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in 17 jurisdictions worldwide

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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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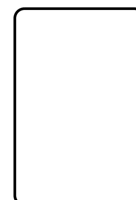

Austria

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Preliminary and jurisdictional considerations in insurance litigation

1 In what fora are insurance disputes litigated?

Insurance disputes in Austria must be asserted by judicial process. The option of a non-litigious procedure only exists in certain cases stipulated by the Austrian Act on Non-Contentious Proceedings. However, this does not include indemnification claims in connection with insurance disputes.

Jurisdiction in Austria is regulated as follows.

District courts are competent for the judgment in first instance regarding all cases under civil law involving amounts of no more than €15,000. Regional courts (courts of first instance) are competent for the judgment in first instance concerning all cases that have not been conferred to the district courts. Furthermore, they are responsible as second instance courts to rule on appeals against decisions by the district courts. The third organisational level provides for higher regional courts. These courts of second instance rule on civil and criminal matters as appellate courts.

As well as these official proceedings, insurance disputes are also referred to arbitration in respective agreements by the involved parties.

2 When do insurance-related causes of action accrue?

According to the general conditions for statutory liability insurance (AHVB), which shall be brought as an example, an insured event describes a damaging event originating from the insured risk, which gives rise or can give rise to damage claim liabilities on the part of the policyholder. (The AHVB are non-binding standard policy conditions of the Austrian Associaton of Insurance Companies.) Several damaging events based on the same cause shall be deemed to be one insured event. In addition, damaging events based on similar and time-related causes shall be deemed one insured event if there is a legal, economic or technical connection between these causes.

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

An insurer usually has to take into account different considerations and strategies from the ones to be considered by a policyholder or damaged party. While an insurer will initially probably raise the question of whether the claim is legitimate and whether the insurer is liable to pay damages at all, the damaged party will likely focus on being compensated as far as possible for damages suffered. In addition, the insurer will examine whether there is another insurance obliged to pay damages. A policyholder for example has to focus on being able to evince and argue clearly and unambiguously the respective insurer's duty of coverage, thus not revealing all circumstances of the case in order to maintain one's coverage. Furthermore, any claims for recourse on the part of the insurer are subsequently to be considered as well as an amicable settlement, which might produce a more cost-efficient result for the insurer.

4 What remedies or damages may apply?

By means of appeals losing parties can contest court decisions (eg, judgment). In civil proceedings, appeals are always ruled on by the higher instance. For court decisions that have not yet become legally binding, the following means of appeal can be resorted to:

- appeal;
- revision;
- recourse; and
- appeal of the decision on appeal.

Furthermore, against legally binding judgments the following means of appeal exist:

- revocation action; and
- action for resumption.

The appeal is directed against a judgment of first instance. It must be filed within four weeks of the date on which the ruling is made known. If the judgment has been delivered orally in the presence of both parties, an appeal must either be made immediately orally or in written form within 14 days of the date on which the minutes of the proceedings are made known. The appeal must be prepared by a lawyer.

The means of appeal against a judgment of second instance is called revision. Likewise, a lawyer must prepare it. The given time period is usually four weeks, but could also be two weeks.

An appeal of the decision on appeal is only admissible for points of law of major importance. For example, this may be the case if the court of recourse deviates from the Supreme Court's jurisdiction or if such jurisdiction is lacking or inconsistent.

In exceptional cases, proceedings that have already been finally decided, may be contested by revocation action (eg, based on the assumption of serious error in the proceedings). Furthermore, proceedings, which have already been legally closed, may be reopened if the judgment was based on an act punishable by a court of law (eg, false witness testimony, falsification of documents).

Interpretation of insurance contracts

5 What rules govern interpretation of insurance policies?

The Austrian insurance contract law does not provide for any express provisions regarding the interpretation of policies; thus, the general rules pursuant to the General Civil Code (ABGB) apply with respect to contract interpretation. According to section 914 of the ABGB, initially the provisions are to be interpreted pursuant to their wording. If the interpretation, according to section 914, produces an ambiguous result, section 915 of the ABGB stipulates the ambiguity rule, according to which an unclear contractual provision

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shall be borne by the party resorting to it. Furthermore, the insurers make use of the standard insurance policy conditions (AVB) that must be expressly agreed on. With respect to their interpretation, the interpretation rules for general terms and conditions apply. They are governed by the ABGB as well as by the Consumer Protection Act (KSchG).

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

The examination of insurance policy provisions in AVB foresees three steps. First, the provision is examined with regard to its clarity according to section 869 of the ABGB. In addition, consumers can call on section 6, section 3 of the KSchG, according to which a provision is ineffective if it is ambiguous or worded in an incomprehensible manner. Only if this examination shows that the provision has indeed become part of the contract a validity examination is to be conducted according to section 864a of the ABGB. With respect to this matter, despite the client's acceptance of the general terms and conditions, unusual and unfavourable provisions that the client should not have had to expect do not become part of the contract. This examination is supposed to protect the client particularly from 'small print'. Pursuant to section 15a of the Insurance Contract Law (VersVG), the insurer cannot refer to any provision of an agreement if this provision contradicts mandatory provisions listed in section 15a of the VersVG. Finally, section 879 of the ABGB provides for the examination of the content of the contractual provisions. Section 1 contains a general 'good faith' clause whereas section 3 is confined to auxiliary conditions of the contract. These conditions are ineffective if they are grossly discriminatory with respect to the contracting party. In turn, section 6, section 1, 2 of the KSchG, gives consumers another means of performing controls. Section 6, section 1 lists all provisions against public policy. Finally, such contradictions will be solved according to the aforementioned rules of section 914 and section 915 ABGB.

Notice to insurance companies

7 What are the mechanics of providing notice?

The policyholder is obligated to give notice of a claim to the insurer immediately upon gaining knowledge of such fact. Telephone notification regarding the claim is sufficient at this point in time. The general conditions for AHVB provide for a time period of one week from the date of knowledge of the damage. The policyholder bears the burden of proof with respect to the existence of an insured event and the amount of damage. Subsequently, the policyholder has to provide all information required by the insurer in order to process the claim. Other rules may be stipulated in the insurance contract or the respective terms and conditions.

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

Claims-made policies typically provide for conditions subsequent of the insured to instantly notify the insurer of any circumstances that may result in a liability case. Such notification of circumstances has to specify the alleged wrongful act of the insured in relation to the circumstances of the case, the time of its commission as well as the potential loss. Even though according to the typical wording of the conditions subsequent the insured is 'obliged' to give notifications of circumstances, notifications of circumstances grant the insured the possibility to 'freeze' the policy at the time of the notification of circumstances.

In a third-party claim, the insured is obliged to instantly notify the insurer of such claim. Again the insured has to specify the alleged wrongful act in respect to the circumstances of the case, the time of its commission as well as the potential loss. Notification of claim has to be made at the latest before the period of insurance expires or – if stipulated – within a period of record. If, however, the insured fails to notify the insurer immediately of a claim and if such late notification results in an increase in risk, the insurer may deny coverage due to a failure to carry out duties.

9 When is notice untimely?

Insurance contract law does not set forth a general time limit with respect to providing notice of insurance claims. However, most general insurance terms and conditions include the clause 'immediately, but within one week at the latest'. Moreover, the policyholder has to give notice on its own initiative and must not wait for a respective request by the insurer.

10 What are the consequences of late notice?

In the event of a breach of obligation on the part of the policyholder (ie, the duty to give notice) with respect to the insurer being released from its obligation to perform, section 6 of the VersVG refers to the respective insurance policy. However, if the insured party breached an obligation through no fault of its own, the insurer is not to be considered released from performance. Pursuant to section 33, section 2 of the VersVG, even in the event of the insured party not giving notice of the claim, the insurer cannot claim release from its obligation to perform if it became aware of the insurance claim by other means.

In case of a breach of an obligation that aims to reduce the danger of an increase of risk, insurers cannot successfully deny coverage if the respective breach of obligation has no influence on the insurance case.

Insurer's duty to defend

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

Defence obligation means the satisfaction of legitimate claims and the defence against unfounded claims. In the event of a claim, in accordance with the general conditions for AHVB, the insurer shall bear the costs of assessment and defence against a third party's claim for liability for damages. Furthermore, the insurer shall cover the judicial and extrajudicial costs appropriate to the circumstances for determining and defending a claim for damages even if the claim turns out to be false.

Beyond that, insurance shall cover the costs of the defence led by the instruction of the insurer in criminal or disciplinary proceedings. Rules deviating from this may be agreed between the insurer and the policyholder.

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

Since in most cases it is a mandatory requirement to be represented by a lawyer before all courts in Austria, insurers regularly mandate a lawyer for judicial defence. If an insurer responds to a coverage inquiry in a delayed manner or if it fails to forward important documentation in time, the insurer might be held liable for damages resulting thereof. However, if the lawyer mandated by the insurer causes, for example, a procedural error resulting in an unfavourable judgment for the insurer, the lawyer shall reimburse the insurer. In both cases the policyholder does not suffer any consequences.

Standard commercial general liability policies

13 What constitutes bodily injury under a standard CGL policy?

In the event of a claim, the insurer assumes compliance with all obligations to pay damages suffered by the policyholder due to bodily injury, material damage or financial loss. Bodily injury means the killing of people, bodily harm or damage to people's health.

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In most cases, CGL insurance means voluntary contributions in order to be protected in the event of a claim. Depending on its business purpose, a business may also be legally required to take out public liability insurance. For example, the Austrian Law on Boilers requires the operators of original inspection bodies and boiler inspection bodies to take out insurance in order to make sure that any claims for compensation can be satisfied. These insurance policies must take out cover of a type and to an extent customary in fair business dealings. The concrete contents regarding the establishment and the extent of the liabilities are to be regulated individually in the respective insurance policy contracts as the case arises. In the event of bodily injury, the insurer, within the scope of its liability for damages, is obliged to pay all treatment costs, damages for pain and suffering as well as any possible loss of earnings or compensation for disfigurement. In addition, damages for grieving or shock may be included in its obligation to pay compensation.

14 What constitutes property damage under a standard CGL policy?

The ABGB stipulates the notion as anything different from a person and serving the purpose of usage by humans shall be deemed to be property in the legal sense. According to the general conditions for statutory liability insurance, property damage is regarded as the decrease in value of property in consequence of an action causing – in economic terms – the compromising of the property's usability for the fulfilment of its original purpose. Property damage can range from light scratches to total destruction. If expressly agreed, aside from the material value, another interest can be insured. The subject of non-life insurance is not the property itself, but the interest of maintaining the property. The interest's value attributed within the framework of the contractual relationship accounts for the insured value.

15 What constitutes an occurrence under a standard CGL policy?

CGL insurance protects the interests of an entrepreneur if a damage event occurs for which compensation may be due within the framework of the entrepreneur's operating activities. Significant liability risks are often connected with operational and commercial activities. Such a liability is called 'absolute liability' and results from a permitted danger (eg, the operation of a dangerous facility). Unlike statutory liability due to a tortious act, absolute liability does not take into consideration any fault on the part of the damaging party. The basic idea behind absolute liability lies in the fact that anyone who derives benefits from dangerous activity (eg, the operation of a power plant) considered to be useful and permitted by society, is also to be held liable for any damages resulting from the danger of these activities. In order to enable the insurability of any such risks, maximum limits of liability are usually set. In Austria, for example, CGL insurance for power plant owners is governed by the Federal Statutory Liability Act, for nuclear plant operators by the Nuclear Liability Act and for aeroplane owners by the Aviation Liability Act.

16 How is the number of covered occurrences determined?

According to the general conditions for AHVB, the amount insured represents the maximum amount payable by the insurer for an insured event. Depending on the amount of the premium and policy arrangements, the insurer is responsible for paying the simple or multiple respective amount insured for insured events occurring within the insurance period. The concrete coverage is stipulated by the individual insurance policy and depends on the amount of the premium. In practice, a cap of the amount of the sum insured per insurance period is often agreed upon. The policyholder is covered until the maximum amount is reached, regardless of the number of claims. Series claims are principally not included in coverage. With respect to coverage, this multitude of insured events of series claims is regarded as a single insured event.

17 What event or events trigger insurance coverage?

The type of event that must occur to trigger insurance coverage depends on the type of the concluded insurance:

- fire insurance: according to the VersVG, it includes fire, lightning strike and explosions plus the resulting consequences;
- hail insurance: damaging of agricultural produce due to hail;
- transport insurance: with transport insurance, the triggering events can be manifold and will individually depend on the policy's concrete provision. The VersVG stipulates that all transit risks are included in coverage;
- statutory liability insurance: covers the policyholder's liability towards a third party. This particularly includes indemnity claims of any kind for the policyholder's culpable behaviour;
- legal costs insurance: for legal costs insurance the event triggering coverage is a legal issue on part of the insured party, concerning which the insured party has contacted a lawyer who seeks compensation for his or her involvement; and
- accident insurance: any type of accident suffered by the insured party can trigger insurance coverage. It is not relevant whether the accident happened within the framework of sports activities or when doing handicraft work. However, whether the accident happened during leisure or work hours is to be taken into consideration.

In conclusion, the events triggering coverage can be manifold and not many general rules can be established. Nevertheless, there are hardly any explicitly excluded events that require insurance coverage to be denied in advance. Both the general conditions for statutory liability insurance and the VersVG notably name the state of war as an exception.

18 How is insurance coverage allocated across multiple insurance policies?

Before discussing coverage under multiple insurance policies, the respective insurance contracts must be examined thoroughly as to whether the coverage issue can be clarified due to an interpretation of a specification. If the insurance policies indeed show the existence of liability on the part of more than one insurer, the problem of establishing who will assume which payment will arise. In principle, every insurance policy is liable for the payment of the entire claim by the insured party. Communication between the obligated insurance companies is important in order to resolve the issue. If an agreement cannot be reached in this way, the insurers are at risk of being sued by the policyholder, who has not yet received compensation.

First-party property insurance

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

First-party insurance in particular protects small and medium-sized businesses against negligent errors caused by their employees, which directly affect the business in the form of pecuniary loss (ie, they do not constitute property damage or consequential financial damage).

Statutory liability insurance and pecuniary loss liability on the other hand are primarily – but not exclusively – aimed at third-party damages. Therefore, if an employee of the insured company causes damages to a third party, the insured company's disadvantages arising from such damages will be covered within the framework of statutory liability insurance. Beyond that, another significant difference with respect to first-party insurance lies in the fact that, for example, D&O insurance normally covers the board of directors, the CEOs, the supervisory board, the advisory board and the executive staff. D&O insurance does not provide for liability for an error

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on the part of an employee, which is why it is also referred to as 'managers' liability insurance'. However, as described in question 21, most D&O insurance policies waive the exclusion of first-party losses entirely.

Such a waiver of first-party losses in a D&O insurance policy excludes damage claims by the company insofar as the insured person holds a major interest in it. This risk exclusion is of special practical importance since it leads to the fact that changes in the shareholding structure of insured persons also automatically change the extent of coverage. This in turn may subsequently result in the fact that the company's risk provisioning displays unexpected gaps. Furthermore, the managers' private assets – without any knowledge on their part – may be put in jeopardy based on a lack of sufficient insurance coverage.

Needless to say, first-party insurance is not intended to make the majority of common insurance obsolete but – on the contrary – to complement it. It blends in with other existing insurance coverage options without replacing them.

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

First-party insurance policies concluded by Austrian insurance companies insure pecuniary losses on the part of the policyholder suffered by the policyholder due to employees' actions. Pecuniary losses mean all damages other than bodily injury or property damage that cause a loss in the policyholder's assets. An example for such a scenario could be the faulty money transfer to an insolvent company, which cannot be reversed.

Since, as already stated, property damages are not included in insurance coverage, the issue concerning the assessment of the lost legal asset does not arise. Pecuniary loss takes the form of money, which is why the evaluation is made based on the nominal value.

Directors' and officers' insurance

21 What is the scope of D&O coverage?

D&O insurance is a pecuniary damage liability insurance only. It provides compensation for financial loss but does not normally cover compensation for bodily injury and material damages.

Insurance coverage generally includes all bodies (the board of directors, CEOs, supervisory board and advisory board) as well as the executive staff of a company subject to the duty of care in compliance with the limited liability company law. The company itself is not included in the coverage.

The scope of D&O insurance encompasses the evaluation with respect to the issue of liability, defence against unjustified claims and indemnification of insured persons in respect of justified claims. If – within the coverage period, criminal proceedings are initiated against an insured person on the grounds of a breach of duty, the insurer may also take on the defence costs.

First-party losses (claims by companies against insured persons holding shares of their own in the company) are compensated only to a limited extent unless the participation is only a small stake. Many providers, however, waive the exclusion of first-party losses entirely.

Coverage is always excluded in the case of wilful damage.

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

The uniqueness with respect to a D&O policy lies in the fact that it constitutes insurance on account of a third party. The rare case of bodies insuring themselves does exist; however, usually the company acts in the role of the policyholder and premium payer insuring all its bodies.

As to internal liability cases, which make up the vast bulk of all D&O claims, this fact leads to a peculiar situation since typically the insurer, the policyholder and the injured third party face each other. However, in the situation of internal liability the policyholder is also the injured third party. Due to the close connection between body and company, this situation often leads to precarious consequences.

There have been cases where the acting persons could not resist construing breaches of duty within the framework of ill-fated management decisions in order to be included in the coverage by the D&O insurance policy.

Update and trends

There are plans to ease the granting of loans to companies for Austrian insurance companies. This on the one hand opens an interesting possibility for insurers to invest on the market, and on the other should provide financial capital for the market.

The admissibility and the necessity of D&O insurance is no longer in dispute in Austria. However, the regulation is still not quite without reservations, in particular in light of the behaviour-steering purpose of the D&O liability. According to detractors, the insurability of internal liability claims does not seem to be compatible with it. In our view this criticism is without reason as each body is free to have its own liability insurance so the behaviour control could be also affected.

At present, such insurance is associated with approximately 3 per cent of the eligible companies in Austria. Thus, it is safe to say that this insurance model is taking root and is no longer limited to publicly owned firms and the industry.

Finally, significant changes are to be expected regarding the market of life insurance due to the impact of the financial crises.

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