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Israel

INSURANCE DISPUTES

Contributor

Granot Speiser Law Office

Adv. Shai Granot

Founder, Senior Executive Partner | shaig@grs-law.co.il

Adv. Sagi Sakian

Partner, The Insurance and Litigation Departments | sagis@grs-law.co.il

This country-specific Q&A provides an overview of insurance disputes laws and regulations applicable in Israel.

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ISRAEL
INSURANCE DISPUTES

1. What mechanism do insurance policies usually provide for resolution of coverage disputes?

Insurance policies usually provide multi-layered mechanisms in case coverage disputes arises.

The most common mechanisms that can be usually found in insurance policies are either **local mechanism** – i.e. between the insurer and the insureds, or **external mechanism**, that is outsourced, usually when the local mechanism fails:

- **[local mechanism]** The most basic mechanism in case of coverage dispute is the negotiation between the parties involved in the coverage dispute, i.e. the insured and the insurer and their legal counsels.
- **[local mechanism]** Another mechanism that is included in insurance policies comes in the form of *allocation*. When a dispute regarding coverage arises, depending on the extent of the dispute, the parties agree to use their best efforts to determine a fair and reasonable allocation that properly represents the relative legal and financial exposure of the insureds.
- **[external mechanism]** In case the local mechanisms fail, usually policies also contain external mechanisms such as the reference of the dispute to a member of the local Bar Council, which is mutually agreed by the parties, or in lack thereof – to be nominated by the Chairman of the Bar Council, based on written submissions of the parties.
- **[external mechanism]** Mediation – insurance policies sometimes contain a mechanism that allows the parties to conduct mediation regarding the coverage dispute.
- **[external mechanism]** Arbitration – sometimes (rarely), the policies also allow arbitration as a form of dispute resolution.

It is important to note that usually a policy contains a provision that stipulates that the policy is governed by, subject to and interpreted by the Israeli Law, and that any dispute shall be exclusively litigated under the exclusive jurisdiction of Israel.

2. Is there a protocol governing pre-action conduct for insurance disputes?

In addition to the mechanisms set out in the answer to the previous question, although not specifically governed by law, there are general pre-action obligations the parties are expected and required to fulfil by the courts before filing for a court claim, governed by general civils laws, such as under section 12 and 39 to the Contracts Law (General Part), 1973-1973, that govern the obligation of the parties to exercise their rights in “good faith”.

3. Are the Courts in your region adept at handling complex insurance disputes?

In Israel, there is no dedicated court to adjudicate insurance disputes, and they are handled in the civil courts. Although the Israeli courts possess extensive experience and expertise in handling intricate insurance disputes, the field of insurance law is constantly evolving, leaving several legal questions in the insurance disputes field unlitigated and unresolved.

4. Is alternative dispute resolution mandatory in your jurisdiction?

In Israel, alternative dispute resolution is not mandatory, with one reserved exception. As a customary practice, alternative dispute resolution methods, such as mediation or arbitration as mentioned earlier, are contingent upon the mutual consent of both parties and are not legally obligatory.

The reserved exception arises when a court claim is filed with a civil magistrate court, for a claim exceeding NIS 40,000 (with the exception of a claim for compensation

due to bodily injury or a claim arising from the law on compensation for victims of road accidents), and then the parties are obliged, by law, to be referred to a "Mahut Meeting". The term "Mahut" is an acronym for "A meeting of Information, introduction, and coordination to examine the possibility of settling the dispute through an alternative dispute settlement mechanism". This meeting is facilitated by a certified mediator.

It is important to note, however, that the Mahut Meeting serves as a preliminary step during which the appointed mediator outlines the procedure. Subsequently, both parties either agree to pursue mediation for the claim's resolution, or either one party declines, leading to the case being returned to the litigation process in court.

5. Are successful policyholders entitled to recover costs of insurance disputes from insurers?

It is possible for successful policyholders to be entitled to recover the costs of insurance disputes from insurers under certain circumstances, and the position of an insured that wins in a claim against an insurer is the same as any other plaintiff who is successful in their claim. The procedural rules state that a party who wins his claim is also entitled to an award of court costs and expenses in his favor.

However, the specific rules governing the recovery of costs can vary depending on the nature of the dispute, the terms of the insurance policy, and the decisions of the courts.

For example, in cases where a genuine dispute arises between the Policyholder and the insurer due to unprecedented issues stemming from complex circumstances, and where the insurer maintains a reasonable position, the recovery of costs may be minimal or non-existent, even if the court rules in favour of the Policyholder.

Generally, if a policyholder successfully prevails in an insurance dispute, they may be awarded costs associated with legal fees, court expenses, and other related costs.

6. Is there an appeal process for Court decisions and arbitral Awards?

In Israel, there is an appeal process available for both court decisions and arbitral awards, although the procedures differ between the two.

For court decisions, parties generally have the right to appeal to a higher court if they believe there are legal errors in the judgment or if they disagree with the outcome. The appeal process typically involves submitting an appeal petition outlining the grounds for appeal, followed by a review of the case by a higher court. The first appeal to a higher court can be lodged without requiring permission or authorization to do so. The appellate court may affirm, reverse, or modify the lower court's decision based on its assessment of the legal issues involved.

Regarding arbitral awards, the ability to appeal is more limited. According to the **Israeli Arbitration Law, 5578-1968**, in general, arbitral awards are final and binding on the parties, and there is limited recourse for appealing them, except when the parties agreed in advance that the arbitral award can be appealed in front of an arbitrator, or alternatively, in front of the court, via a petition for permission to appeal, under certain preliminary conditions, such as that the parties mutually agreed that the matter will be ruled by the arbitrator in accordance with the law, and that the parties also mutually agreed that the matter can be appealed with the court. However, under certain circumstances, such as when there are procedural irregularities or the arbitrator exceeded their authority, parties may seek to challenge an arbitral award through a process known as setting aside or vacating the award. This process typically involves filing a petition with the appropriate court and demonstrating specific grounds for setting aside the award as provided under Israeli law.

Overall, while both court decisions and arbitral awards may be subject to some form of review or appeal in Israel, the procedures and grounds for appeal differ between the two.

7. How much information are policyholders required to disclose to insurers prior to inception of the policy?

Generally, in Israel, policyholders are required to disclose all material information to insurers prior to the inception of the policy, according to the **Insurance Contracts Law, 5571-1981 ("Insurance Contracts Law")**. Material information refers to any facts or details that could influence the insurer's decision to accept the risk, determine the premium, or establish the terms and conditions of the policy. This obligation is based on the principle of utmost good faith, which requires both parties to act honestly and fairly in their dealings. Failure to disclose material information accurately and completely results in various courses of actions – from diminished compensation to the insureds, to instances where the insurer may void the policy or deny a claim

based on non-disclosure. It is essential for policyholders to provide full and accurate information to insurers to ensure the validity and effectiveness of their insurance coverage.

8. What remedies are available for breach of the duty of disclosure, and is the policyholder's state of mind at the time of providing the information relevant?

Remedies for breach of the duty of disclosure by a policyholder typically depend on the nature and severity of the breach, and are governed under section 7 to the **Insurance Contracts Law**. If a policyholder fails to disclose material information to an insurer, the remedies available to the insurer may include:

- Reduced Liability: In typical cases, non-severe cases of failure to disclose, the insurer may only be liable for sums they would be liable if the insured had properly disclosed the information.
- Voidance of the Policy: The insurer may have the right to void the insurance policy ab initio (from the beginning), treating it as if it never existed. This means the insurer would not be obligated to provide coverage for any claims, and premiums paid may be forfeited. It is important to note that such remedy is in the extreme cases when the disclosure was made with fraudulent intent, or if a reasonable insurer would not have entered an insurance contract under the disclosed circumstances.
- Denial of Claims: If the breach of the duty of disclosure relates to specific information relevant to a claim, the insurer may deny coverage for that claim based on the non-disclosure.
- Legal Action: Although rarer and depending on the specific circumstances, the insurer may pursue legal action against the policyholder for damages resulting from the breach of the duty of disclosure.

Regarding the policyholder's state of mind at the time of providing the information, it can be relevant in certain circumstances. If the policyholder knowingly and intentionally withholds material information from the insurer, it may strengthen the insurer's case for voiding the policy or denying a claim. However, if the failure to disclose was unintentional or due to a genuine misunderstanding, it may influence the outcome of any legal proceedings or negotiations between the parties. Ultimately, the courts would consider all relevant factors, including the policyholder's state of mind, when determining the appropriate remedy for the breach of the duty of disclosure.

9. Does the duty of disclosure end at inception of the policy?

In Israel, the duty of disclosure generally extends beyond the inception of the policy, and is governed under sign D to the Israeli **Insurance Contracts Law,** sections 17-21. While the duty of disclosure is most critical during the underwriting process when the policy is being issued, it is an ongoing obligation throughout the duration of the insurance contract. Policyholders are generally required to promptly disclose any material changes in circumstances that may affect the risk or the insurer's decision to provide coverage.

For example, if a policyholder experiences significant changes in their business operations, property, or health status during the policy term, they may have a duty to inform the insurer of these changes. Failure to disclose such material changes could potentially impact the validity of the policy or the insurer's obligation to pay claims which may be connected to such material changes.

However, the specific duration and scope of the duty of disclosure may vary depending on the terms of the insurance contract, the type of insurance involved, and applicable legal principles. It is essential for policyholders to carefully review their insurance policies and understand their ongoing obligations regarding disclosure to ensure compliance with contractual and legal requirements.

10. Are certain types of provisions prohibited in insurance contracts?

Yes, in Israel, certain types of provisions are prohibited in insurance contracts. The **Insurance Contracts Law**, and subsequent amendments set forth regulations and restrictions aimed at protecting policyholders and ensuring fairness in insurance contracts. Prohibited provisions may include clauses that unfairly limit or exclude coverage, unfairly favor the insurer, or otherwise contravene public policy or statutory requirements.

Some examples of prohibited provisions in insurance contracts in Israel may include:

- Article 263 to the **COMPANIES LAW 5759-1999**, stipulates that there will be no validity to the provision in the company's articles of association or bylaws, which allows

the company to enter into a contract to insure the liability of its officer, that permits the exemption of an officer from his liability towards the company in several instances, such as the breach of duty of care with intent or recklessly.
- There are articles in the Insurance Contracts Law are cogent, meaning they can't be stipulated by the parties, while some of those articles are cogent unless the change benefits the insured, in accordance with articles 39, 52, 64, 67, 71 to the **Insurance Contracts Law**.

These prohibitions are intended to promote transparency, fairness, and consumer protection in the insurance market. Insurance contracts in Israel must comply with these legal requirements, and provisions that violate them may be unenforceable or subject to legal challenge. It is essential for insurers and policyholders alike to be aware of these regulations and ensure that insurance contracts adhere to the relevant legal standards.

11. To what extent is a duty of utmost good faith implied in insurance contracts?

In Israel, a duty of utmost good faith (also known as *uberrimae fidei*) is implied in insurance contracts to a significant extent. This duty requires both the insurer and the insured to act honestly, fairly, and transparently in all dealings related to the insurance contract.

Under this principle, the insured is obligated to disclose all material information that could reasonably influence the insurer's decision to accept the risk, determine the premium, or establish the terms and conditions of the insurance policy. Failure to disclose material information accurately and completely may result in diminished indemnification or on extreme cases the voidance of the policy or denying a claim based on non-disclosure.

Similarly, the insurer is required to deal fairly and honestly with the insured, providing clear and accurate information about the terms, coverage, and limitations of the insurance policy, even if the insured did not request such information. The insurer must also handle claims promptly and fairly, adhering to the terms of the policy and applicable laws and regulations.

The duty of utmost good faith applies throughout the duration of the insurance contract, from the initial application and underwriting process to the renewal or termination of the policy. Both parties are expected to maintain the highest standards of integrity and transparency to ensure the integrity and enforceability of the insurance contract.

Courts in Israel interpret and apply the duty of utmost good faith in accordance with statutory articles, case law, and principles of equity and fairness. While the exact scope and application of the duty may vary depending on the specific circumstances of each case, it is a fundamental principle that underpins the regulation of insurance contracts in Israel.

12. Do other implied terms arise in consumer insurance contracts?

Yes, besides the duty of utmost good faith, several other implied terms may arise in consumer insurance contracts in Israel. These implied terms are often derived from common law principles, statutory articles, and legal precedents, and they help to ensure fairness and protection for consumers in insurance transactions. Some of these implied terms may include:

- Implied Terms of Coverage: Consumer insurance contracts in Israel may imply certain terms regarding the scope and extent of coverage provided under the policy. These terms may include coverage for risks that are reasonably within the contemplation of the parties, as well as obligations on the insurer to fulfil its contractual duties in good faith.
- Implied Duty of Care: Derived from torts law, Insurance contracts typically imply a duty of care on the part of the insurer to handle claims promptly, fairly, and in accordance with the terms of the policy. This duty may include obligations such as investigating claims thoroughly, providing clear explanations of coverage, and processing claims in a timely manner.
- Implied Duty of Disclosure: While the duty of utmost good faith places a primary obligation on the insured to disclose material information, insurers also have an implied duty to request relevant information and make reasonable inquiries to ensure they have a full understanding of the risks being insured.
- Implied Terms of Contractual Interpretation: Consumer insurance contracts may be subject to implied terms of contractual interpretation, which govern how the terms of the contract are construed and applied. These implied terms may include principles such as contra proferentem (interpreting ambiguities against the drafter) and giving effect to the reasonable expectations of the parties.

- Implied Duty of Fair Dealing: In addition to the duty of utmost good faith, insurers may have an implied duty of fair dealing toward insureds, which requires them to act reasonably, honestly, and fairly in all dealings related to the insurance contract.

These implied terms, among others, help to ensure that consumer insurance contracts in Israel are governed by principles of fairness, transparency, and accountability, and they provide important protections for insured individuals and policyholders.

13. Are there limitations on insurers' right to rely on defences in certain types of compulsory insurance, where the policy is designed to respond to claims by third parties?

In Israel, certain types of compulsory insurance, especially those designed to respond to claims by third parties, may have limitations on insurers' rights to rely on defences. The rationale behind such limitations is to ensure that the injured third parties are adequately protected and compensated, regardless of any potential disputes between the insurer and the insured.

One notable example of compulsory insurance in Israel is compulsory motor vehicle insurance (known as "**MTPL**" – Mandatory Third Party Liability insurance), which is required by law for all vehicles. In the case of MTPL insurance, there are statutory articles that limit insurers' ability to rely on certain defences when responding to claims by third parties injured in accidents involving insured vehicles.

Under the MTPL insurance regime in Israel, insurers are generally required to provide coverage for liability arising from bodily injury or property damage caused by the insured vehicle, regardless of any disputes or defences that may exist between the insurer and the insured. This means that insurers may be obligated to compensate injured third parties even if the insured was at fault or breached certain policy terms.

14. What is the usual trigger for cover under insurance policies covering first party losses, or liability claims?

Insurance policies covering first-party losses or liability claims typically activate coverage based on specific triggers outlined within the policy terms. These triggers vary depending on the nature of the coverage:

- First-Party Losses: Coverage for first-party losses, such as property damage or business interruption, is typically initiated by events or perils specified in the policy. These events could include incidents like fires, thefts, natural disasters, or other circumstances causing direct physical harm to the insured property, and properly notifying the insurer of said insurance event.
- Liability Claims: Insurance policies addressing liability claims activate coverage when there's a substantiated event or incident resulting in legal obligations for the insured to compensate a third party. Such events might involve bodily harm, property damage, or financial losses attributable to the insured's actions or negligence, and properly notifying the insurer of said insurance event.

The precise criteria for triggering coverage are delineated within the insurance contract. Therefore, it's imperative for insured individuals or entities to thoroughly examine their policies to comprehend the conditions for coverage, including covered perils, exclusions, and the procedure for filing claims. Furthermore, insurers typically undertake assessments to verify claim validity and ensure adherence to policy stipulations before granting coverage.

15. Which types of loss are typically excluded in insurance contracts?

Insurance contracts commonly delineate exclusions aimed at managing risk and ensuring the affordability of coverage. While exclusions may vary depending on the policy, typical exclusions encountered in insurance contracts in Israel include:

- Deliberate Acts: Losses stemming from intentional acts or wilful misconduct by the insured are often excluded from coverage. This exclusion serves to discourage fraudulent claims and shield insurers from providing coverage for unlawful behaviour.
- Nuclear and Warfare Risks: Many insurance contracts exclude coverage for losses resulting from nuclear accidents, acts of war, civil disturbances, or terrorist activities.
- Natural Disasters: Insurance policies may exclude coverage for losses caused by certain natural calamities, including floods, earthquakes, or tsunamis. Insurers may provide separate policies or endorsements to address these risks due to their potential for widespread devastation.

- Business Interruption Exclusions – Pandemics: Some insurance contracts exclude coverage for business interruption losses triggered by specific events, such as pandemics, epidemics, or government-mandated closures. This is especially more prevalent since the COVID-19 outbreak. Such exclusions acknowledge the complexities in quantifying and managing risks associated with broad business disruptions.
- Environmental Liability: Losses related to environmental pollution, contamination, toxic waste or clean-up expenses may be excluded from coverage under standard insurance policies. Specialized environmental liability insurance may be available to address these risks separately.

It is important to note that insurers may offer endorsements or supplemental coverage options to address excluded risks for an additional premium.

16. Does a 'but for' or 'proximate' test of causation apply, and how is this interpreted in wide area damage scenarios?

Both the "but for" and "proximate" tests of causation may apply, depending on the specific circumstances of the case and the principles applied by the courts. Generally, these tests help determine whether an insured event or peril is the direct cause of the loss, which is crucial for assessing coverage under insurance policies.

These tests are especially relevant where a damage is done in large scale and by numerous causes and/or factors, which can make the interpretation of causation complex. Israeli courts may consider various factors, including the foreseeability of the event, the extent of the insured peril's contribution to the loss, and any intervening causes that may have exacerbated the damage.

In such scenarios, courts may apply a flexible approach to causation, considering the unique circumstances of the case and the overarching principles of fairness and equity. The goal is to ensure that insured parties receive coverage for losses that are reasonably connected to the insured event, while also recognizing the potential influence of other contributing factors.

17. What is the legal position if loss results from multiple causes?

When loss results from multiple causes, the general legal position involves a nuanced analysis of the specific facts, contractual provisions, and applicable legal doctrines relevant to each case.

Generally, when loss results from multiple causes, some which may be not covered by the policy, in the relationship between the Insured and the Insurer, a typical "Allocation" clause may be activated, in order to determine what is a "fair and reasonable" allocation for which the insurer will be liable, under the specific circumstances of the incident.

Depending on the type of policy, the insurer may also indemnify the insured for the full amount of loss, and activate a "Subrogation" clause, that allows the insurer to assume the rights of the insured to file a lawsuit against the causal agent to ensure the interests of the insurers are kept.

18. What remedies are available to insurers for breach of policy conditions?

The remedies available to insurers for breach of policy conditions vary, and range from none – when the breach of the policy condition was insignificant and had little to no impact on the rights of the insurers, through decreased liability of the insurer, for instance when the insured did not act to minimize the damage done due to the insurance event in a reasonable manner, per article 61(b) to the **Insurance Contracts Law**, to a complete annulment of the liability of the insurer, in extreme cases, such as when the insurance event had occurred deliberately by the insured, as per section article 26 to the **Insurance Contracts Law**.

Generally, the insured is obligated to act in good faith and to follow the provisions of the policy – just like the insurer. As the policy is considered to be an (insurance) contract between the insurer and the insured, the remedies that are available are also often included as part of the provisions of the policy, to ensure that are met in full.

Lastly, another remedy that can be considered for insurers, is the ability to act on a commercial level – and not just per the policy's terms and conditions. For instance, a "problematic" insured may be flagged as a greater risk to the insurers, which will ensue greater premiums and harsher terms in the renewal of the policy.

19. Are insurers prevented from avoiding liability for minor or unintentional breach of policy terms?

It is generally not prohibited from the insurer to attempt to avoid liability due to a minor or unintentional breach of policy terms; at the same breath, it is important to note that if it is indeed a minor breach of the policy terms, it is possible that the court will reject such an argument for coverage rejection or reduction.

20. Where a policy provides cover for more than one insured party, does a breach of policy terms by one party invalidate cover for all the policyholders?

Under normal circumstances, and under the assumption that the breach of policy terms is not extreme in a way that affects and voids the policy for other parties as per its provisions, a breach of one insured party does not necessarily invalidate cover for all the policyholders.

The above is taking into consideration that some insurance policies contain the “Severability” clause, that specify that the acts or omissions of one insured party do not affect the coverage of other insured parties under the same policy. These clauses ensure that each insured party’s coverage is evaluated independently, and a breach by one party does not necessarily impact the coverage of others.

The materiality of the breach will also be examined in such cases – minor or unintentional breaches that do not materially affect the insurer’s risk exposure or the insured’s entitlement to coverage may not invalidate coverage for other policyholders. However, significant breaches that undermine the insurer’s interests or the fundamental purpose of the insurance contract may have broader implications.

Extreme cases when a breach of one policyholder might invalidate cover for other policyholder includes fraudulent Acts, such as when the breach involves fraud or intentional misconduct by one insured party, insurers may have grounds to deny coverage for all policyholders under the principle of uberrima fides (utmost good faith) and/or under article 26 to the **Insurance Contracts Law**.

21. Where insurers decline cover for claims, are policyholders still required to comply with policy conditions?

Generally, even if insurers decline cover for claims, policyholders are generally still required to comply with policy conditions unless those conditions are directly linked to the specific coverage being denied, and therefore coverage examination for that specific event stop. Compliance with policy conditions is typically a contractual obligation imposed on the insured party throughout the term of the insurance policy, regardless of whether a claim is ultimately accepted or denied by the insurer.

This, of course, does not deny the policyholder from contesting the denial of coverage, which should be examined by the policyholder.

22. How is quantum usually assessed, once entitlement to recover under the policy is established?

Once entitlement to recover under the policy is established, the assessment of the amount of compensation payable to the insured party, is usually determined by following established procedures and principles, such as:

(1) providing evidence – the insurer will examine documentation and evidence to support the claim of damages;

(2) examining terms and conditions of the policy – some provisions of the policy may be relevant, such as “retention / deductible”, “retroactive date”, “limit of liability”, and more;

(3) evaluation of damages – the insurer may appoint adjusters or claims handler to properly assess the monetary value of the damages based on prevailing market rates or industry standards;

(4) negotiations and settlements – which is possible during and after the assessment of the quantum, and may involve discussions of the valuation of the damages, applicability of the policy terms and conditions, and other relevant factors;

(5) in case of disagreement – dispute resolution, which can come in the form, inter alia, further discussions, mediation, and arbitration, to resolve any disagreement.

23. Where a policy provides for reinstatement of damaged property, are pre-existing plans for a change of use relevant to calculation of the recoverable loss?

This highly depends on the specific terms and condition

of the insurance policy. Insurance policies typically detail the conditions for reinstating damaged property. If the policy covers reinstatement costs, insurers may be obliged to reimburse expenses for restoring the property to its original state.

Another factor to take in mind is the disclosure of such change plans to the insurer prior to the inception of the policy, or during the policy's term, in a way that might have affected the determination of coverage or premium of the policy – and as such, might give rise to an increased obligation for such a change in the recoverable loss.

24. After paying claims, to what extent are insurers able to pursue subrogated recoveries against third parties responsible for the loss?

The Israeli **Insurance Contracts Law** specifically allows subrogation under article 62 ("**Article 62**"). Additionally, typically a subrogation clause will be part of the insurance contract, which further validates the insurers right to pursue subrogated recoveries against third parties responsible for the loss.

However, it is important to keep in mind there are some limits to the subrogation right, as set under Article 62. Some examples to that are: **(1)** that the insurer may not utilise the subrogation right in order to receive from the third party more than the amount the insurer has indemnified the insured; **(2)** or in cases where the insurance event was caused by a relative of the insured or a person who the insured had working relations with, and a reasonable insured would not have pursued to file a claim against that person.

25. Can claims be made against insurance policies taken out by companies which have since become insolvent?

It is generally possible to make claims against insurance policies of companies which have since become insolvent, but results may greatly vary, depending on the specific circumstances such as the provisions of the policy, and the state of the insolvency of the policyholder, and as long as the policy has not been terminated.

For instance, if claims are made **during the insolvency proceedings**, the administrators appointed for the insolvency may treat the insurance policy as an asset of the company, as customary in Israeli case law, and utilise it as part of the insolvency proceedings in case claims are being filed against such insolvent company, and the priority of such claims is determined in accordance with the specific nature of the claim.

Another example would be mechanisms such as the **Run-Off coverage**, which extends coverage for claims made after the policyholder becomes insolvent or ceases operations, for a limited period of time after such event.

26. What are the significant trends/developments in insurance disputes within your jurisdiction in recent years?

Significant trends/developments in insurance disputes in recent years in Israel include the following areas:

Insurtech Innovation: The rise of insurtech startups has brought technological advancements like AI and blockchain to the insurance sector, reshaping processes and customer experiences. These innovations are likely to introduce new legal and regulatory considerations in insurance disputes, particularly regarding data privacy and technology adoption.

Cyber Insurance Challenges: With the surge in cyber threats and data breaches, there's been a corresponding uptick in cyber insurance claims. Insurers are grappling with underwriting cyber risks and addressing complex claims arising from cyber incidents, leading to disputes over coverage, liability, and policy exclusions.

Epidemic-Focused Clauses: Following the COVID-19 epidemic, there has been an increased focus on provisions specifically designed to mitigate possible unexpected circumstances that are related to the consequences of an outbreak of an epidemic, taking into consideration the experience gained from the recent COVID-19 epidemic.

Alternative Dispute Resolution: There's a growing inclination towards alternative dispute resolution methods like mediation and arbitration to resolve insurance disputes efficiently.

27. Where in your opinion are the biggest growth areas within the insurance disputes sector?

As **technology** is an ever-growing field during this era, and consequentially the increased frequency and severity of cyber incidents, including data breaches and ransomware attacks, we expect to see an even bigger growth in this field within the insurance dispute sector.

Subsequently, the **Insurtech** area seems to be keeping

a steady extensive growth, as the AI and other technology implementation is a growing field, along with disputes related to technological innovation such as intellectual property rights and data ownership.

With the increased globalisation, innovation and advancement in technology, we also expect to see a growth in the **directors and officers liability dispute sector**, as new complex matters are brought to legal adjudication more than ever.

Contributors

Adv. Shai Granot
Founder, Senior Executive Partner
shaig@grs-law.co.il

Adv. Sagi Sakian
Partner, The Insurance and Litigation Departments
sagis@grs-law.co.il