Legal 500
Country Comparative Guides 2025

Israel

Insurance Disputes

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The contributors thank Adv. Naomi Zicherman for her assistance.

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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 disputes between the insurer and policyholder?

Under Israeli law, insurance policies typically offer various mechanisms for resolving coverage disputes between the insurer and the policyholder. Initially, disputes are often addressed through internal processes, allowing the policyholder to contest decisions such as claim denials. If these internal mechanisms or negotiations fail, more formal avenues are available, including litigation and alternative dispute resolution methods such as mediation or arbitration. Mediation is a voluntary process wherein a neutral third party facilitates negotiation between the parties to reach an agreement. Arbitration may also be mandated by an arbitration clause within the policy, with the decision of the arbitrator being binding. However, in the case of standard form contracts, the imposition of a mandatory arbitration clause is generally restricted to prevent the more powerful party from coercing the weaker party into arbitration.

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

Israeli law does not establish a specific protocol governing pre-action conduct for insurance disputes. However, principles of good faith, transparency, and procedural efficiency are emphasized, guiding the conduct of parties involved in such disputes. For instance, insurers are obligated to provide detailed rejection letters, and insured parties are encouraged to engage in early communication to resolve potential conflicts. These practices, supported by case law and regulatory guidelines, aim to minimize unnecessary litigation and promote optimal outcomes.

3. Are local courts adept at handling complex insurance disputes?

While Israeli courts are generally adept at handling complex insurance disputes and demonstrate the ability to resolve intricate factual conflicts or hear experts when necessary, other constraints such as courts' congestion and the lack of specific expertise in insurance matters can affect the efficiency of proceedings. In such cases, alternative dispute resolution mechanisms, like arbitration or mediation, may offer a more expedient and efficient path to resolution.

4. Is alternative dispute resolution mandatory?

In Israeli law, an obligation to use alternative dispute resolution mechanisms (ADR) may arise if explicitly stipulated within the contractual agreements between the parties, although the enforcement of such clauses can be contested under certain circumstances. A particular scenario where ADR consideration becomes obligatory is in proceedings before the Magistrate's Court, where the claim amount exceeds ILS 40,000. In these cases, parties are mandated to attend a “Mahut” session, an acronym for Information, Introduction, and Coordination. This session involves the parties and a court-appointed mediator, allowing them to thoroughly assess the potential to resolve the dispute through mediation. The Mahut process does not compel parties to engage in full mediation; each party retains their right to decline mediation beyond the first Mahut session and continue the proceedings with the court.

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

Policyholders who succeed in their claim may be entitled to reimbursement of legal expenses and attorney fees from their insurers. This entitlement is generally subject to the court's discretion and is influenced by various factors, including the conduct of the parties and other considerations of justice. The exact amount and conditions for reimbursement can vary, but typically, they do not fully cover the actual costs incurred by the successful party. Additionally, in liability insurance, the insurer will indemnify the insured for reasonable legal expenses incurred in defending against third-party claims covered under the policy.

6. Is there an appeal process for court decisions and arbitral awards?

Appeals against court judgments in Israeli law are generally permitted as a matter of right for final decisions of first instance courts, though certain procedural

requirements and time limitations apply. Interim decisions typically require permission to appeal. The appellate court will primarily review questions of law, while showing considerable deference to factual determinations made by the lower court. If a party wishes to appeal the decision of the appellate court, and there is a higher court, they may seek permission to appeal. In contrast, arbitration awards are generally not subject to appeal unless explicitly provided for in the arbitration agreement. The parties may stipulate that appeals will be heard by another arbitrator rather than a court. However, a party may seek to annul the arbitration award within a specific time frame. The grounds for such annulment are limited, and courts apply a stringent standard when considering these requests. The following can serve as grounds for annulment: the arbitrator exceeded their authority under the arbitration agreement or failed to apply the law when contractually required to do so; a party was denied adequate opportunity to present their arguments or evidence; the content of the award contradicts public policy, etc.

7. How much information is the policyholder required to disclose to the insurer? Does the duty of disclosure end at inception of the policy?

The policyholder's duty of disclosure to the insurer involves providing a full and honest written response to any written question posed by the insurer about a material matter that could affect a reasonable insurer's decision to enter into the contract or its terms. If a question is overly broad and combines various issues without distinction, the policyholder is not required to provide such a response unless the question was reasonable at the time of contract formation. Additionally, if the policyholder intentionally conceals a matter known to be material, it is considered equivalent to providing an incomplete or dishonest answer.

Following the inception of the policy, the policyholder must continuously disclose any material changes affecting the insurer's risk assessment, requiring immediate written notification of such changes. This includes changes in previously asked matters, those specified as material in the policy, or corrections to previous responses.

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?

If a policyholder provides an incomplete or dishonest response to a material question, the insurer is entitled to cancel the contract within thirty days of becoming aware of this, provided the insurance event has not yet occurred, by issuing written notice to the policyholder. Upon cancellation, the policyholder is eligible for a refund of premiums paid for the period following the cancellation, less the insurer's expenses, unless the policyholder acted with fraudulent intent. Should the insurance event occur before the contract is cancelled, the insurer is obligated to pay only proportionally reduced benefits, calculated based on the terms that would have been offered had all information been known at the time of contract signing. The insurer can be entirely exempt from liability if the response was given with fraudulent intent or if a reasonable insurer would not have entered into the contract even at higher premiums, in which case the policyholder is entitled to a refund of premiums paid after the occurrence of the insurance event, minus the insurer's expenses.

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

Insurance contracts in Israel, like all contracts, are subject to general contract law principles, particularly given the inherent power imbalance between insurer and insured. This means provisions contradicting public policy or basic principles of fairness and good faith are prohibited. For example, ambiguous or hidden limitations on coverage, misleading descriptions of policy terms, and retroactive reductions in coverage are generally unenforceable. Courts interpret ambiguous clauses against the insurer (as the drafter) and prioritize the insured's reasonable expectations.

Furthermore, Israeli law imposes specific restrictions on insurance contracts. Certain provisions are categorically prohibited, particularly in standard form contracts. Mandatory arbitration clauses may not be included in an insurance policy. Additionally, many provisions of the Insurance Contracts Law (1981) are either mandatory or can only be modified to benefit the insured.

Over time, case law has also invalidated certain contractual provisions for various reasons, including those contradicting public policy or imposing implicit conditions for coverage. These restrictions aim to protect the insured as the weaker party and ensure fairness and transparency in insurance relationships.

10. To what extent is a duty of utmost good faith

implied in insurance contracts?

In Israeli law, insurance contracts are subject to an enhanced duty of good faith, which can significantly influence the conduct of both insurers and insured. While both parties must act in good faith, insurers might bear a higher burden due to their dominant position and expertise. Judicial interpretations have further emphasized this duty, highlighting the need for insurers to maintain transparency and fairness.

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

In Israeli insurance law, other implied terms may arise in consumer insurance contracts, depending on the specific circumstances of the case, the parties' intentions, and how explicit the agreement was in reflecting those intentions. These terms are not explicitly stated in the policy but are inferred to ensure the contract operates fairly and effectively. For example, these implied terms include the insurer's obligation to handle claims promptly and the insured obligation to take reasonable steps to prevent further loss.

12. 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?

Under Israeli law, the default position is that any defense an insurer can raise against the insured can also be raised against third-party claimants. However, in certain types of compulsory insurance, particularly where there is a statutory obligation to purchase insurance for the benefit of third parties, the insurer's right to rely on defenses against third-party claims may be restricted.

A key example is compulsory motor vehicle insurance, where the Israeli legislature has established a list of conditions and limitations on the insurer's liability that are invalid against third parties, such as restrictions related to the driver's age, physical, or mental condition. Additionally, in other cases, Israeli case law or regulations seek to prevent situations where a minor breach by the insured prevents the third party from receiving insurance benefits. For instance, it has been determined that an insurance company cannot reject a third party's claim due to the insured's lack of cooperation or failure to notify the insurer of the occurrence of the event.

13. What is the usual trigger for cover under insurance policies covering first party losses, or liability claims? Are there limitation periods for the commencement of an action against the insurer?

Insurance coverage typically depends on the policy type. Generally, coverage is triggered when the insured risk materializes during the policy period, not when the loss is discovered. However, some policies specifically require both the occurrence and discovery of the loss to be within the policy period. After the insured event occours, the insured must notify the insurer immediately. The limitation period for claims is usually three years from the occurrence of the insured event (excluding, for example, third party liability coverges which apply other limitation periods). Limitation periods may be extended in certain circumstances, such as when key facts are discovered later or if the insurer acknowledges the insured's right of action. Specific policy terms and the nature of the loss (e.g., ongoing payments for loss of work capacity) can also affect the limitation period. According to Section 31A of the Insurance Contract Law, as well as regulatory guidelines and case law, the insurer has a duty to disclose information about applicable limitation periods to the insured, subject to certain limitations.

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

Insurance contracts commonly exclude several types of losses, including subjective damage that cannot be objectively measured, consequential or indirect losses, damages arising from inherent defects of the insured property, inevitable losses that occur in the normal course of events, pure economic losses without physical damage, and damages caused by intentional acts of the insured.

15. Do the courts typically construe ambiguity in policy wordings in favour of the insured?

In Israel, courts do typically interpret ambiguities in insurance policy wordings in favor of the insured, especially when the insurer, as the stronger party, drafted the contract, though it may also occur in other cases. This approach is based on general contract law principles and recognition of the power imbalance between insurers and insureds. Thus, ambiguous clauses might be interpreted against the insurer to protect the insured's reasonable expectations. This judicial tendency also stems from the professionalism attributed to insurers and

their heightened duty of good faith. Consequently, for example, ambiguous or hidden limitations on coverage and misleading policy descriptions might be interpreted to benefit the insured.

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

Israeli insurance law mainly uses the "proximate cause" test which examines whether an insured risk served as the dominant factor leading to the damage. Additionally, Israeli case law emphasizes the principle of directness, requiring that the damage directly result from a risk against which the policyholder is insured. The "proximate cause" test sets a lower threshold than the "but for" test commonly used in tort law, which requires proving the damage would not have occurred without the specific cause.

Parties to an insurance contract may explicitly agree to apply the stricter "but for" test standard or other standards. However, courts maintain discretion in interpreting causation based on the specific circumstances of each case.

In complex scenarios involving multiple contributing factors, courts may employ additional tests to determine causation, maintaining flexibility in their approach while preserving the fundamental principles of insurance law.

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

The legal position regarding the loss resulting from multiple causes may vary based on the circumstances of each case, but some general principles typically apply. Generally, if a loss arises from multiple causes and at least one of those causes is covered by an insurance policy, the insurer will be liable for the loss. This holds true even if other contributing causes are not covered by the policy, unless a specific exclusion applies. However, if one of the contributing causes is explicitly excluded by the policy, the insurer will generally not be liable for the loss, even if other contributing causes are covered. Additionally, negligence by the insured or a third party, even if contributing to the loss, does not necessarily negate the causal link between the insured risk and the loss, unless otherwise specified by the parties.

18. What remedies are available to insurers for breach of policy terms, including minor or unintentional breaches?

Insurers have various remedies for breaches of policy terms, ranging from proportional payment reductions to full exemption from liability or contract termination. The appropriate remedy depends on the severity of the breach, the state of mind of the insured, and its impact on the loss. In cases of intentional or fraudulent breaches, or where a reasonable insurer would not have agreed to the policy even with adjusted terms, insurers may be fully exempt from liability (though they must refund the insured's payments after deducting expenses). However, if the breach did not materially affect the risk, the insurer may not necessarily be able to exercise its available remedies, as the matter is subject to the court's discretion.

19. 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 the Israeli legal framework, when an insurance policy covers multiple insured parties, a breach of policy terms by one insured party does not necessarily invalidate coverage for all policyholders. The Israeli Supreme Court has recognized the "innocent insured" doctrine, which suggests that an insurer's defense against one insured due to their fault does not automatically apply to another insured who acted in good faith. However, the application of this doctrine is not yet fully established in Israeli case law and depends on three main factors: the relationship between the insured parties' interests; the timing the insurer's defense claim regarding the breach was raised; and whether the breach by one insured was dependent on fault.

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

When insurers decline cover for claims, policyholders are generally required to comply with the conditions of the policy, such as providing information and cooperating with the insurer. However, this requirement can vary depending on the specific circumstances of each case, particularly if the policyholder's obligations are directly related to the declined coverage. In addition, if the policyholder's obligations under the policy condition are deemed unreasonable or excessively burdensome, courts may adjust the policyholder's obligations accordingly.

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

Once entitlement to recover under the policy is established, the quantum assessment determines the amount to be paid. This calculation is based on an evaluation of the loss or damage, using evidence that the insured must provide. Evaluation of such evidence may be conducted through various methods, including assessment by an independent appraiser, evaluation by the insurer's in-house assessors, or application of predetermined values as prescribed in the policy terms (such as in property coverage). Subsequently, the policy's terms determine necessary deductions for deductibles, policy limits, and other conditions. Ultimately, interest and linkage differentials may be added to the sum. The quantum assessment can, of course, be subject to dispute, which may be resolved through settlement negotiations or, if necessary, through legal proceedings.

22. 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?

Under Israeli law, when a policy provides for the reinstatement of damaged property, the primary aim is to restore the property to its pre-damage condition. Generally, pre-existing plans for a change of use are not relevant to the calculation of the recoverable loss. However, this matter largely depends on the specific circumstances of the case and the terms of the policy. If the plans were declared by the insured and included in the agreement between the parties, it is likely that they could be considered in the assessment of the recoverable loss.

23. After paying claims, are insurers able to pursue subrogated recoveries against third parties responsible for the loss? How would any such recoveries be distributed as between the insurer and insured?

Under Israeli law, insurers have a right of subrogation once they have paid out insurance benefits, unless such right has been expressly waived in the insurance policy. This legal mechanism allows insurers to seek recovery from third parties who are responsible for the insured loss, up to the amount of the benefits paid. Importantly, the insurer's exercise of this right must not compromise the insured's ability to obtain further compensation from the third party beyond what the insurer has covered. If the insured receives any compensation from the third party that should be directed to the insurer, they are obligated to transfer it to the insurer. Moreover, should the insured engage in any actions, such as settlements or waivers, that negatively impact the insurer's subrogation rights, they must provide compensation to the insurer for any resulting loss.

24. Is there a right to claim damages in the event of late payment by an insurer?

Insurance benefits should be paid within 30 days after the insurer receives all necessary information and documents to determine liability. If the benefits are undisputed (while applying a standard of good faith), they must be paid within 30 days of the submission of the claim to the insurer.

Failure to pay within these timeframes results in the application of linkage differentials from the date of the insurance event, and linked interest starting 30 days after claim's submission. Courts may impose special interest rates, which are mandatory for personal insurance claims.

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

Third parties can generally make claims against insurance policies even if the insured company is insolvent, provided the policy is still valid. Under the Insurance Contract Law, in liability insurance, the insurer may, and upon the third party's request must, pay the insurance benefits directly to the third party, given that the insured is notified in writing 30 days in advance and does not object. The said right conferred on a third party is limited, as any defense available to the insurer against the insured, can also be used against the third party. Furthermore, the Insurance Contract Law specifically addresses various insolvency scenarios, such as the issuance of a liquidation order, or certain cases where a resolution for voluntary liquidation is made. In these cases, the insured's rights under the policy will not be part of the insolvency estate but rather transfer to the third party that is holding a cause of action covered under the liability insurance policy, subject to any defense that the insurer could have asserted against the insured.

26. To what extent are class action or group litigation options available to facilitate bulk

insurance claims in the local courts?

Class actions serve as an important mechanism in the insurance sector due to power imbalances between insurers and insured individuals and the complexity of insurance contracts. They are particularly effective when individual damages are minor, but the collective harm is significant.

The Class Actions Law enables lawsuits against insurers and insurance agents regarding insurance contracts, whether or not a transaction was completed. However, specific challenges may arise, such as proving the causal link between claims and damages in claims for misleading policy descriptions by insurers, which can vary significantly between class members. Additionally, section 8(b)(2) of the Class Actions Law protects insurers by allowing courts to reject motions to approve class actions if the potential harm to the insurer's financial stability outweighs the expected benefits to the class members.

27. What are the biggest challenges facing the insurance disputes sector currently in your region?

The significant uncertainty in global markets, and particularly in Israel over the past two years due to political and economic changes, has directly impacted how insurance companies operate, including their decision-making processes in managing disputes and settling claims. Insurance companies are increasingly cautious in their approach to litigation and settlements as they navigate this unpredictable landscape. Today, more than before, it is challenging to forecast market conditions even two years ahead, making it difficult for insurers to make confident long-term decisions regarding dispute resolution and claim management.

28. How do you envisage technology affecting insurance disputes in your jurisdiction in the next 5 years?

The growing adoption of artificial intelligence tools will likely enhance efficiency in claims processing and risk assessment of insurance disputed and legal proceedings. These technologies may help insurers better analyze case merits and potential settlement values by processing large volumes of data, legal precedents and policy documentation. While this technological shift could reshape the legal landscape of insurance disputes through more data-informed negotiations, questions remain about implementation challenges, regulatory adaptation, and how the balance between automated and human decision-making will ultimately evolve in claims resolution.

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

The insurance disputes landscape in Israel has been significantly shaped by increasing regulatory scrutiny and enhanced consumer protection measures, prompting insurers to adapt their claims handling processes. Additionally, there has been a gradual shift toward alternative dispute resolution methods and mediation, as both insurers and policyholders seek more efficient and less costly ways to resolve conflicts in an uncertain economic environment.

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

We can expect significant growth in insurance disputes concerning cyber policies as organizations face increasingly sophisticated threats that test policy boundaries and definitions. We can also expect litigation relating to cloud insurance as more businesses migrate their operations to digital platforms, creating complex liability questions when disruptions occur. Naturally, we anticipate growth in insurance products covering artificial intelligence technologies, mirroring the increasing adoption of these tools and the unique risks they present.

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