurer to assess coverage under the policy and understand the developments in the matter.

10 When is notice untimely?

Notice is usually considered to be untimely when it can be established by the insurer that the notice was not provided to the insurer as soon as practicable and the delay in notification prejudiced the insurers' assessment of the claim.

In *Satpal v United India Insurance Co* RP No. 2068 of 2013, the NCDRC held that 'As far as merits of the case are concerned, learned State Commission rightly allowed appeal as there was delay of more than 30 days in intimation to Insurance Company and thus, petitioner violated terms and conditions of the policy'. In *Hukam Singh and Giriraj v United India Insurance Co Ltd* RP No. 4028 of 2012, it held that:

> *The intimation given to the financing bank cannot be a substitute for the intimation required to be given immediately to the insurance company. Purpose of such intimation of theft to the insurance company is to enable the insurance company to take steps to protect their interest by appointing investigators to trace the vehicle. The petitioners obviously have failed to protect the interest of the insured by failing to immediately inform the report of theft in terms of the general condition 5(i)(b) of the insurance policy referred to in the impugned order.*

In *Bajaj Alliaz General Insurance Co Ltd through Shri Ashutosh Singh, Dty Manager v Mr K Eswara Prasad* RP No. 2555 of 2012, it was held by the NCDRC that 'delay in intimation to the insurance company is fatal. In the case in hand, apparently there is long delay in lodging FIR and intimation to the insurance company about the theft of the insured car and in such circumstances, complaint is liable to be dismissed.'

In the case of *HDFC ERGO General Insurance Co v Bhagchand Saini* RP No. 3049 of 2014, the NCDRC held that any delay in the notification of theft to the police or the insurer in motor vehicle policies is fatal to the claim. Over the past few months, the position in *Bhagchand Saini* has been relied on by the NCDRC in *National Insurance Company Ltd v Babu A Sirsat*, MANU/CF/0772/2014, *Bihar State Hydroelectric Power Corporation Ltd v National Insurance Co Ltd*, *Saurashtra Chemicals Ltd v National Insurance Co Ltd* and *Jatinder Singh v Oriental Insurance Co*.

11 What are the consequences of late notice?

Insurance contracts require that the claims or circumstances of the claims are intimated to the insurer within the time period specified in the policy. This requirement may be expressed as a condition or a condition precedent to the insurer's liability under the policy, and the consequences of non-compliance will, to some extent, depend upon whether the notification clause is expressed as a condition or condition precedent. If the notice clause is a condition, the insurer will have to show that it suffered prejudice on account of the delayed notice, but if the clause is a condition precedent, then in theory no prejudice is required to be shown for placing reliance on the clause.

In practice, however, irrespective of whether the notice clause is expressed as a condition or condition precedent, courts previously have stated that the condition relating to notice should not prevent settlement of genuine claims where there is a delay in intimation or in submission of documents due to unavoidable circumstances. This is the position that the Indian insurance regulator (IRDAI) has also recommended in its circulars, where insurers were directed not to reject claims unless and until the reasons for delay are specifically ascertained and recorded, and the insurers are satisfied that the delayed claims would have been rejected even if they had been reported in time. Courts and consumer fora have also followed the view that clauses limiting the period for notification of claims are not to be construed

strictly, and have often overturned the rejection of a claim where the delay was reasonably justifiable.

The IRDAI also recommends that insurers should incorporate additional wording in the policy documents that suitably highlights that a delay in intimating a claim or submitting the relevant documents to the insurer will be condoned if the delay is proved to be for reasons beyond the control of the insured.

The Supreme Court of India has passed judgments enforcing the agreed terms and conditions between parties. In *Export Credit Guarantee Corp of India Ltd v Garg Sons International*, 2013 (1) SCALE 410, the court allowed a claim to be rejected on grounds that timely intimation of claims was under a credit insurance policy. The court further ruled that the terms and conditions of a contract should be strictly followed '[...] it is not permissible for the court to substitute the terms of the contract itself, under the garb of construing terms incorporated in the agreement of insurance. No exceptions can be made on the ground of equity. The liberal attitude adopted by the court, by way of which it interferes in the terms of an insurance agreement, is not permitted.'

Despite this ruling of the Supreme Court, this approach is not always followed, and further clarification on the issue is necessary to settle the legal position.

Insurer's duty to defend

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

Insurance carriers that use a duty to defend clause in their policies have the obligation to manage the litigation process from the notification of the claim. At the same time, insurers have the right to select the defence counsel who would be appointed. The insured usually has no control over the defence counsel assigned.

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

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

There does not appear to be any Indian case law relating specifically to an insurer's breach of its duty to defend. We understand, however, that this issue is a subject of dispute in the United States, and the position there appears to be that an insurer that erroneously refuses to defend an insured will have no right to subsequently rely on policy defences and appeal against the order of the court. However, one of the biggest risks associated with an insurance company's incorrect choice not to defend an insured is that it may be held liable for breach of contract, specifically if the insured can establish that his or her claim is in fact covered by the policy.

As set out more fully below, once a company has unjustifiably failed to defend, the insurer is not only prevented from raising policy defences, but also has liability for the amount of the judgment rendered against the insured or for the amount of the settlement; expenses incurred by the insured in defending the suit; and any additional expenses caused by the breach of the insurance contract.

However, this does not necessarily mean that the company is liable for more than its policy limits. Unless the insurer has acted in bad faith by refusing to defend its insured (or by failing to act reasonably to settle a claim within its policy limits), it is not liable for that portion of the judgment or settlement in excess of its policy limits.

An unjustified refusal to defend does not arise where the refusal to defend is based upon a conflict of interest. Further, an insurer has not unjustifiably refused to defend where it has offered a defence under a reservation of rights but the insured rejects the reservation of rights. Where coverage is in question, the insurer is not required to provide an unconditional defence.

Standard commercial general liability policies

14 What constitutes bodily injury under a standard CGL policy?

The scope of bodily injury under a CGL policy may vary from one policy to another, but bodily injury is generally understood to mean any bodily injury, sickness, disease or death that is sustained by a person. *Black's Law Dictionary* defines bodily injury as 'physical damage to a person's body'.

Update and trends

The Financial Resolution and Deposit Insurance Bill 2017 (Bill), tabled before Parliament in August 2017, has recently attracted much attention. This has mainly been due to the objections raised by various regulatory bodies such as the Reserve Bank of India and the Insurance Regulatory and Development Authority of India (IRDAI), regarding the Bill's proposal to give certain overarching powers to a new regulator called the Resolution Corporation. The proposed regulator shall be empowered to ensure continuity of a failing institution by transferring its assets and liabilities, merging it with another institution or reducing its debt.

The Bill proposes various amendments to the Insurance Act 1938 (Act), adding that where an insurance company is classified as a failing institution, the powers exercisable by the insurance regulator, IRDAI, under the relevant provisions of the Act, shall be exercised by the Resolution Corporation. The Bill further proposes to empower the Resolution Corporation to sell or transfer the portfolios of an insurance company to another insurance company, and restrain critical insurance companies from writing any new business. According to available press reports, IRDAI has objected to this Bill, citing multiple instances when companies were restructured 'without any loss to the customers', and has emphasised its ability to resolve bankruptcy among insurers. The Bill is presently undergoing scrutiny before a Joint Committee of both Houses of the Parliament.

15 What constitutes property damage under a standard CGL policy?

What constitutes property damage under a standard CGL policy may differ in scope from one policy to another, but it is usually understood to mean physical injury to tangible property resulting in the loss of use of that property.

16 What constitutes an occurrence under a standard CGL policy?

What constitutes an occurrence under a standard CGL policy may differ in scope from one policy to another, but it is usually defined as an accident, including continuous or repeated exposure to substantially the same general harmful conditions.

17 How is the number of covered occurrences determined?

In the event that multiple covered claims are made by the insured in the course of the policy year, the insurer is liable to indemnify the insured until such time as the limit of liability set out under the policy is exhausted.

It appears, therefore, that there can be no predetermined number of covered occurrences to which a policy may respond, and the number of occurrences that trigger coverage under the policy is determined solely by the limit of liability set out under the policy and the time at which such sum is exhausted. There are certain policies that make the deductible applicable individually to each and every loss that arises under the policy.

18 What event or events trigger insurance coverage?

This will be dependent on the wording of the insuring clause in a policy. By way of illustration, cover under a D&O policy will be triggered if there is a claim (written demand, suit, complaint) made against a director or officer of a company who has taken out the policy.

19 How is insurance coverage allocated across multiple insurance policies?

Policies usually contain another insurance clause to cater to situations where the claim notified may be covered by two or more policies covering the same risk. This clause will determine how the loss will be allocated or distributed between the policies and the level of risk to be borne by each insurer. This other insurance clause would normally say either that the policy operates in excess of any valid or collectible insurance or that the policy will contribute rateably in proportion to the amount covered under the contract and that covered under the other policy. If both policies operate in excess over one another, or when there are no such terms in the policy, there will be rateable allocation between different policies.

First-party property insurance

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

The scope of first-party property coverage policies is determined by the terms of the policy. The property policies could be exclusion-based policies where all risks other than those specifically excluded are covered or named-perils policies where only the specific perils named within the terms of the policy would be covered.

The terms and conditions of property and engineering insurance cover are currently governed by the policy wordings specified by the former Tariff Advisory Committee. Very few modifications to these policy wordings have been permitted.

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

There are various methods of valuation. The choice of appropriate valuation method depends on the purpose of the valuation and on the nature of the assets involved. The various methods used for valuation are as follows:

Detailed estimate basis
The detailed estimate method involves working out the bill of materials for various materials such as cement, sand, brick, reinforcement steel, joinery and masonry, along with the cost of labour. Unit rates for various types of work such as brickwork, plastering, reinforced concrete cement and woodwork can also be used for calculating the value of the building.

Plinth area rate method
The *All India Standard Schedule* published by the National Buildings Organisation annually publishes the normal market rate prevailing for construction in a particular area. In the plinth area rate method, such published rates can be used to estimate the value either by perusing the sanctioned plan or by actual measurement. The reinstatement value is obtained by multiplying the plinth area by the rate or unit area.

Fair value method
This represents the value in exchange. This method of valuation is applicable to assets that can be currently exchanged in the market for value (eg, whatever may be the cost of production of liquid petroleum gas, its value in the market for sale in exchange for cash is the fair value).

Depreciation method
This method involves valuing property by deducting appropriate amounts on a yearly basis as depreciation from the book value of the asset.

Book value
This represents the written down value of the assets in the book of accounts. In the first year, this represents the actual cost of the asset, and with each passing year, appropriate depreciation is charged and the value of the asset is accordingly reduced. Over a period of time, the asset value becomes so low that it will not reflect the true worth of the asset.

Market value
In this method, depreciation is allowed on the current replacement value of the asset for the number of years it has been in use to arrive at market value.

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

Insurance policies are routinely issued to provide cover against losses caused by natural disasters. Such disasters include lightning, storm, cyclone, typhoon, tempest, hurricane, tornado, flood and inundation, earthquake, volcanic eruptions and other convulsions of nature. Policies are also issued on an 'all risks' basis, which would cover losses arising out of any cause whatsoever (unless excluded), and would also cover natural disasters. The operation of these policies is similar to other policies insofar as notification, appointment of surveyor, exclusions, conditions precedents, etc, are concerned. However, the court or tribunal is often called upon to decide what the proximate cause was for the loss and whether the proximate cause was a covered peril or an excluded peril.

Directors' and officers' insurance

23 What is the scope of D&O coverage?

D&O policies typically taken out by companies provide cover for the following:

- the personal liability of directors and officers of the company (policyholders or the company's subsidiaries arising due to wrongful acts in their managerial capacity);
- the personal liability of a director outside the entity (company's director or officer who has been asked to serve as a director or officer of another company) arising due to wrongful acts in their managerial capacity; and
- the amounts paid by the company for losses caused by directors and officers of the company arising due to wrongful acts in their managerial capacity.

The scope of the cover may be extended by way of endorsement to cover the company for securities actions made against the company and employment practice violations.

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

We have not seen much litigation in the context of D&O policies in India. In addition, D&O policies typically have an arbitration clause, so most disputes would first be referred to an arbitral tribunal. Unlike in other jurisdictions, such as the United States, we have not seen disputes being raised in India in respect of allocation, scope of cover and coverage for a claimant's attorneys' fees.

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Cyber insurance

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

Cyber insurance policies provide cover, inter alia, for claims arising out of:

- negligent disclosure of personal or corporate information;
- the introduction of unauthorised software, computer code or viruses to third-party data;
- denial of access of an authorised third party to its data; and
- the wrongful appropriation of a network access code of a company.

Policies cover, inter alia, the professional fees incurred in engaging cyber-risk specialists to identify the cause of breaches and independent advisers to advise on mitigation of any adverse effects.

26 What cyber insurance issues have been litigated?

We have seen a growing number of cyber insurance covers being issued and claims being made under them. This has also led to an increased requirement for forensic expert analysis for the purposes of assessment of coverage under such policies. This trend is likely to continue in view of the growing cyber risks.

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?

Yes, terrorism insurance cover is provided in India through the Terrorism Risk Insurance Pool. The pool was formed as an initiative by all non-life insurance companies in India in April 2002 after terrorism cover was withdrawn by international re-insurers post 9/11. The pool is adequate for any eventuality, as its size has crossed 45 billion rupees.

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