INSURANCE LITIGATION

Switzerland

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Insurance Litigation

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Quick reference guide enabling side-by-side comparison of local insights, including into preliminary and jurisdictional considerations; interpretation of insurance contracts; providing notice; duty to defend; standard commercial general liability policies; first-party property insurance; directors' and officers' insurance; cyber insurance; terrorism insurance; and recent trends.

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PRELIMINARY AND JURISDICTIONAL CONSIDERATIONS IN INSURANCE LITIGATION

Fora

In what fora are insurance disputes litigated?

In Switzerland, insurance disputes are often settled out of court and litigation and arbitration are relatively rare.

If no settlement can be reached, most insurance disputes are litigated in state courts. There are no special courts for insurance matters and in a domestic context, the general rules of the Swiss Civil Procedure Code apply, which means that the competent court is typically determined by the place of domicile or residence of the defendant. The competent court may also be determined by a forum selection clause. Such clauses are enforceable except in certain circumstances (eg, in consumer contracts where the consumer may not waive the jurisdiction options provided for in the Swiss Civil Procedure Code). When Swiss Civil Procedure Code permits, parties are more likely to choose to litigate insurance matters in the Cantonal Commercial Courts. These are specialised courts established in four cantons (Zurich, Berne, Aargau and St Gallen), which generally decide in disputes where both parties are registered in the Swiss commercial register or in an equivalent foreign register. However, under certain conditions, the Commercial Court can also be chosen by a non-registered claimant.

Some insurance contracts (in particular, under international insurance programmes) contain arbitration clauses (including the applicable rules of arbitration) to exclude the state courts from having jurisdiction. If an insurance contract provides for arbitration, typically all disputes related to or arising out of the contract will be resolved by arbitration rather than state courts.

Law stated - 21 February 2023

Causes of action

When do insurance-related causes of action accrue?

Insurance-related claims are usually breach of contract claims, based on the allegation that an insurer breached its obligation to defend and/or indemnify the insured. The timing of claim accrual is generally the occurrence of the fact that triggers the insurer's obligation to pay. As such, the duty to defend usually arises as soon as there is a need for legal protection. With regard to the duty to indemnify, claim accrual depends on the type of insurance and the insurance contract. Under a property insurance, it is usually the realisation of the insured risk (eg, under a fire insurance, the date of the fire event). Under a liability insurance, it is usually the date on which the insured’s liability is established on the basis of a (final) court decision. For a claim to be viable, it must be filed within the limitation period provided for in the Federal Insurance Contract Act, which nowadays is generally five years.

Under certain circumstances both the insured and the insurer may also file for a declaratory judgment regarding preliminary questions (eg, which policy applies to determine in particular the temporal scope of cover).

Law stated - 21 February 2023

Preliminary considerations

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

The following questions may be relevant for consideration either for the insurer or for the insured. Is the damage sufficiently established to have a claim? What is the scope of cover? Is there a clear exclusion of coverage? What is the

temporal scope and the territorial scope of the insurance policy or policies? Are there several policies out of which only one applies, for example, due to a series of claims clause? Are there several insurers, maybe as co-insurers or as excess insurers? Where is jurisdiction? Is the forum arbitration or a state court? Is the claim due for payment at all? Was the insurer provided with all the facts and documentary material to assess the claim? Is the burden of proof an issue? Where is the line to be drawn for or against a settlement, for or against a trial? In addition, insurers should carefully consider whether litigation may set precedents for the interpretation of certain (standard) clauses.

Law stated - 21 February 2023

Damages

What remedies or damages may apply?

Usually, the insured will file an indemnity claim against the insurer for its damages that appear to be covered under the policy in question. Under certain circumstances, also as a pre-question to the indemnity claim, one party may seek relief for a declaratory judgment, typically on the applicability of one single policy out of several policies. If a policy provides for defence cost coverage (eg, a D&O liability litigation) also such defence costs may qualify as damages.

Swiss procedural law and Swiss international arbitration rules also provide for compensation for the legal fees incurred by the party succeeding in the insurance litigation (or arbitration) as well as court fees to be paid by the party losing the case.

Law stated - 21 February 2023

Under what circumstances can extracontractual or punitive damages be awarded?

Under Swiss law, extracontractual or punitive damages do not exist in the sense as known in the US and other Anglo-Saxon legal systems. Swiss courts, in principle, cannot enforce punitive damages either, even if the applicable foreign substantive law provides for those damages, as punitive damages are usually considered contrary to Swiss public policy.

Law stated - 21 February 2023

INTERPRETATION OF INSURANCE CONTRACTS

Rules

What rules govern interpretation of insurance policies?

In general, insurance policies must be interpreted in accordance with the same rules as other contracts. The content of a contract is determined by the common actual intent of the parties at the time of the conclusion of the contract (subjective interpretation). If the common actual intent cannot be determined, the presumed intent of the parties must be assessed, which requires the examination of the relevant clause's objective meaning (objective interpretation).

To determine the objective meaning of a contract or clause, it must be determined how reasonable parties would have understood the contract or clause in good faith and in light of all the circumstances. The wording of the contract acts as a starting point. Additional means of interpretation are the contract structure, the purpose of a clause and of the contract in general, the circumstances of the contract conclusion, the appropriateness of an interpretation or industry custom and practice, etc.

If neither the subjective nor the objective interpretation lead to a clear result, the general ambiguity rule provides that clauses are to be interpreted to the disadvantage of the drafter or the party that is considered to have more industry

expertise and that caused the use of the pre-formulated terms and conditions.

In addition to the general ambiguity rule, article 33 of the Federal Insurance Contract Act states a similar rule that specifically applies to exclusions in insurance contracts. The rule provides that if a provision remains ambiguous, the meaning of the provision that is more favourable to the insured shall prevail.

Law stated - 21 February 2023

Ambiguities

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

A provision is considered ambiguous when the means and rules of interpretation have not led to a clear result and the interpretation of the clause is not only disputed, but at least two different interpretations appear to be seriously justifiable. This applies to all contracts, not just insurance policies. According to the ambiguity rule, ambiguous clauses are interpreted to the disadvantage of the drafter or the party that is considered to have more industry expertise and that caused the use of the pre-formulated terms and conditions.

In addition, article 33 of the Federal Insurance Contract Act states the same rule specifically for exclusion clauses in insurance contracts. Accordingly, if a clause remains ambiguous in the sense as described above, the meaning of the provision that is more favourable to the insured prevails.

Law stated - 21 February 2023

NOTICE TO INSURANCE COMPANIES

Provision of notice

What are the mechanics of providing notice?

The Federal Insurance Contract Act provides for a number of different notice or information obligations of the policyholder:

When entering into an insurance contract the policyholder has to notify the insurer, upon request, of all facts relevant to the assessment of the insured risk, to the extent the policyholder is aware or should have been aware of such facts. Relevant are facts that are likely to influence the insurer's decision to conclude the insurance contract in general or on the agreed terms. If the policyholder, upon request, incorrectly discloses or conceals a relevant fact, the insurer may – under certain circumstances – terminate the contract. The insurer's request, the policyholder's notification as well as the insurer's notice of termination must be made in writing or in another form that allows proof by text.

During the term of the insurance contract, the policyholder is obliged to promptly notify the insurer in writing if the insured risk has increased without the policyholder’s influence or involvement. If the policyholder fails to do so, the insurer may – under certain circumstances – be released from its future obligations under the policy. If the risk increase was caused by the policyholder, there is no statutory notice requirement (however, the policy may stipulate such an obligation), but the insurer is – again under certain circumstances – automatically released from its future obligations under the policy.

Finally, and most important, the insured is obliged to notify the insurer as soon as the insured becomes aware of the occurrence of an insured event and of the respective claim under the insurance policy. While Swiss law does not impose a duty that such notification must be made in writing, the policy might do so (and often does). Insurance policies may also define a specific time frame in which notice is to be provided. In principle, late notification does not have any legal consequences for the insured except where the insured is at fault and the delay leads to an increase in the loss.

Law stated - 21 February 2023

Obligations

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

The Federal Insurance Contract Act does not provide specific rules for claims-made policies. According to the general rule, the insured is obligated to provide notice to the insurer as soon as the insured becomes aware of the occurrence of an insured event and of the respective claim under the insurance policy. While Swiss law does not impose a duty to make the notification in writing, the insurance policy might do so (and often does).

In claims-made policies, the decisive 'event' is defined as a third-party claim made against the insured. Many policies state that a third-party claim is considered to be made as early as when the insured becomes aware of any circumstances that could give rise to such a demand at any future time. The insured must therefore take special care to detect any such claims and to provide notice to the insurer in time.

Law stated - 21 February 2023

Timeliness

When is notice untimely?

Article 38 paragraph 1 of the Federal Insurance Contract Act states that the insured is obligated to provide notice to the insurer as soon as the insured becomes aware of the occurrence of an insured event and of the respective claim under the insurance policy.

Swiss statutory law does not state a specific time frame, but certain insurance policies might do so. If the insurance policy is also silent on this issue, there may be case law, depending on the type of insurance, that indicates more precisely how quickly the insured must act. However, case law does usually not set specific time limits and courts decide on a case-by-case basis whether a specific notice is considered timely.

Law stated - 21 February 2023

What are the consequences of late notice?

Article 38 paragraph 2 of the Federal Insurance Contract Act provides that in case of late notice, the insurer is entitled to reduce the compensation by the amount by which it would have been reduced if the notice had been made in time. However, the provision is not mandatory, and the parties are free to agree on the legal consequences. It is therefore common that the insurance policy goes further and denies the insured any compensation in the case of late notice.

There are two legal requirements for a reduction (or denial) of coverage in case of a late notice: The insured must have been at fault, and the late notice must have had a causal influence on the amount of the compensation (ie, it must have led to an increase in the loss). This rule is, in principle, mandatory. Only insurance policies concluded with certain categories of beneficiaries (eg, insurance companies, banks or companies with a professional risk management) may waive the requirement of the insured's fault.

Law stated - 21 February 2023

INSURER'S DUTY TO DEFEND

Scope

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

The insurer is obligated to either take all necessary measures to defend the insured against unjustified claims or to cover the insured's defence costs.

In the former case, the insurer will act on behalf of the insured and negotiate with the injured, conclude settlement agreements or litigate and hire an attorney, if necessary. The insurer bears all related costs, in particular attorney and court fees. While the insurer must proceed in the insured's best interest, it remains mainly the insurer's decision which measures shall be taken.

In the latter case, the insured will act on their own but may need the prior consent from the insurer before going forward with certain measures, particularly entering into a settlement agreement. Thus, the insurer will remain in the background, and its role will be reduced to assume the defence costs.

The insurance policy might also entitle the insurer – under certain conditions – to pay an unjustified claim instead of defending the insured against it. The insurer usually chooses to do so in cases where the defence costs are potentially higher than the claim itself.

Law stated - 21 February 2023

Failure to defend

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

If the insurer acts on behalf of the insured defending the insured against an unjustified claim, the insurer is obligated to act with due care and in the insured's best interest. If the insurer breaches the duty of care, the insurer may be liable to the insured.

If the insurer fails to defend the insured or to cover the insured's defence costs, the insured must initiate a coverage claim against the insurer and file a lawsuit to enforce the right to be defended. However, until such coverage claim is decided, the insured will have to bear the defence costs. If the coverage claim is successful, the insurer has to defend the insured or assume the insured's defence costs, and the insurer may also be liable for damage that the insured suffered due to the insurer's (initial) inactivity.

Law stated - 21 February 2023

STANDARD COMMERCIAL GENERAL LIABILITY POLICIES

Bodily injury

What constitutes bodily injury under a standard CGL policy?

Such a policy essentially provides for bodily injury sustained by third parties (and not by the policyholder) as a result of an occurrence. Typical examples are product liability cases, such as a defect machine causing an accident, or the well-known cases of asbestos causing fatal lung defects. Under the freedom of contract, the insurer in the policy usually defines the scope of 'bodily injury', which can mean both a purely physical problem and/or a non-physical distress.

Under a standard CGL, the term bodily injury usually means death, physical injury, or other impairment of the health of individuals, including heart attacks or mental disorders resulting from an incident. Insurance will also cover claims for pecuniary losses, losses of earnings, and for pain and suffering resulting from a bodily injury.

Law stated - 21 February 2023

Property damage

What constitutes property damage under a standard CGL policy?

Under a standard CGL policy, property damage is defined as the destruction, damage, or loss of movable and immovable property (including any subsequent pecuniary loss or loss of earnings that the injured party suffers as a result). Not included is the mere impairment of a property's functions without any impairment of the property's physical substance. Death, injury, other impairment of the health of animals and loss of animals are deemed to be equivalent to property damage. Property damage is an injury of a tangible property and will not include intangible assets such as reputation or goodwill.

Cover of property damage in Switzerland is often combined in policies with economic or financial loss due to a business interruption caused by the property damage.

Law stated - 21 February 2023

Occurrences

What constitutes an occurrence under a standard CGL policy?

An occurrence is any event, incident, act or behaviour that happens during the policy period and that leads to a damage covered under the policy. A policy might further define the time of occurrence. For example, the time of occurrence might be deemed as the time when the damage is first discovered, or, for bodily injuries, as the time when the injured consults a doctor for the first time due to symptoms caused by the injury in question. Quite frequently, the question arises whether an event or a series of events constitutes a single occurrence or multiple occurrences and therefore multiple insurance claims.

Law stated - 21 February 2023

How is the number of covered occurrences determined?

The number of covered occurrences is usually not limited by number, but rather by capping the insurance sum covered in a specific insurance period. There is also the possibility of defining a sublimit for specific occurrences. Furthermore, claims series clauses play a pivotal role in reducing the number of covered occurrences (and thus limiting the insurer's risk). A claims series clause typically aggregates all claims arising from damages that are related in a certain way into one 'occurrence' and thus into one claim under the policy. The question whether multiple claims are deemed a claims series is relevant for the question whether a limit or sublimit and a deductible will be applied once (for a claims series as one single occurrence or claim) or several times (for each occurrence or claim).

Law stated - 21 February 2023

Coverage

What event or events trigger insurance coverage?

The insurance contract determines the trigger either as a claim asserted against the insured (claims-made policy) or an occurrence taking place at a certain point in time (occurrence policy), usually during the policy period.

Law stated - 21 February 2023

How is insurance coverage allocated across multiple insurance policies?

The insurance contract may provide for allocation rules. We have to distinct between (1) multiple policies covering the same insurance period and (2) multiple policies covering each an insurance year or period over a total period of time.

In case (1), multiple policies will either provide each for a pre-defined part of the total coverage as co-insurers, and if not defined, allocation is made in proportion of the insurance sums provided in the policies; or coverage may be structured among them with a primary policy and excess policies structured as a 'tower of layers' where allocation is made in the order of the levels, while the 'lowest' or 'primary' will be exhausted first (following the self-retention of the insured). Layers further up in the tower might only have to provide coverage to the extent the amount of the claim reaches their upper levels of exhaustion.

In case (2) where multiple insurers cover a row of insurance years over a total time period of insurance, there are various possibilities imaginable how coverage on the total damage could be allocated. Usually, the damage is exactly calculated for each insurance period and each policy. If such a calculation does not appear to be objectively possible, the total damage is usually allocated among the applicable policies in proportion of the insurance sums provided by the policies.

Law stated - 21 February 2023

FIRST-PARTY PROPERTY INSURANCE

Scope

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

First-party property insurance policies compensate a policyholder for physical loss, destruction or damages to property owned or (regularly) used by the policyholder.

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Valuation

How is property valued under first-party insurance policies?

The basis of recovery and loss adjustment under a first-party insurance is generally either the 'replacement cost' or the 'actual cash value (ACV)'. Replacement cost coverage usually allows the policyholder to recover the amount required for the new acquisition or new production of an equivalent property. In contrast, ACV coverage typically covers the depreciated value of the lost or damaged property. Which type of valuation applies depends on the policy language and the type of coverage. Some policies also provide that valuation of property that is not replaced or repaired shall be at ACV.

Law stated - 21 February 2023

Natural disasters

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

Yes, insurance for natural disasters is available. For buildings, it is mandatory in most cantons to have a buildings insurance covering certain types of natural disasters such as floods, fires or storms. Coverage depends on the policy language. However, the policyholder can generally recover the damage caused by the natural disaster to the insured property as well as the damage resulting from the extinguishing and clearing work. There is usually a wide range of limitations or exclusions, which vary depending on the type of natural disaster (eg, exclusion for damage due to poor building land, faulty construction, poor building maintenance, failure to take preventive measures).

Law stated - 21 February 2023

Pandemic

Is insurance available in your jurisdiction for pandemic-related losses and, if so, how does it generally apply?

Yes, such insurance is available. However, while many insurance policies provide coverage against losses related to epidemics or infectious diseases, they specifically exclude pandemic-related losses. Under such policies, it is crucial for the insurer to clearly define where to draw the line between an epidemic and a pandemic. In addition, especially since the emergence of covid-19, insurers tend to limit coverage against infectious disease-related losses to specific diseases. The policy usually provides coverage against the financial consequences of closures of a business or parts of a business (ie, against damage resulting from business interruption), as well as damage resulting from the disposal or removal of contaminated or suspected contaminated goods. Coverage may also include damages resulting from closures of direct suppliers or buyers.

Law stated - 21 February 2023

DIRECTORS' AND OFFICERS' INSURANCE

Scope

What is the scope of D&O coverage?

The persons insured under a D&O policy are typically and particularly: (1) the directors and officers as well as the management, the internal auditors and the founders; (2) members of staff who have an independent decision-making function in important areas of responsibility of the company (de facto directors or officers); and (3) chief representatives and authorised officers.

A D&O insurance protects the insured from claims that arise from a breach of duty. Depending on the policy, insurance might also cover legal protection costs in criminal proceedings, provided they are instituted against the insured on account of a breach of duty. Coverage is limited to cases in which the insured did not act wilfully or intentionally. In addition, there are usually exclusions for claims in connection with civil penalties, criminal fines and reparations with a criminal or exemplary character (including punitive or exemplary damages), with money laundering or with tort. The insurance policy might also not be applicable to claims asserted in the United States.

Law stated - 21 February 2023

Litigation

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

One issue that has gained importance in recent years is the question of coverage of criminal proceedings instituted against the insured. The reason is that such proceedings are not covered if the insured has acted with a certain degree

of intention. Disputes may arise on the interpretation of what degree of intention is required for coverage to be excluded or under what circumstances a certain degree of intention is deemed 'established' (eg, whether a final court judgment is required). This in turn affects the question of how far into the criminal proceedings the insurer must advance defence costs, as once the required criminal intent of the insured is established in the sense of the policy, the insurer can cease to advance costs and reclaim the costs already paid.

Law stated - 21 February 2023

CYBER INSURANCE

Coverage

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

Commercial cyber insurance usually first and foremost covers attacks on the insured's IT system by third parties or insureds whereby the IT system of the insured or of a third party is damaged. This does not include property damage on the IT hardware. Covered are in particular attacks carried out by malware, computer viruses or ransomware, denial-of-service attacks or hacker attacks. Certain policies also cover social engineering attacks.

The insurer will typically bear, among others:

- restoration costs such as the costs of restoring the data or removing malware from the insured's IT system;
- loss of earnings and costs incurred due to business interruption;
- costs associated with a data breach, such as expenses incurred in notifying authorities and persons who are potentially affected, or legal fees in connection with regulatory or administrative proceedings brought against the insured;
- coverage against third-party claims for damages arising from a cyber attack on the insured's IT system, including defence costs in case of an unjustified claim; and
- crisis management costs, such as costs of experts to identify security gaps or costs of a PR agency to help the insured with crisis communication.

Law stated - 21 February 2023

Litigation

What cyber insurance issues have been litigated?

We are not aware of any cyber insurance issue that has been litigated before Swiss state courts up to this date.

Law stated - 21 February 2023

TERRORISM INSURANCE

Availability

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

Certain insurers offer insurance for damage caused by terrorist acts in Switzerland, either as stand-alone coverage or through additional terms to the underlying insurance policy. Such policies might cover damage caused by fire, explosion and similar incidents that are directly or indirectly attributable to terrorism. In the policy, terrorism is usually defined as act of violence or threat of violence aimed at achieving political, religious, ethnic, ideological or similar aims.

Depending on the policy, coverage might be exclusively limited to acts of terrorism or extended to include riots, civil war and other threats.

Law stated - 21 February 2023

UPDATE AND TRENDS

Key developments of the past year

Are there any emerging trends or hot topics in insurance law in your jurisdiction?

With effect from 1 January 2022, a revised version of the Federal Insurance Contract Act (ICA) entered into force. The revised ICA introduced a number of new provisions, such as:

- a 14-day right of revocation; the possibility of retroactive insurance coverage if an insurable interests exists;
- the elimination of the deemed approval rule according to which the policyholder had to request the correction of an incorrect policy within four weeks, otherwise the policy was deemed approved; an extension of the limitation period from two to five years (with some exceptions);
- the introduction of an ordinary termination right for the policyholder by the end of the third or any following year if the insurance contract has been executed for a longer term; or
- the introduction of a general direct right of claim of the third-party injured person against the insurer for all liability insurances.

Law stated - 21 February 2023

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