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LL.M. Program
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ISSUES IN DETERMINING THE SCOPE OF INSURANCE POLICY COVERAGE

What are the main issues and respective possible solutions in determining the scope of insured risks and related compensation within insurance policies?

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INTRODUCTION

Insurance firms are increasingly seen to be providing a range of services that can be termed as risk management services. This term applies to services meeting consumption smoothing and services which address contingent needs.[1]

As the insurance is starting to engage more ambits of contemporary world, the products offered by insurance companies are getting more diverse. Although this makes some legal relations safer, but as a result legal conflicts arising from the insurance agreements are getting more frequent. As the recent data shows litigation of insurance problems continued to engage the courts on an increasing scale. This left courts to face the problems connected with clarifying the text of insurance policies, also with unexplained definitions of specific terms.

One of the major problems resulting in litigations are the issues arising from different interpretations of insurance policies. In most cases insurance policies are offered on a take-it-or leave-it basis, but still policyholders enter the insurance agreements with certain expectations. That is to say the policyholders presume a definite scope of accidents that shall be indemnified.. In some cases it overlaps with the scope of accidents stated in the policy, but frequently policyholders do not realize the actual extent of compensation the insurer offers by the policy.

According to Article 983 (2) the Civil code of RA Voluntary and compulsory insurance may be carried out in the Republic of Armenia. Voluntary insurance is the insurance carried out at volition of the policyholder through conclusion of an insurance contract with the insurer.

Compulsory insurance constitutes relations arising independent from the will of the policyholder with the insurer by virtue of law, the types, conditions and implementation procedure whereof is regulated by this Code, the Law of the Republic of Armenia “On insurance and insurance activities” and relevant laws on compulsory insurance.

Not even going deep into elaboration of the mentioned norm, it is obvious that in Armenia issues with explanation of the insurance agreements’ text and terms mainly concern the voluntary agreements. The reason is that the rights and obligations of the parties, also other terms,

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[1] Ajit Ranade and Rajeev Ahuja, *Issues in Regulation of Insurance,* ol. 35, No. 5, 1 Money, Banking and Finance, 1, (2000)

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are stipulated by the insurer himself and may sometimes appear to be wage or unexplained, or else too biased.

According to Article 447 (1) In interpreting the conditions of a contract, the court shall rely on the literal meaning of the words and expressions contained therein. In case of vagueness of the literal meaning of a condition of a contract, it shall be defined through juxtaposing the other conditions of the contract and the overall meaning of the contract.

According to the second part of the same article Where the rules contained in point 1 of this Article do not provide an opportunity to determine the content of the contract, the real common will of the parties must be clarified given the objective of the contract. Moreover, all relevant circumstances shall be considered, including negotiations and correspondence preceding the contract, the practice established in the interrelations between parties, customary business practices, further behavior of parties.

Considering the specific essence of insurance in majority cases courts can face problems when applying to text interpretation of insurance policy clauses, that are mainly stipulated by insurers themselves.

In this regard it is important to reveal the initial intent of the insurer when stating one or another provision in the policy, and the intent of the policyholder when entering the agreement. One of the major issues is that when the court interprets one provision of the policy, the interpretation becomes somehow mandatory for other policyholders either. In RA considering the article 10 (4) of Judicial code if the interpretation is made by the RA Cassation court, it becomes mandatory for everyone trying to implement that provision. Obviously, many problems can arise both for the insurance companies when writing their policies and for the courts, when trying to decode those provisions.

As Kenneth S. Abraham states, based on the debates of recent years, there are four conceptions of insurance. Each of the conceptions allows determining the extent to which the language of an insurance policy should determine its legal effect. And it is precisely the ambiguity of standard-form policy language that is usually at issue. Consequently, when a court holds that a policy provision is ambiguous and interprets it in favor of coverage, the holding applies to everyone whose policy contains that provision. What is objectively reasonable for one policyholder to expect is usually objectively reasonable for all who are covered by the same,

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standard-form policy [2]

As it was already mentioned policyholders often enter the agreement with certain expectations that sometimes are justified, but are not considered compensated. To avoid stating such provisions in the agreements for the insurer it is important to decide a reasonable scope of coverage that will justify the majority policyholders' expectations. However, policyholders' expectations cannot be considered as vital factor in stipulating insurance policies.

Nevertheless, insurance companies are not totally free when writing their policies, either. As the insurance companies play a major public role for the society's well being, the insurance policy terms or rates are usually strictly regulated by the state. That is to say, in most cases, even when speaking about voluntary policies, insurance companies are not totally free to state certain provisions in their regulatory policies or else make amendments to them. That is one way to lessen misunderstanding and any obstacles for the policyholders in understanding the policy terms. In other words, state regulatory is considered as a tool for customer protection in the sphere of insurance. State's strict regulatory helps to decrease the misinterpretations and arguable cases regarding the insurance policies. This basically concerns the compulsory insurance policies, inasmuch as the state commissioner (in case of MTPL the state commissioner is the Bureu of car insurers) bargains over the policy terms in favor of potential policyholders.

In this regard, it is important to clarify the list of risks when declaring the scope of insurance policy coverage, also to find solutions both for the phase of writing the agreement provisions and interpreting those provisions during any conflict regarding its implementation. In this regard it is important for the courts to view the policies in certain light, which affects the conflict settlement results.

Chapter 1. Four conceptions of insurance: Finding out the one that more truthfully reflects the genuineness of insurance policies.

Currently existing insurance law literature distinguishes between different conceptions of insurance policies. Particularly, Kenneth S. Abraham analyzes the conceptions in his article. In this chapter we are going to touch upon the mentioned article, bringing our own examples, as a result mentioning the best one in the light of the

[2] Kenneth S. Abraham, *Four Conceptions of Insurance*, 161:653, Penn. law review, 1, 15, (2013).

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protection of both insurers' and policyholders' rights.

According to part 4 of article 437 of the Civil code "The conditions of a contract shall be determined at the discretion of the parties, except for the cases where the content of the relevant condition is prescribed by law or other legal acts". In the light of the mentioned norm insurance policies can firstly be regarded as a voluntary agreement between individual and insurer. In literature it is considered as **contract conception.**

Actually insurance is considered as an agreement of transferring a risk to a party, who's business is selling such contracts. The legal content of such contracts generate certain rights, obligations and specific behavior for the parties.

In most disputes concerning the coverage extent, the policyholders point out different arguments, which indeed do not correspond to the contract conception of insurance. For instance, policyholders state that they did not expect certain risks to be out of policy coverage, or else that the coverage does not correspond to their expectations, or the provision were not In such cases it is important to recognize that the insurance policy is a voluntary agreement. That is to say the parties (particularly the policyholder) agreed to all the terms of the agreement in their discretion.

Nevertheless, the mentioned can be contested as most insurers write their policies on standard forms with the policyholders having little awareness of what they are purchasing. The fact that the policyholders do not read the complex terms of the contract at the time of signing, results in conflicts later on. In practice policyholders read the terms of the contract by the time a conflict arises. Thus, any knowledge of the terms that the occasional policyholder gains by reading the policy at the point the conflict arises has no bearing on the policyholder's intent at the time of purchase.[3] That is to say policyholder's intent at the time of purchase may differ from the real one revealed at the point of the conflict occurs.

However, the very idea of contractual concept, is that the parties are totally free to enter or not to enter into the agreement, and that the parties are supposed to know the whole content of the contract before entering into it.

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[3] *Id* at 9

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In this regard one case in Armenian court practice can be discussed. A construction company claims in the court invalidity of the insurance policy covering risks arising out of damage of the property to be constructed. The claimant argued the invalidity based on the article 313 of Civil Code of RA, regarding the agreement as slavery. The claimant argued that he did not have any choice other than entering into insurance agreement having such legal content.[4]

In practice insurance policies contain certain amount of franchise, which is the sum that the insurer disclaims itself responsible for it. In some policies the franchise sum is fixed, while in others it is enlisted as a percentage of possible damage. If the insurance agreement includes provision stipulating franchise sum, this means that the insurer will not pay the mentioned amount when the insurance event occurs. In large-scale agreements, such as construction agreements, the franchise sum is usually high.

Article 313 (1) of Civil Code of RA states that "A transaction made under the influence of fraud, violence, threat, at the malicious collusion of the representative of one party with the other party, as well as a transaction that a person has been compelled to enter into, due to grave circumstances, in ultimately disadvantageous conditions for him or her, from which the other party has benefited (enslaving transaction), may be declared as invalid by the court upon the claim of the injured person".

In the mentioned case the amount of franchise sum did not match the policyholder's expectations, as it was too high. The Policyholder claimed the sum to be so high, that any insurance event will not be indemnified by the insurer in the future. Thus the policyholder asserts that the agreement should be declared invalid, as the policyholder entered into the agreement only to get a loan (grave circumstances) in ultimately disadvantageous conditions (with high franchise sum).

Court rejected the claim, finding that the claimant entered into the agreement in his discretion and the content of the insurance policy became compulsory for him from

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[4] *Karasam LLC v. Nairi Insurance LLC, ԵԿԴ/1211/02/17, http://www.datalex.am/?app=AppCaseSearch&case_id=14355223812353014*

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the very moment of signing it. Claimant's arguments that he entered into insurance agreement not totally in his discretion, but because it was required by the construction loan agreement were declared as unfounded by the court. In this regard the court stated that the claimant should have assessed the whole financial burden, including the insurance premium, before acquiring the construction loan.

Summing up the case, we may assert that it is an obvious example of the court taking into consideration the contract conception of insurance. However, when reviewing the policy in light of contract conception the rules on adhesion contracts are not applicable. Those rules are more relevant when discussing the product conception.

The contract conception also focuses on the possibility of both parties to bargain about the contract terms, but if the party entered into the voluntary insurance agreement, it can be supposed that the possibility existed. The same reasoning was developed in the mentioned case. However the fact that the insurance policies do have standard forms and are designed more or less generally somehow contradicts the contract conception.

In our opinion the contract conception is more proper when the parties are not deprived of the possibility to bargain over the contract terms, otherwise, this concept can be put under question.

Another important thing about the contract conception is that questionable provisions are interpreted by the courts and become obligatory even for the parties later entering into same agreement. In Armenian court practice this can result in certain problems. Particularly, this is because most of the judges are not well prepared to interpret narrowly insurance law specific provisions the way it really complies with the initial will of the drafters. This is generally because one of the parties (the insurer) has narrow professionals of insurance market and some details can be interpreted the way it contradicts the whole insurance law scheme.

Frequently, in the phase of settling the problem cases the concepts used by the policy writers lose touch to factors having vital role in the meaning of those provisions. Therefore, court should maintain the link between the meaning of legal concept and the

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reason for its adoption. This is less relatable to financial mediator, as mediator has narrows specialists hired, that are less likely to lose link between the meaning of legal concept and the purpose of its origin.

According to article 10 (3) of Judicial code of RA during the examination of their case, everyone has the right to refer to the comments of the Court of the Republic of Armenia on the interpretation of the law and other normative legal act in the judicial act entered into force of another case with similar facts. The court addresses such legal arguments. This means that court's interpretations become somehow obligatory for other policyholders, which challenges the contract conception, as the parties are deprived of choice in further cases either, as the other party can always refer to comments made by court that previously examined a case with similar facts. Nevertheless, insurers almost always appear in favorable site, as they have a chance to amend their provisions the way it leaves less place of clarification to courts, defining the scope of coverage best way possible for themselves.

All of the mentioned arguments put the contract conception under the question. Moreover, just looking through the article 290 (2) of CC of RA "The expression of concerted will by two parties (bilateral transaction) or by three or more parties (multilateral transaction) shall be required for entering into a contract", it is relatively obvious that in case of insurance agreements the concreted will of the insured is not expressed. That is to say policyholders do not have a total discretion when expressing their concreted will.

The other conception of insurance the author touches upon is the **public utility conception**. In our opinion this conception is more truthful when entering into compulsory insurance agreements. In Armenian reality the largest sector of compulsory insurance is MTPL, therefore this mostly concerns the MTPL policies. This is also relatable for other types of compulsory insurance (for ex. insolvency managers' liability insurance). However, as this sector is not as large as MTPL, the state exercises less

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control.

In case of compulsory automobile insurance state regulates both the rates and principles inserted in insurance provisions in MTPL agreements. In case of MTPL the owner of the automobile is provided with compulsory liability insurance, but neither he, nor the insurer stipulate contract provisions. This is the exact contrary of contract conception.

Obviously, in cases of individual health or liability insurance policies the state has a slight role as a regulator, thus this conception somehow incorrect. Not going deep into analyzing the conception we can assert that this is more relevant for compulsory insurance policies, taking into consideration its major public role.

However, in general we do not agree with this way of conception of insurance as a whole, as it is relevant for certain branch of insurance only. As it was already mentioned only in case of MTPL the provisions of contract are stipulated by the state commissioner (Berau of car insurers) and both of the parties do not have a decisive voice on any of the provisions. Apparently, this concept is not relatable to voluntary insurance.

The other one is the product conception. One argument in favor of the conception is the fact that in insurance companies new policies are called products. The main reason for this is the standard language of insurance agreements offered to indefinite number of people. Although those agreements are designed taking into consideration the reasonable expectations of potential policyholders, but the provisions generally are not debated or bargained with individual buyers. Thus policyholders buy products prepared by insurance companies that insure the risks they need.

As Kenneth S. Abraham correctly highlights, according to the proponents of the product conception of insurance, insurers should be liable if the insurance policies they designed are defective, just as the sale of goods is ordinarily subject to an implied warranty of merchantability and merchantability and manufacturers are liable in tort for injuries resulting from product defects. Under the product conception, disputes center on

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the validity of these provisions.[5]

In Armenian legislation this conception is revealed as contracts of adhesion. According to article 444 (1) of Civil code of RA a contract of adhesion shall be the contract, the conditions whereof are defined by one of the parties in a formulary or other standard form, whereas the other party may accept these condition by a full adhesion to the offered contract.

As in majority cases the insurance policies are created by the insurers themselves like certain products, the policyholders adhere to those insurance contracts buy paying for those products.

According to Article 444 (2) of Civil code of RA A party adhering to a contract shall be entitled to demand rescission or change of a contract where, although the adhesion contract does not contradict the law and other legal acts, but it deprives that party from the rights usually granted under such contracts, excludes or limits the liability of another party for violating the obligations or contains other conditions explicitly non-gratuitous for the adhering party which the latter, based on its own reasonably acknowledged interests, would have not accepted if provided with the opportunity to participate in the defining of the conditions of the contract.

Apparently, the contracts of adhesion reflect the very essence of product conception, as the policy is considered as a product bought by the policyholder that can have defects (invalid provisions) and be amended by the court.

Examining market practice, we can come to a conclusion that courts or arbitrators seek to find a specific purpose for stipulating certain provisions in the policies. Both insurer's and policyholder's intent should be counted.

One example of insurer's remote intent is the case when the insurer rejected policyholder's claim on the bases that he did not demand to commence an administrative proceeding.

10.1.2 provision of CASCO rules stipulated by board of "Nairi Insurance" LLC

[5] Abraham, *supra* at 24,

states that in case of insurance event the policyholder, the beneficiary or authorized driver have to inform the corresponding authority (the police, fire service) about the event, to demand administrative proceeding, and to provide the insurer by the results of that proceeding, except for the cases when the insurer released them from the listed obligations.[6]

The facts of the case are as stated below: The policyholder having bought CASCO insurance gets into car accident (more precisely self car crash) and does not demand an administrative proceeding to be conducted. The insurer considers this a violation of its rights, as he is deprived of being fully aware of the accident circumstances and denies the policyholder's application of compensation. Also it is important to mention that the insurer did not in any way release the policyholder from the obligation to demand administrative proceeding.

After getting the rejection, the policyholder applied to the office of financial system mediator (hereinafter Mediator). The Mediator found the requirement to demand administrative proceeding defective and invalid. Particularly, the Mediator stated that in cases of self car crash (no other automobile is involved) the requirement about demanding administrative proceeding becomes a formality, thus is defective, as it will not help in finding out the real circumstances of the accident. The Insurer claims that the main aim of the provision is deduction of moral hazard. That is to say to escape compensation of the cases when the policyholder tries to get money as a result of fraud. The administrative proceeding can contribute to revealing the truth concerning all the circumstances of the accident. In case of not following this requirement even in cases of self car crash can violate insurer's rights.

However, the financial mediator found the provision on requiring administrative commence defective in cases of self car crush, as it does not serve any purpose and puts

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[6] Board of "Nairi Insurance" LLC, *Rules of automobile insurance,* 2019, https://www.nairi-insurance.am/files/91d564cb656421c8533dP750-01-01_Cascopaymanner_4_01.12.19.pdf

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additional obligations on policyholder.

The Insurer than contested the decision in the first instance court, alleging that the fundamental aim laying under the provision was neglected by the Mediator.[7] Although the case has not yet resulted in final judgment, the ruling of court will be decisive for the parties, as the court may declare the mentioned provision invalid based on article 444 (2) of Civil code of RA. In that case the provision is expected to be excluded from the policy and not be implemented to other policyholders.

However, even it was not resulted in judicial case this is an example of the Mediator considering the insurance policy as a product sold by the insurer. The Mediator analyzed and regarded as defective a provision that was stipulated in the contract and agreed by both of the parties. If the mediator viewed the policy in the light of contract conception it would not have regarded it as a contract of adhesion, and would not declare invalid any of the provisions of the policy.

Compared to article 10.1.8 of "Rules on voluntary automobile insurance" established by the board of Ingo Armenia CJCS the above discussed provision can be considered to be vague. In article 10.1.8 the insurer denies to pay compensation when the policyholder's conduct resulted in depriving the insurer of the opportunity to reveal the real factual conditions of insurance event. That is to say in this case the insurer does not require its policyholder to commence administrative procedure in each case, but reasonably expects the policyholder not to conduct any activity depriving the insurer of opportunity of finding out the true circumstances of the event. In this case the insurer has an opportunity to examine each case with its specific details and decide.

This emphasizes the fact that viewing the policy under different conceptions may result in different outcomes in terms interpreting the terms of insurance policy.

As in view of product conception the policy is perceived to be a certain product

[7] Nairi insurance v. Financial Mediatior, ԵԴ/35624/02/19, http://www.datalex.am/?app=AppCaseSearch&case_id=45880421203982657

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created and sold by the insurer it is important to take into consideration that insurers draft the provisions pursuing certain aim that should not be neglected when solving the conflicts. This is implemented as the producers of other products pursue a definite aim when designing their products. However, the insurers should design their provisions considering the reasonable expectations of policyholders and try their best to exclude ambiguous provisions.

Another example of this conception in international practice is the case of *Susan Plevin v. DAS Legal Expenses Insurance Company Limited and Miller Gardner Limited (in administration)*[8]*,* where in the context of an after-the-event legal expenses insurance policy, the England and Wales High court held that where standard-form policy terms and a policyholder-specific schedule contained contradictory terms, the more individualized term in the schedule should prevail over the standard-form policy wording. In doing so, the High Court considered that where policy terms are truly contradictory, rather than ambiguous, and contained in different policy documents, the *contra proferentem* principle of construction did not assist the Court in resolving the inconsistency. However, the Court acknowledged that where contradictory terms are contained in the same policy document, the principle may be applicable.[9]

Another case to be discussed in the view of product conceptions is *Jasmine Voskanyan v. Nairi Insurance LLC*[10]. The facts of the case are as follows:

The employer (money exchange center) of the claimant acquired for the claimant an injury insurance policy which covered the only those accidents that happened in the

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[8] *Susan Plevin v. DAS Legal Expenses Insurance Company Limited and Miller Gardner* Limited *,* [2019] EWHC 1339 (Comm)

[9] *Allen & Overy LLP,* *Recent insurance litigation cases and trends in United Kingdom (England & Wales), 2019,* ***https://www.lexology.com/library/detail.aspx?g=f4cbb3af-420c-4dda-be05-1c51bee57f3d***

[10] *Jasmine Voskanyan v. Nairi Insurance LLC, ԵԴ/25071/02/19, http://www.datalex.am/?app=AppCaseSearch&case_id=45880421203962763*

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result of handling her job responsibilities. That is to say the employer acquired an insurance product with a specific limitation.

The claimant accidentally fell to the ground and injured her leg when going to the bank to exchange money. The main factual basis for the claim she considered the fact that she went to the bank during her working hours and the exchange of the money was necessary for her employment place.

One thing the claimant missed in this regard is that the insurance covered accidental risks arising from handling her **job responsibilities.** In order to find out whether the accident falls within the insurance coverage it is highly important to define the exact framework of the claimant's job responsibilities. The mentioned responsibilities were listed in her labor agreement. According to the agreement she was supposed to work as a cashier and to currency exchange trading.

Summing up the given facts we can conclude that from the side of insurer the insurance event falls out of the insurance policy coverage, as the risks insured were limited to those arising out of conducting currency exchange trading. However, the claimant may have expected her injury to be covered as she attended the bank to exchange money for her employer. The key point is that whether attending to bank will be regarded by court as conducting job responsibilities.

Nevertheless, this is a pending case and there is no final judgment yet, but it is a landmark example of product conception. The issue is that the product was acquired with certain **"limitation in usage"** and compensation will not be due, if the scope of limitation is somehow crossed.

In this regard one possible scenario is for court to decide that the provision in the policy is too wide and includes every activity conducted by the claimant during her working hours. This will mean that the insurer stipulated an ambiguous provision that does not clearly reflect the scope to of the risks to be covered.

However, the court can also find the scope of limitation clear and declare any activity conducted out of workplace not compensable.

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Another case of policyholder requiring an insurance product with certain limitation is ***Artur Khachatryan v. Ingo Armenia CJSC*** **.**[11] The facts of the case are as follows.

The claimant required voluntary automobile insurance (CASCO) that was limited to compensate damages arising from the certain types of possible accidents enlisted in "Rules on automobile voluntary insurance" established by Board of Ingo Armenia CJSC. [12] Particularly, the mentioned policy covered damages arising from 3.17 car accident, 3.18. fire, 3.19. damages caused by flying or falling object, 3.20. spontaneous disaster, 3.21. illegal actions of third parties, 3.22. animals' activities, 3.23. robbery.

During the trial it was established by the First instance court of RA (Court) that the claimant's car was damaged during car wash from mixing cold and hot waters. Insurer denied the compensation claim, stating that the cause of the damages was out of insurance policy coverage.

The court found the denial decision to be completely correct, as the risks covered by the policy were clearly stated in the policy and rules on CASCO insurance. Also the denial was based on Article 1003.1 1 (4) of Civil code of RA, according to which he insurance company shall be entitled to reduce or refuse to pay the insurance indemnity subject to payment under the insurance contract, where: there are other grounds envisaged by law or contract for reducing or refusing the payment of insurance indemnity.

Court stated that according to article 3.29. of mentioned CASCO rules damages arising from operation of the car are not considered compensated, unless otherwise stipulated by the agreement between the parties. As there was no specific exclusion

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[11] *Artur Khachatryan v. Ingo Armenia CJSC,* ԵԴ/25717/02/18,
http://www.datalex.am/?app=AppCaseSearch&case_id=45880421203899911
[12]Board of Ingo Armenia CJCS, *Rules on automobile voluntary insurance*, edited in 2020,
https://ingoarmenia.am/insurance_type/%d5%a1%d5%be%d5%bf%d5%b8%d5%b4%d5%a5%d6%84%d5%a5%d5%b6%d5%a1/

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agreed by the parties, Court regarded the insurance event to be out of required coverage.

The Courts judgment was appealed to the Appellate court of RA based on the same legal and factual rules stated in the claim. The Appellate court's reasoning and finding were the same as the Court's, resulting in denial of appellate claim and leaving the initial judgment in force.

The decision of the Appellate court was contested to Cassation court of RA and there is no final decision of court on this issue. However, based on the reasoning provided by both courts we can analyze this case in view of both product and contract conceptions.

Particularly, both courts took into account the fact that the claimant required CASCO policy as a product with certain "limitations in usage". Thus, if the insurance event fell out of the scope of risks provided by the policy, it was not considered indemnified. Nevertheless, courts also stated that the parties were provided an opportunity to stipulate other conditions by separate agreement, as article 3.29 of CASCO rules allowed them to do so. Court also tried to view the policy in the light of contract conception, stating that there was no specific provision in the contract that could make article 3.29 not applicable.

The issue is that some policyholders will want broader coverage at a higher premium, whereas others will want narrower coverage at a lower premium. The mentioned case is a classic example of a policyholder that prefers to pay less for a limited coverage. Thus it is essential to be well aware of the product that you or someone in behalf of you buys, and perceive that the compensation is due only when the insurance event lies in the frames of the limitation.

In this regard the product conception seems more truthful, as poses obligation on the insurers to properly design the provisions and bear the negative consequences, as well as on policyholders to properly study product to be bought. In our opinion, this conception sometimes goes hand in hand with contract conception, as in some cases the parties can change, exclude or include certain provisions of adhesion contracts by

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specifying it in the insurance policies.

The last one is the governance conception. According to Abraham "the core concept of this theory is that, in some settings, insurance functions like government by influencing policyholders' conduct and protecting them against misfortune. This view appears to conceive of insurance as a surrogate for government. However, because policyholders are not necessarily homogeneous, their interests will not always coincide—just as the interests of citizens under a government do not always coincide. In insurance, the interests of the majority and the minority of policyholders may be in conflict. In the behavior-control story that proponents of the governance conception tell, insurers are seen as coercing or influencing individuals in ways that government also sometimes coerces. One possible implication of the governance conception is that insurers should be subject to some of the obligations that are imposed on government because the relationship between insurers and their policyholders falls somewhere between the public relationship of government to its citizens and the private relationship between contracting parties". [13]

As you may see in this view the insurance policies are regarded as a set of rules and obligations imposed on the policyholders that should be followed. That is to say, the insurer is considered as an authority that provides privileges only to those who strictly follow the stipulated rules and do not breach them.

This concept is also discussed by S. W. J. van der Merwe. [14]

One of the central aims of insurance policies is to reduce moral hazard, or the prospect that policyholders will take less care knowing that they are insured.[15]

A landmark example of denial of the claim because of non-performance of the

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[13] Abraham, *supra* 33-35

[14] S. W. J. van der Merwe, *The Concept of Insurance and the Insurance Contract,* Vol. 3, No. 2, The Comp. and Inter. L. J. of Southern Africa, 1970

[15] Tom Baker, *On the Genealogy of Moral Hazard*, 75 Tex L Rev 237, 23.

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obligations stipulated by the policy that resulted in contributing to insurance event is *Estate of Luster v. Allstate insurance company*[16].

Mrs. Wavie Luster was a widowed woman living alone in her house in Merrillville, Indiana. On or about February 10, 1999, at the age of 83, Mrs. Luster applied for homeowner's insurance through Allstate agent Robert Burkus. In the application Mrs. Luster said she had been living in the home since 1965 and was living alone.

Mrs. Luster's homeowner's insurance policy provided dwelling protection and personal property protection for loss occasioned by fire, lightning, explosion, or smoke and contained a provision that should Mrs. Luster die, coverage would continue to the end of the premium period for her legal representative. The policy provided for coverage to abate if the loss at issue was caused by "any substantial change or increase in hazard, if changed or increased by any means within the control or knowledge of an insured person," and specified that Allstate would not cover loss caused by "Vandalism or Malicious Mischief if your dwelling is vacant or unoccupied for more than 30 consecutive days immediately prior to the vandalism or malicious mischief."

In October 2001, Mrs. Luster fell and injured herself and was hospitalized. Mrs. Luster remained at Outlook Manor from November 2001 until early April 2006, when she was readmitted to the hospital after a fall. When released from this second hospital stay, Mrs. Luster went to Miller's Merry Manor to receive skilled nursing care, and she died about a week later, on April 15, 2006.

At Mrs. Luster's direction, Mr. Gikas continued all of the utilities in the home and paid a neighbor to check on the home regularly and take care of all the necessary maintenance and repairs, but did not

[16] *Estate of Luster v. Allstate insurance company,* CASE NO. 2:07-CV-226RM (N.D. Ind. May. 20, 2009

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After Mrs. Luster's death in April 2006, Mr. Gikas opened an estate on Mrs. Luster's behalf and received permission to sell the Merrillville house. Mr. Gikas listed the home for sale through a realtor and continued to pay for utilities and maintenance. About three months later, on July 27, 2006, a fire at the house did extensive damage to the walls, carpeting, furniture, draperies, and clothing inside the house.

The estate requested compensatory damages for the loss suffered as a result of the fire, consequential damages for economic loss and emotional distress suffered as a result of Allstate's alleged bad faith refusal to pay Mrs. Luster's claim, and punitive damages for Allstate's allegedly malicious, fraudulent, and oppressive conduct.

Allstate claims that coverage is excluded because either: 1) Mrs. Luster's home was unoccupied for 30 days immediately before a fire caused by vandalism or malicious mischief or 2) there was a substantial increase in hazard known to Mrs. Luster's estate but no one notified Allstate of the change in use and occupancy of the home preceding the fire. According to Allstate, Mrs. Luster's failure to physically live at her house resulted in a substantial change in the house's use or occupancy of which Mrs. Luster, or her legal representative, was required to inform Allstate.

Moreover, Allstate did not have knowledge of facts sufficient to constitute notice of a change in occupancy. The fire occurred while the house was unoccupied — while the hazard was increased.

The N. D Indiana court rejects the estate's argument that the increase in hazard disappeared, and fire coverage became valid again, upon Mrs. Luster's death. No one occupied the home after Mrs. Luster was hospitalized following her October 2001 fall, so the disqualifying event was not abated.

The court acknowledged that in many areas a building vacated by a tenant, and left unoccupied, is subject to increased hazards of fire, thus rejected the estate's claim.

In this regard the insurance company is acting as a state, denying the application based on the fact that policyholder contributed to the insurance event. This is done to reduce the increase of moral hazard, which is the main adverse consequence of insurance

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agreements.

Apparently, this conception is more precise in case of compulsory insurance agreements. In that regard the insurer's role more resembles the one of a state, as it stipulates equal conditions for policyholders, regarding both the premium rates and obligations imposed. As it was already mentioned the only compulsory insurance is the MTPL. In case of auto liability insurers are permitted to base their rates on the insured's past loss experience (the well-known bonus-malus system). However, in other types of insurance policies the governance concept starts to get weaker.

Summing up all the analyzed conceptions of insurance we can divide those as more relevant either to compulsory, or voluntary insurance. If we discuss provision of voluntary insurance policies the one conception containing all the attributes of voluntary insurance **is the product conception. Within that conception when concluding the contract both the main notion of adhering contracts, and the free expression of will are present.**

Whereas in case of compulsory insurance the state theory becomes more relevant, as the state exercises the function of controller in more emphasized way. That is particularly demonstrated in the fact that in case of MTPL insurance both of the parties are deprived of the opportunity to stipulate the rules governing relations between them.

Chapter 2. The main obligations put on the policyholders that should be followed.

It is manifestly a well-known fact that within the insurance market standardized policies are inset. The main reason for policy standardization is that it grants the consumers an opportunity to compare the insurance market more precisely. The other reason is that standardized policies include all the amendments made by corresponding litigation.

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Only by employing the same language as others can insurers effectively tap into the pool of precedent. This, in turn, lends insurers an important degree of certainty about how their contract language applies, which helps them to price their policies accurately.[17]

As it was previously mentioned one of the main aims of the insurance policy is to reduce the moral hazard. This is for policyholders and beneficiaries to hold a primary obligation to care for the loss. Imposing provisions reducing moral hazard means to indulge policyholders to take care of the property even at the time it is endangered.

More commonly this provisions in Armenian practice are stipulated as obligation for the policyholder to refrain from a certain conduct in one or another way.

5.3.3 provision of CASCO rules stipulated by board of "Nairi Insurance" LLC states "according to these rules the insurer does not compensate in case the insurance event occurred as a result of leaving the engine of the transportation vehicle operating or unobserved.

The mentioned provision, obviously, aims to reduce moral hazard. That is to say to oblige the policyholders to care for endangering the automobile to loss. In case of non-performance of the mentioned obligation makes the insurance event to fall out of policy coverage. Referring to the conceptions discussed above, this case falls under governance conception, as it puts clear obligations on the policyholder who will be deprived of indemnity if violates those obligations.

An interesting example of non-conformity of that provision is as follows. The policyholder's car got damaged at the half of the way to countryside, near the canyon. Leaving the vehicle unobserved and with engine operating the policyholder tried to fix the problem. He left the automobile and before he could even touch the automobile it moved down to the canyon. As a result the car's damages were estimated as 10,000,000

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[17] • Daniel Schwarcz, *Reevaluating Standardized Insurance Policies,* U. Chi. L. Rev. Vol 78, No. 4, p. 1273, (2011)

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AMD.[18]

Although the policyholder had acquired CASCO insurance policy prior to the car crush, his application was denied because of non-observance of the mentioned 5.3.3 provision. Nevertheless, the policyholder argues that the non-observance of the car engine did not directly result in the car crush. Anyway, the insurer demanded an expertise, which restated that the car crush was because of leaving the engine of the transportation operating and unobserved.

Thus the policyholders should be extremely careful with studying and observing the provisions of the insurance policies, as they can lead to rejecting of their claims.

The discussed provision is designed to reduce the risk of moral hazard. In most policies one can find terms directed to deduction of moral hazard risk. For example the 10th chapter of CASCO insurance rules of Ingo Armenia CJSC is dedicated to reduce moral hazard risk. A similar term as was discussed in Sasha Hakobyan v Nairi Insurance LLC, can be considered the 10.1.2. article of CASCO rules of Ingo Armenia CJSC. According to the latter if the policyholder does not implement reasonable and possible actions to avoid the damages or else to reduce it, than the insurer can deny to pay compensation.

Within chapter 14 of “Rules on voluntary automobile insurance” established by Board of Rosgosstrakh-Armenia CJSC[19] list of additional basis for rejecting the compensation is stipulated. Those terms are also directed to reduce the risk of moral hazard. In contrary to Nairi Insurance LLC this insurer considered some administrative offenses to be basis for rejecting compensation, to refrain its policyholders from administrative offenses that are more likely to result in car accidents.

Apparently, as it was discussed in governance theory, the insurer imposes certain

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[18]Sasha Hakobyan V. Nairi insurance LLC, ԵԴ/10015/02/19,
http://www.datalex.am/?app=AppCaseSearch&case_id=45880421203932894

[19] Board of Rosgosstrakh-Armenia CJSC, *Rules On Voluntary Automobile Insurance,* 03.03.2014, http://www.rgs.am/up/files/TC750-01-02-ED5_ARM.pdf

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obligations on its policyholders, and rewards with compensation only those who accurately perform their duties under the policy. Those obligations may defer from one insurer to another, but the holistic logic under that kind of terms is deduction of moral hazard risk.

Another basic building block of the conditions section is the insured's duty to provide information and support to the insurer in the defense of the liability and damages suit. It is also one of the most contentious issues in the relationship between an insurer and policyholder in situations in which the insurer has reserved its rights. The insured's obligation to provide information so that the insurer can assess liability, damages, and coverage invariably must be balanced with the need to protect the insured's attorney-client privilege with defense counsel. Liability policies typically include, as a condition to coverage, a provision requiring the insured to cooperate with the insurer. The typical "cooperation" clause states that "the insured shall cooperate with the company and, upon, the company's request, assist in making settlements, in the conduct of suits ... ; and the insured shall attend hearings and trials and assist in securing and giving evidence and obtaining the attendance of witnesses." [20]

The supreme court of Minnesota described the purpose of cooperation clause in Juvland v. Plaisance case.[21]

The issue involves the cooperation clause of a liability automobile insurance policy issued to Charles Plaisance by State Farm Mutual Automobile Insurance Company. The cooperation clause reads as follows:

The insured shall cooperate with the company and, upon the company's request, shall attend hearings and trials and shall assist in effecting settlements, securing and giving evidence, obtaining the attendance of witnesses and in the conduct of suits. The

[20] David H. Anderson at el, 50 Insurance Cases Every Self-Respecting Attorney Or Risk Professional Should Know, *What is the "Duty to cooperate", 21, 2012*

[21] *Juvland v Plaisance,* 96 N.W. (2d) 537, 255 Minn. 262 (1959)

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insured shall not, except at his own cost, voluntarily make any payment, assume any obligation or incur any expense other than for such immediate medical and surgical relief to others as shall be imperative at the time of accident."

After examining the facts of the case Court mentioned that “it is a material part of the policy…designed to afford the insurer an opportunity to defend, and to protect it against possible collusion between the insured and persons claiming covered damages; and, in the absence of waiver or estoppel, a substantial breach of such a provision resulting in prejudice to the insurer will relieve it of responsibility both to the insured and the injured third parties."

The insurance company's affirmative defense in the instant case is limited to general allegations that the insured willfully, and with intent to deceive and defraud his insurer misrepresented material facts pertaining to the accident and that he failed to cooperate with his insurer. This affirmative defense carries with it the burden of proof. It clearly suggests probable fact developments at trial determinable only by a jury or other fact finding tribunal.

Summing up these two principles, we can assert that the insurer puts obligations on the policyholders that should be properly followed, otherwise it can result in denial of the presented claims. Anyhow, this chapter is to emphasize the main logic under the insurance policy provisions, that is to say the insurer indemnifies his policyholders in case they conduct according to terms of the insurance policy. When analyzing this in the light of insurance policy conceptions, this resembles the governance conception. That is to say the insurer (state) gives the priority to be compensated only to those policyholders (citizens) that match their conduct with the stipulated imperative norms.

The policyholders face many problems when finding out whether an accident is considered to be an insurance event in the view of the certain insurance policy. A

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noteworthy case within travel insurance policy is *Artashes Hakobyan v. Nairi insurance.*[22]

Generally, within the framework of travel insurance policies the Insurer indemnifies the expenses arising from emergency medical care that are prescribed by a physician. However, the exact events requiring medical care are compensated if the event is not excluded from the policy.

The facts of the above-mentioned case are as follows: Hakobyan buys a travel insurance policy and left for Greece on vacation for two weeks. After a few days his health condition worsens and he gets an ischemic insult. The insurer indemnified the hospital expenses in the amount of 1000 euro.

After a hospital treatment for half month Hakobyan gets discharged from the hospital. Anyway, doctors prescribe him a further medical care. As it the medical care is too expensive in Greece, he decides to return back to Armenia. As Hakobyan did not recover totally, he was prescribed to return back on the special automobile with medical staff. This means of transportation costs Hakobyan 3.000.000 AMD, which he later claims from the insurance company to indemnify.

According to 4.2.1 provision of Travel insurance rules stipulated by board of "Nairi Insurance" LLC[23] states that the Insurer indemnifies Expenses of medical-transportation services arisen at the time of occurrence of Insurance event that include: 4.1.2.1. Transportation costs (excluding air ambulance) of the Insured person to the nearest medical institution from the place of occurrence of Insurance event to provide an emergency medical care,

4.1.2.2. Expenses of transportation (excluding air ambulance) of the Insured person to another medical institution instructed by physician,

[22] Artashes Hakobyan v. Nairi Insurance LLC, ԵԴ/15710/02/19, http://www.datalex.am/?app=AppCaseSearch&case_id=45880421203944635

[23] Board of "Nairi insurance" LLC, Travel insurance rules and conditions, 2016, file:///Users/elinanersisyan/Downloads/Travel%20_ENG.pdf

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4.1.2.3. Expenses of medical repatriation of the Insured person instructed by physician that include the expenses of changing the date of flight of the Insured person to his permanent residency if an air ticket exists, otherwise the cost of an economy class flight air ticket to the Insured person's permanent residency.

Analyzing the mentioned provisions we can conclude that the Insurer precisely stipulated the cases when he indemnifies the transportation expenses, and it does not include the return of the patient by special transportation means.

Taking into consideration the above-mentioned the Insurer denied the policyholder's claim. Moreover, under the section 6 of the travel insurance terms the maximum sum insured is stipulated. Particularly, according to 6.4 article of the terms "Expenses related to life threatening acute conditions of the chronic diseases are indemnified at the maximum amount of 1000 Euros equivalent to AMD calculated by the exchange rate of Central bank of Armenia at the day of the Insurance event".

The Insurer asserts that the ischemic insult is considered to be life threatening acute conditions of the chronic diseases, thus he indemnified the hospital expenses in the amount of 1000 euro. In this case the insurer asserts that even if the return of patient by special transportation means is compensable, the maximum amount of insured sum has been already spent.

On the other hand, the claimant asserts that ischemic insult does not have anything common with chronic diseases. Summing up the arguments of both sides, court decided that the burden of proof lays upon the claimant.

It is important to mention that this is a pending case and has not yet resulted in final judgment. But analyzing the possible success of the claim in light of established Armenian court practice, the most possible scenario may be of court framing the scope of insurance events laying on the literal meaning of the provisions. As the events that are regarded to be compensated does not include the repatriation of insured by special means, most probably the court will not support the claimants reasoning.

However, another possible setup may be for court to view the conflict under product theory and regard the mentioned provisions defective and not serving its purpose. The last one is less possible as courts avoid declaring policy provisions invalid without critical reasons.

On the other hand the policyholders try to alter the initial will of the parties trying to fit the accident under the insurance event that can be indemnified.

In American Home Assurance Co. v. Hughes[24] the Virginia Court of Appeals recognized the general principle that ambiguities in insurance con-tracts are generally resolved against the insurer, but refused to extend this principle to convert a disability policy into a life insurance policy. Thepolicy in Hughes was issued in May 1964, to cover mortgage payments ona home in the event the mortgagor became disabled. Shortly thereafter, the mortgagor became ill and remained disabled until he died.

His wife then filed suit to compel the insurer to continue making the mortgage payments, maintaining that since her husband had not recovered, his "disability" continued beyond his death. The insurance contract did not specifically state that the death of the mortgagor terminated the insurance, but other policy provisions, such as the one stipulating that the insured must remain under a physician's care while under a disability, made this intent reasonably clear.

The insured’s wife tried to alter the initial will and aim the insurer put when stipulating the policy provisions. As a result her claim was denied, as she tried to get money by adjusting the terms in her favor.

<u>CHAPTER 3. Recent issues with insurance policy coverage caused by COVID-19.</u>

[24] *American Home Assurance Co. v. Hughes* 209 Va. 514, 165 S.E.2d 411 (1969).

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With devastatingly large growth of COVID-19 during the beginning of 2020 both in Europe and USA, the economic downturn was inevitable. The global pandemic poses major challenges to certain business sectors such as airlines, travel and leisure, and causing significant stock market volatility.

In this point, it is very essential to analyze the correlation of COVID-19 and issues concerning the insurance policy coverage.

COVID-19 continues to have an unprecedented effect on business operations throughout the world. While the availability of insurance coverage for pandemic-related losses is still far from certain, it is imperative that business leaders review their insurance policies and give notice of any potential claims as soon as possible.

Below we will discuss opinions of lawyers or law firms started on the success of this type of claims. However, most acknowledge that coverage will ultimately depend on the specific facts of the claim, the policy language and applicable laws. Moreover, actions taken by federal and state authorities in response to this pandemic are continuously changing and may impact insurance coverage. More importantly, most Insurance Service Office (ISO) property insurance policy forms contain exclusions for losses arising out of virus or bacteria.[25]

According to the mentioned article most of the policyholders start to look through policy provisions just now. In most cases the business owners are quite surprised that the business interruption policies include a wide exclusion of loss due to viruses. In some cases the compensation is not due even if the business interruption is due to "civil authority".[26]

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[25] Shawn Henson et al., *Insurance Coverage Questions in Light of Coronavirus, 20.03.2020,* https://www.akingump.com/en/experience/industries/national-security/covid-19-resource-center/insurance-coverage-questions-in-light-of-coronavirus.html

[26] *Id* at 2

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On 17th of March, 2020 a suit was filed in a Louisiana state court by a restaurant seeking a declaration of coverage for coronavirus-caused losses under a business interruption policy.[27]

The facts of the case are as follows: Oceana Grill, which describes itself as "a well-known New Orleans restaurant in the heart of the French Quarter," alleges that it is an insured under an "all risks" property policy issued by Lloyd's that includes business interruption and an "extension of coverage in the event of the businesses closure by order of Civil Authority." The policy covers direct physical loss unless the loss is specifically excluded or limited.

The seafood establishment is seeking a judicial determination that the Louisiana governor's public gathering restriction and New Orleans **mayor's restriction on restaurant operations, trigger the Civil Authority provision of the Lloyd's policy.** In particular, the complaint seeks a declaration that the policy provides coverage to plaintiffs for any future civil authority shutdowns of restaurants in the New Orleans area due to physical loss from Coronavirus contamination and that the policy provides business income coverage in the event that the coronavirus has contaminated the insured premises.

Key to unlocking it is that the complaint maintains that the global pandemic is exacerbated by the fact that the deadly virus physically infects and stays on the surface of objects or materials, 'fomites,' for up to twenty-eight days, particularly in humid areas below eighty-four degrees. Further, the complaint states that it is "clear that contamination of the insured premises by the Coronavirus would be a direct physical loss needing remediation to clean the surfaces of the establishment.

Oceana Grill's apparent argument is that the presence of the coronavirus causes physical loss to the affected premises. Thus, if Oceana Grill is shut down, because other restaurants in the area have suffered a physical loss on account of the presence of the coronavirus, then it is entitled to so-called Civil Authority coverage for its losses. If the

[27] Cajun Conti, LLC, et al. v. Certain Underwriters at Lloyd's London, et al., 2020

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coronavirus were present in Oceana Grill itself, then the restaurant asserts that it would be owed coverage for business interruption.

In general, and putting aside any precise policy language that may apply, one critical requirement for the potential availability of business interruption insurance is that there has been physical damage to property. This is either to the insured's own covered premises, or, for purposes of losses on account of the actions of a civil authority, another's premises. Either way, it will be necessary for Oceana Grill, and policyholders in general, to prove that the presence of the coronavirus causes physical loss to the affected premises.

Second, the Oceana Grill complaint has much to say about the fact that the Lloyd's policy does not contain a "virus" exclusion. This is because Insurance Services Office, Inc. (ISO), for its business interruption policies, introduced a mandatory "virus" exclusion in 2006. This is going to play an important part in determining the potential availability of business interruption coverage for coronavirus-caused losses.**[28]**

Obviously, normally many of the insurance policies do contain viruses as explicit exclusions. However, in the mentioned case the main key issue is the fact that, the loss is caused because of civil authority. That is to say when the local government adopted a decision that ceased the business activity.

As we do not have much information about the policy language and the provisions in this case, we cannot accurately assess the possible success or failure of the claim. However, the claim is more likely to be successful, if Oceana Grill provesc that the loss was due to authorities conduct, but not directly because of the virus.

On the other hand the insurer's arguments should be based on proving the existence of the direct casual link between the virus and the loss. A major argument in

[28] Edward M. Koch, Randy J. Maniloff and Marc Penchansky, *Insurance Coverage and Bad Faith Alert*, 2020, https://www.whiteandwilliams.com/resources-alerts-First-Coronavirus-Coverage-Suit-Filed-For-Business-Interruption.html

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favor of Oceana Grill is the fact, that the virus did not exist in restaurants area, and the lockdown was only to reduce the risk of virus spread.

However, in other business interruption policies provisions excluding compensation even in case of “civil authority” are stipulated. Emma Mcilroy, owner of the Portland-headquartered brand Wildfang, with two additional stores in Los Angeles and New York City, had to close her businesses. When contacting the insurer to apply for compensation she found out that there is a broad exclusion of loss due to virus or bacteria which applies to all coverages provided by your Commercial Property insurance, including (if any) property damage and business income coverage.

Moreover, The lack of coverage applies even if the closure is due to “civil authority” — in other words, even when the governor has declared a state of emergency and required businesses deemed non-essential to close.

As the policyholder said “I was utterly devastated,”. “I’m not an expert in insurance, but when I bought ‘Business Interruption insurance,’ I assumed it would cover government-mandated shutdowns and global pandemics.” [29]

That is a classical case of misconception of the product bought by the policyholder. The policyholder, obviously, expected any loss caused to his commercial property to be compensated, especially the loss caused by “civil authority”.

Anyhow, the lawyers do advice the businesses to report to their insurers and claim for the compensation, not to be rejected for missing the time limits. As for the future success of the claims there is a prediction that with raising quantity of coverage litigations due to “civil authority” courts can interpret the policies in a way the compensation will be due.

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[29] Many Business Insurance Policies Won’t Cover Loss Due to Coronavirus, Journal Monthly Portland, 2020, https://www.pdxmonthly.com/news-and-city-life/2020/03/an-exclusion-in-most-insurance-policies-means-small-businesses-wont-be-covered-for-coronavirus-loss

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In contrary to business interruption policies that have less possibility of future success, according to KPMG global travel insurance may offer cover if a customer is diagnosed with the virus before or during their trip - but not for travel that is cancelled because of the pandemic, unless a customer has taken out premium `any cause' cover, which very few have.[30]

Probably the largest part of insurance compensation will be directed to cover losses caused by large event cancellations. One of those may be cancelation of Tokyo Olympics this year. Certain part of those losses will be covered by big reinsurers, as the losses caused by large scaled policies in majority cases are reinsured.

In Armenian reality no insurance company provides a business interruption policy. However, according to rules on property insurance stipulated by insurers, if the property of the restaurant is insured under property insurance policy, the insured recovers losses caused by property damage. This may refer also to business losses because of property damage. Thus, the only ground to apply for compensation is the existence of physical loss.

Consequently, in Armenia if the business is shut down because of COVID-19, it does not have any legal basis to rely on insurance indemnity.

Speaking about the private health insurance policies, we should mention that the tests and corresponding treatment are not included in the insurance policy coverage. As the COVID-19 test is provided within the framework of state order, which is exclusion in majority health insurance policies, individuals get those tests from the state directly on free bases. For example article 5.1.22 of "rules on voluntary health insurance" established by board of Ingo Armenia CJSC declare the illnesses enlisted in

[30] Laura J. Hay, Do insurers have COVID-19 covered, KPMG global, 2020, https://home.kpmg/xx/en/home/insights/2020/03/do-insurers-have-covid-19-covered.html

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state order to be not compensable.[31] Similar provisions are included in most of health policies in different institutions.

Moreover, if the policyholder waives to profit from state order, that does not make the insurance company liable to pay for the service provide. More detailed it is explained by the first instance court in *Qankor LLc v Haykaz Davtyan.*[32]

However, there is little possibility that the test will be conducted during providing health care of those illnesses that are included in policy coverage, so the insurer may be imposed to pay also for the test. However, there is no available data yet on such kind of issues in order to discuss.

Generally, according to medical health care policies the insurers' obligation to indemnify emerges as a result of emergency insurance events. As a rule, only acute and emergency conditions give basis for insurance indemnity.

Moreover, among the world the private hospitals have been asked to support the national health support. This is adopted practice for example in England[33] or Australia.[34] As a result it is likely to have an impact on consumers who have private medical insurance and are currently, or due, to receive treatment.

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[31] Board of Ingo Armenia CJSC, "rules on voluntary health insurance", 2019, https://ingoarmenia.am/insurance_type/%d5%a1%d5%bc%d5%b8%d5%b2%d5%bb%d5%b8%d6%82%d5%a9%d5%b5%d5%b8%d6%82%d5%b6/

[32] Qankor LLC v Haykaz Davtyan, ԼԴ2/0038/02/18, http://www.datalex.am/?app=AppCaseSearch&case_id=30962247438253929

[33] NHS and private hospitals join forces to fight coronavirus crisis, The Guardian, 2020,

https://www.theguardian.com/world/2020/mar/14/coronavirus-nhs-private-hospitals-join-forces-academics-warn-over-strategy

[34] Private hospitals to be used in coronavirus fight, The Camberra Times, 2020 https://www.canberratimes.com.au/story/6705150/private-hospitals-to-be-used-in-coronavirus-fight/

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Most privately insured treatment is likely to fall under non-urgent care and may need to be delayed due to coronavirus. Insurers need to communicate effectively, timely and compassionately with customers.[35]

As the number of current affected people in Armenia is not widely increased, the private hospitals are not much engaged in the fight against coronavirus. But with the increase in quantity of affected patients, Armenia will face the same problems as many insurers and insured people among the whole world. Thus it is a responsibility for insurance companies to make aware their policyholders about possible changes in the conditions of the acquired policies.

As a summary, we can state that the global pandemic affected almost all ambits of peoples' lives these days. It also did not leave insurance market unaffected. Obviously, the number of claims and lawsuits will increase by the time, and international insurance market should be ready for the modern world challenges. Anyhow, with the given situation it is better for the insured people to follow the obligations set forth in the agreements, with the hope that lawyers will find loopholes in the insurance policies to get compensation from the insurance companies.

4. CONCLUSION.

In the first chapter of this paper we elaborated on the different conceptions of insurance policies, by bringing examples from both Armenian and international case law practice. The risks were enumerated on the view of each conception trying to emphasize the most precise one which would lessen the possible risks. As a conclusion, we think that the product conception is the best one containing all the attributes of insurance.

[35] Financial Conduct Authority, *Insurance and coronavirus (Covid-19): our expectations of firms,* 2020 https://www.fca.org.uk/firms/insurance-and-coronavirus-our-expectations

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Within that conception both the main notion of adhering contracts, and the free expression of will when concluding the contract are present. Therefore we think that the body which is to interpret terms of the policy should take into account the product theory in order to solve the conflict correctly.

In the frameworks of Chapter 2 the two main principles of insurance were discussed: the aim to decrease the moral hazard and duty to provide information and support to the insurer. It is important for the policyholders to recognize all the obligations imposed on them by the virtue of insurance agreements. In many cases the policyholder can insure certain risks, but not get compensation because of non-performance of his own duties. Thus the policyholders should know that the duty of the insurer to provide compensation is directly interconnected with his obligations to follow the insurance terms. Moreover, the insurers can be posed to risks such as alteration of the initial expectations when entering into insurance agreement.

As for the chapter 3, it enumerates the current issues emerging from the wide spread of COVID-19. Apparently, many businesses will have losses in big amount due to the virus and government decisions. The business owners search protection under their insurance policies. In this regard, we presented the possible success of such kind of claims and all the risks both parties can face. Also we discuss the first case resulted in litigation because of coronavirus outbreak. However, we do not forget to analyze the correlation between Armenian insurance market and coronavirus either.

As a summary, we can state that the insurance market engaged in the main ambits of peoples' lives. However, taking into consideration the essential role of insurance, the risks are inevitable both when stipulating the norms and when applying for compensation. Thus, both the insurers and the policyholders should precisely determine the scope of risks the insurance policy involves. Anyhow, nowadays it is very essential for courts to to view the insurance policies within the right view, not to alter the initial will of the parties and the main principles put under the exact insurance product.

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