Case Law Trends in Japanese Insurance Law and Their Impact on the Japanese Insurance Act 2008 – Structure of the Act and Anti-Fraud Issues

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I. INTRODUCTION

This paper[1] aims at describing some of the features of the Japanese Insurance Act (hereafter "Insurance Act")[2] by focusing on the impact of the explosion of insurance law cases in Japan since the 1980s. The development of insurance case law, especially cases on a series of anti-fraud defenses and on the interpretation of policy terms, doubtlessly had a significant influence on its shape, volume, and the achieved level of policyholder protection in it. Other decisive factors were the obligation law reform and the long history and influence of supervisory law and practice on the insurance industry in Japan. Although there has already been excellent previous work available[3] whose concerns are quite similar to this paper, this is another trial to demonstrate how the Insurance Act acquired its shape from a different angle.

II. BASIC STRUCTURE OF THE JAPANESE INSURANCE ACT 2008

First, we shall examine the basic structure of the Insurance Act by making reference to its social and economic backgrounds, the preparation of drafts and the development of both private laws and regulatory laws applicable to insurance (see *Table 1*).

1. Scope of Application

Until the Insurance Act 2008 was put into force on 1 April 2010, insurance contracts were subject to the provisions of the Japanese Commercial Code 1899, which listed insurance transactions with the purpose of profit-making as commercial activities (Article 502 no. 9 Commercial Code). As provisions in Part II (Commercial Activities) of the Commercial Code were to regulate commercial activities, the provisions of Part II Chapter 10 ("Insurance") were directly applicable only to profit-making insurance. Where insurance businesses were run by non-profit mutual corporations (*sōgo gaisha*) or cooperatives (*kyōdō kumiai*), we needed statutory provisions *mutatis mutandis* to apply the provisions on insurance in the Commercial Code.[4]

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1 This paper is an expanded sequel to an English summary of my presentation given at the Japan Association of Private Law Symposium, "The Reformation of the Insurance Contract Law," on 6 October 2007: K. KINOSHITA, Asymmetric Information and Defenses against Fraudulent Claim in Insurance Contract, Shihō 70 (2008) 282–280. A PDF version of "Shihō" is available at the e-Journal database "J-STAGE" (http://www.jstage.jst.go.jp/). K. KINOSHITA, *Hoken keiyaku ni okeru jōhō kakusa no zesei oyobi fusei seikyū taisaku* [Redress of Asymmetric Information in Insurance Contract and Defenses against Fraudulent Claims], Shōji Hōmu 1808 (2007) 14.

2 *Hoken-hō*, Law No. 56/2008.

3 S. KOZUKA / J. LEE, The New Japanese Insurance Act: Comparison with Europe and Korea, ZJapanR 28 (2009) 73.

4 As to contracts with mutual corporations, Art. 664, 683 para.1 Commercial Code, *Shōhō*, law no. 48/1899, prior to revision 2008; as to contracts with cooperatives, Art. 103 Agri-

In the beginning of the twenty-first century, the growth of unregulated insurance-like businesses targeting niche markets – called "unauthorized mutual aid business (*mu-ninka kyōsai*)" – became controversial. Their business had not been regulated because the supervisory authority, the Financial Services Agency (hereafter FSA), had difficulty in finding the actual situation of the market. Their scales of business tended to be small, and as the amount of benefits was limited, they could not – and did not try to – satisfy the minimum capital fund and other strict requirements set by the Insurance Business Act (hereafter IBA)[5] to be licensed as insurance companies (Art. 5, 6, 8-2 etc. IBA). In order to include these businesses under the statutory regulation, in 2005 a more relaxed supervision framework on the Small-Amount Short-Term Insurance (*shōgaku tanki hoken*) was newly introduced in Articles 272 to 272-43 IBA.

In leveling the playing field among various types of service providers, the time was ripe to renew statutory contract law to be equally applicable to insurance and similar contracts whose substance was equivalent to insurance contracts, regardless of the names or whether the purpose of the business was profit-making. This is the main reason the Insurance Act became independent from the Commercial Code and shall be directly applicable not only to (profit-making or mutual) insurance contracts, but also to other mutual aid contracts (*kyōsai*).

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cultural Accident Compensation Act, *Nōgyō saigai hoshō-hō*, Law no. 185/1947, Art. 9-7-5 Small and Medium Enterprises Cooperatives Act, *Chūshō kigyō tō kyōdō kumiai-hō,* Law No. 181/1949, prior to revision 2008.

5 *Hoken-gyō hō*, Law No. 105/1995, English translation (translated in June 2010) at the Japanese Law Translation website: *http://www.japaneselawtranslation.go.jp/law/detail/?id=2054&vm=04&re=02&new=1*.

Table 1: Legislation History of Private Law and Regulatory Statutes Applicable to Insurance

Development of Private Law Statutes Applicable to Insurance Contracts in Japan		Development of Insurance Supervision Statutes, Supervisory Bodies, and Milestone Events in Japan	
1896	Civil Code		
1899	Commercial Code Part 3 (Commercial Transactions) Chapter 10: (Non-marine) Insurance Part 4 (Commercial Maritime) Chapter 6: Marine Insurance	1900	Insurance Business Act *(abolished in 1995)* ▹ Hereafter insurance business was supervised by the Ministry of Agriculture and Commerce (until 1941).
1911	Amendment of Commercial Code (e.g., effect of non-disclosure was amended from *per se* void contract to insurer's right to terminate contract)	1931	Ordinance on Insurance Solicitation Regulation *(abolished in 1945)*
		1939	Amendment of Insurance Business Act
		1941	▹Hereafter supervised by the Ministry of Finance (MOF) (until 1998)
		1948	Act on Insurance Solicitation Regulation *(consolidated in IBA 1995)* Act on Non-Life Insurance Rating Organization (ANLIRO)
		1949	Act on Foreign Insurance Business Entities *(consolidated in IBA 1995)*
1955	Automobile Liability Security Act (compulsory automobile liability insurance)	1965	▹ MOF showed interpretation of the license rules concerning accident and health insurance
		1966	Act on Earthquake Insurance
1964 | 2005	Drafts on the reform of insurance contract laws (collaboration works of leading academics and industries.) • Indemnity Insurance: in1974 and 1995 • (Marine Insurance: in 1988 and 1995) • Life Insurance: in 1998, 2002, and 2005 • Accident Insurance: 1982, 1995, 1998, 2003, and 2005 • Health Insurance: 1998 and 2005	1991	▹ Japanese Bubble Economy burst, recession started. A number of litigations seeking compensation for damages caused on variable life insurance
		1995	Insurance Business Act ("IBA"), including policyholder's cooling-off right Amendment of ANLIRO ▹ Diversification of product and price started.
		1998	Financial System Reform Act: Amendment of IBA 1995 and ANLIRO ▹ Hereafter supervised by Financial Supervisory Agency (*Kin'yū kantoku-chō*)
2000	Consumer Contract Act	2000	▹ Hereafter supervised by Financial Services Agency (*Kin'yū-chō,* "FSA")
2004	Civil Code modernized in its language	2005	Amendments of IBA introduced regulation on Small-Amount Short-Term Insurance Comprehensive Guidelines for Insurance Company Supervision
2006 | 2008	Working Group on Insurance Law, Legislative Council of the Ministry of Justice (MOJ) (*Hōsei shingi-kai hoken-hō bukai*)	2005 | 2008	▹ FSA ordered business suspension and/or business improvement against the Nonpayment and Leakage of Insurance Benefit
2008	Insurance Act (put into force on 1 April 2010)		
2009 |	Working Group on Civil Code (law of obligations), Legislative Council of the MOJ (*Hōsei shingi-kai Minpō (saiken kankei) bukai*)	2013	Consultation on Amendment of IBA (lifting ban on benefits in kind as fixed sum insurance, statutory rules on product disclosure, and reform of intermediaries regulation)
2013	Interim Draft on the Civil Code Reform		
2015?	Amendment of Civil Code (Law of Obligations)		Since 1998, the IBA was amended in 2000, 2001, 2003, 2005, 2006, 2008, 2009, 2010, and 2012.

2. Classification of Insurance and Repetition of Provisions

We should keep in mind the size of the Act, the classification of insurance, and the arrangement order of the provisions. The literal number of articles is 96; however, the substantial volume of the Act is much smaller. Many provisions that are likely to be found in the part of general provisions in other jurisdictions – such as duty of disclosure, retroactive insurance, time of performance of insurance benefit, effect of cancellation, and return of premiums – are repeated three times according to the type of contracts, with substantially equivalent contents (see *Table 2*).[6] Such repetition was made in order to avoid the technical replacement of terms.

Accident and health indemnity insurance is characterized as a kind of indemnity insurance, and among provisions of fixed sum accident and health insurance, only one article – namely Article 34 on the insured's right to request cancellation – is similarly applicable to that of indemnity insurance. As to accident or health insurance, in the 1990s we experienced a debate, triggered by a Japanese Supreme Court judgment on income compensation insurance (*Shotoku hoshō hoken*) sold by a non-life insurer, over the possibility to find a hybrid nature of accident or health insurance between indemnity insurance and fixed sum insurance. The Supreme Court judgment on 19 January 1989[7] ruled that, judging from provisions calculated on the basis of the sum insured and on the treatment of multiple insurances, income compensation insurance should be classified as indemnity insurance. The Court relied on this classification to affirm the application of the old Article 662 Commercial Code (corresponds to Article 25 Insurance Act)[8] to the case.

Article 25 Insurance Act is regarded as semi-mandatory (Art. 26) but not absolutely mandatory[9] in the sense that obtaining the insured's right should not be coerced to insurers. There is to be room for an accident and/or health indemnity insurance to opt out of the default provision of Article 25. As far as the insurance of persons is concerned, classification of contract may not play an important role in drawing this conclusion. The

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6 Provisions in chapters 3 and 4 are quite similar, and we can find substantial differences only between Art. 38 and 67. Both Art. 38 and 67 provide that those contracts where a death of the insured shall be covered under the policy shall be void without consent of the insured. The difference between them is the exceptional rule. The provision of Art. 67 para. 1 does not require the consent as long as the insured is at the same time a beneficiary.

7 Hanrei Jihō 1302 (1989) 144 = Hanrei Taimuzu 690 (1989) 116.

8 In this case, the claimant, a victim in a tort and the insured of income compensation insurance, claimed for compensation of damages against the defendant, the perpetrator. The defendant argued that the claimant had already received insurance benefits and the amount of benefits had already *ipso jure* been transferred to the insurer. In Japan, it is customary that statutory provisions are also included in the policy conditions, but in the policy conditions of the income compensation insurance there was no clause referring to the subrogation on claims. As the insurer's intention was said to renounce the subrogation right, the Supreme Court's conclusion would exempt the liability of the perpetrator without good reason.

9 O. HAGIMOTO (ed.), "*Ichimon ittō Hoken-hō* [Answering Question by Question on the Insurance Act]" (2009) 141.

Supreme Court judgment can be so understood that the absence of the provision on subrogation should be understood objectively from the reasonable policyholder's perspective, and the insurer's implied will might not be emphasized.

Table 2: Repetition of Provisions in the Insurance Act 2008 – General Provisions and Rules Commonly Applicable to All Types of Insurance

Chapter 1: General Provisions		Art.1: Purpose Art.2: Definitions		
Provisions common to virtually all types of insurance contracts * mark means semi-mandatory provision[10]		**Chapter 2** **Indemnity Insurance**	**Chapter 3** **Life Insurance**	**Chapter 4** **Fixed Sum Accident/Health Insurance**
Section 1 of Each Chapter: **Formation**				
*	Duty of disclosure	Art. 4	Art. 37	Art. 66
*	Retroactive insurance	Art. 5	Art. 39	Art. 68
	Delivery of document (insurance policy)	Art. 6	Art. 40	Art. 69
Section 2 of Each Chapter: **Effect**				
*	Contract for third party (the insured or beneficiary enjoys the benefits *ipso jure*)	Art. 8	Art. 42	Art. 71
*	Decrease in risk	Art. 11	Art. 48	Art. 77
Section 3 of Each Chapter: **Insurance Benefit**				
	Notice of occurrence of damage/death of the insured/cause of insurance benefits	Art. 14	Art. 50	Art. 79
	Exemption from insurer's obligation	Art. 17	Art. 51	Art. 80
*	Time of performance of insurance benefits	Art. 21	Art. 52	Art. 81
Section 4 of Each Chapter: **Termination**				
	Cancellation by policyholder	Art. 27	Art. 54	Art. 83
*	Rescission by reason of non-disclosure	Art. 28	Art. 55	Art. 84
*	Rescission by reason of aggravated risk	Art. 29	Art. 56	Art. 85
*	Rescission on grave grounds	Art. 30	Art. 57	Art. 86
*	Effect of cancellation	Art. 31	Art. 59	Art. 88
*	Limitation of return of premiums	Art. 32	Art. 64	Art. 93
Chapter 5: Miscellaneous Provisions		Art. 95: Prescription Art. 96: Bankruptcy of insurer		

10 Semi-mandatory provisions are explicitly listed in Art. 7, 12, 26, and 33 for indemnity insurance, in Art. 41, 49, 53, and 65 for life insurance, and in Art. 70, 78, 82, and 94 for fixed sum accident and health insurance.

3. Justification for the Minimum Volume of the Act

a) Introductory Remarks

It is obvious that the Insurance Act was born with a small volume. The number of provisions is far less than those statutes on insurance contract in Germany, France, or Italy, which were translated into Japanese before starting discussion on the law reform. There are some causes for the "minimalism" attitude of the Insurance Act[11] to cut off many of nominated rules.

We can say the small and simple output is mainly the result of the rule-setting philosophy, consistently retained over more than decades, to be respectful of the freedom of contract. The active attitude of the Supreme Court at the time of the legislation might frighten the industry into avoiding unnecessary default provisions. The FSA did not wish to renounce or reduce their control over the sales process regulation. The representative of attorneys (Japan Federation of Bar Associations: *Nichibenren*) was not a specialist of insurance law and seemed not to be backed-up by the Nichibenren's consumer committee. Even the representative of the labor unions often did not support the consumers' arguments. Thus, in many issues the voice of consumers could not obtain the majority's support to introduce broader provisions in the Insurance Act.

b) Scope of Weaker Party Protection

In Japan, statutes whose purpose was set to promote consumer protection tend to be born small. We should remember that both the Japanese Products Liability Act 1994 and the Consumer Contract Act 2000 were other examples of statutes that began small. The latter has a very limited list of unfair contract terms (Art. 8 and 9 Consumer Contract Act). This time again, it was very difficult to introduce provisions in the Insurance Act which are based on unfamiliar notions in the current Japanese Civil Code 1896. In 2008, when the consultation on the insurance law reform was in its final stage, the reform of obligation law was in its preparation stage just before the request for consultation was given to the Legislative Council. The result of obligation law reform was unpredictable.

In describing the scope of semi-mandatory provisions that shall accord statutory protection over the weaker parties against insurers, Article 36 Insurance Act does not literally mention the "consumer". It lists the excluded categories of indemnity insurance contracts[12] as follows: (1) marine insurance, (2) insurance of aircrafts and transport by air (both cargo and liability), (3) insurance of nuclear facilities and liability for damages arising from an accident at a nuclear facility, and (4) insurance that indemnifies damages

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11 KOZUKA / LEE, *supra* note 3, 84.

12 There is no provision to exclude the life insurance contract and accident and health insurance contract from the application of the semi-mandatory provisions.

that may arise from business activities conducted by a juridical person or any other association or by an individual engaged in a business.[13]

As to the last category of business entities, it actually adopted virtually the same criteria as that of "business operator" prescribed in Article 2 para. 2 of the Japanese Consumer Contract Act 2000. The Insurance Act does not follow the EU law model of distinction between the large risk and mass risk: it combines several criteria for business size, measuring the bargaining power against insurers in order to protect the individual merchants or small business entities equal to consumers. The position of the Insurance Act means that all the risks which may arise from activities of any association and individuals who are engaged in business or non-profit activities – regardless of their purpose, size of business, or activities – are excluded from the scope of protection under the semi-mandatory provisions.

We knew the structural imbalance of knowledge, experience, and proficiency in insurance transactions, human resources, and bargaining power between the insurers and small business entities. Still, we faced difficulties in formulating the weaker parties in a simple definition. The precise criteria originating in the EU of large risk with a wider scope of protection seemed too complicated to be embedded in the family of basic private law statutes. More decisively, the wider scope of weaker party protection might have been detested as it could have a potentially wider impact upon the upcoming discussion over the scope of consumer protection under the obligation law reform.

c) Case Law Trends on the Weaker Party Protection

The European concept of weaker party protection has to be, at present has been, and hopefully will be achieved by both the case law and the FSA's supervisory practice.

In interpreting policy wordings in favor of policyholders, the Japanese courts seldom emphasize any distinction between consumer and business entities. As listed below in *Table 3*, the Supreme Court does not seem to hesitate in interpreting the policy wording restrictively, even in non-consumer insurance cases.

13 An accident and health indemnity insurance contract for the juridical person or any other association or by an individual engaged in a business is not excluded from the application of the semi-mandatory provisions in the Insurance Act (Art. 36 no. 4 text in the brackets).

Table 3: Post-War Supreme Court Judgments Interpreting Policy Clauses in Favor of Customers

[Case No.] Date of Judgment	Issues	Product	Policyholder (Ph)/ Insured (Id)/Beneficiary (Bf)/ Claimant (Cl)
[1] 20/2/1987 Minshū 41-1, 159	**Duty to notify the occurrence of an insured event:** Insurer shall be exempted from its duty only where no notice was given for reasons impermissible pursuant to the principle of good faith	Automobile liability insurance	**Ph: small/medium company** Id: employee (chairman's son) Cl: third party (successors of a victim)
[2] 30/31993 Minshū 47-4, 3384	**Duty to notify the transfer of an insured object:** The insurer shall be exempted from its duty only where the notice was not made without delay. In this case, the insured object burned down two days after its transfer, so it cannot be said the notice was delayed.	Homeowner's fire insurance	**Pl: flat building owner,** assignor Cl: assignee of property
[3] 30/3/1993 Minshū 47-4, 3262	**Intentional occurrence of insured event:** The exclusion of damages caused by the insured's intentional act is not applicable when the insured had an intention to injure a victim but unexpectedly caused death.	Automobile liability insurance	Ph/Id: consumer Cl: successors of a victim
[4] 25/3/1997 Minshū 51-3, 1565	**Due date of performance of insurance benefit:** The insurer's duty to indemnification is due when 30 days have passed since the insured completed a claim; the insurer is liable for the non-payment of insurance benefits even if it could not finish the investigation within that period.	Fire insurance	**Ph/Id: small or medium company** Cl: creditor of insured (bank); claim right against insurer assigned by assignment order
[5] 3/10/2002 Minshū 56-8, 1706	**Intentional occurrence of insured event:** A life insurer is not exempted from its duty where an insured, the director of the policyholder company, was killed by his wife, another director but with no competence of management, and her motive for murder was personal affairs.	Life insurance of a small size company's representative	**Ph/Bf/Cl: small or medium company** Id: director of the company
[6] 18/7/2003 Minshū 57-7, 838	**Exclusion in the tax advisor liability insurance:** The insurer is not exempted from its duty when a tax advisor caused his or her customer's damages due to a mistake in making an advantageous choice.	Liability insurance for tax advisors	**Ph: Tax Advisor Association Id: tax advisor**
[7] 1/12/2003 Minshū 57-11, 2196	**Initial Date of Prescription Period:** Where an insured goes missing for longer than three years, the prescription period of the life insurer's duty does not start until the death of the insured is discovered.	Life insurance	Ph/Id: consumer Bf: bereaved family
[8] 25/3/2004 Minshū 58-3, 753	**Suicide after a lapse of exclusion period:** Where a life insurance policy provides that the suicide of an insured within a year since the contract was concluded is excluded, the duty of the life insurer is not exempted when the suicide was committed after one year had passed since the contract was concluded, with the intention of having the beneficiaries obtain insurance benefits.	Life insurance	**Ph: small or medium company Id: chairman of the company Bf: company /** bereaved family
[9] 13/12/2004 Minshū 58-9, 2419	**Burden of proof of accidentality in fire insurance:** Those who claim benefits on fire insurance do not have to prove that the fire occurred accidentally.	Shopkeepers' insurance	**Ph/Id: shop owner**
[10] 28/3/2006 Minshū 60-3, 875	**Fetus as insured in automobile insurance:** Where a child of the insured suffered from injury while he or she was a fetus, he or she shall be entitled to claim insurance benefits based on the protection against uninsured automobiles.	Automobile insurance: protection against uninsured automobile	Ph/Id: consumer Cl: child of the insured
[11] 1/6/2006 Minshū 60-5, 1887	**Burden of proof of accidental occurrence:** Those who claim benefits on motor vehicle insurance do not have to prove that submersion of the automobile occurred accidentally.	Motor vehicle insurance	Ph/Id: consumer

[Case No.] Date of Judgment	Issues	Product	Policyholder (Ph)/ Insured (Id)/Beneficiary (Bf)/ Claimant (Cl)
[12] 6/6/2006 Hanrei-Jihō 1943, 14	**Burden of proof of accidental occurrence:** Those who claim benefits on motor vehicle insurance do not have to prove that a scratch on the automobile occurred accidentally.	Motor vehicle insurance	Ph/Id: consumer
[13] 14/9/2006 Hanrei-Jihō 1948, 164	**Burden of proof of accidental occurrence:** Those who claim benefits on fire insurance do not have to prove that office appliances were burnt down accidentally.	Fire insurance on office appliances	**Ph/Id: company**
[14] 17/4/2007, Minshū 61-3, 1026 [15] 23/4/2007 Hanrei-Jihō 1970, 106	**Burden of proof of a theft of automobile:** Those who claim benefits on motor vehicle insurance on the ground that the insured automobile was stolen have only to prove the superficial fact that the automobile was taken away by somebody other than the insured. The claimants do not have to prove that the insured's will had nothing to do with the theft.	Motor vehicle insurance	Ph/Id: consumer
[16] 29/5/2007 Hanrei-Jihō 1989, 131	**Passengers' personal accident insurance:** Where an insured caused a fatal self-inflicted accident at night on a highway by being run over by another automobile just after he got away from the automobile, it satisfies the policy terms "accident caused by driving automobile."	Automobile insurance: passengers' personal accident insurance	Ph/Id: consumer
[17] 6/7/2007 Minshū 61-5, 1955	**Burden of proof of externality:** As to "externality," a beneficiary has only to prove that injury was caused by an action which came from outside the insured's body. He does not have to prove that the action was caused by any sickness.	Mutual aid of accident compensation	Ph/Id: consumer Bf: bereaved family
[18] 19/7/2007 Lex-DB 28132475	**Burden of proof of externality:** An act of another person besides the insured shall be included in the external event. A nonfeasance of those who owe a duty to act with care shall be equivalent to the infringement by other person.	Accident insurance	Ph/Id: consumer Bf: bereaved family
[19] 19/10/2007 Hanrei-Jihō 1990, 144	**Burden of proof of externality:** According to the policy terms, the wording of "external event" shall include a driving accident that occurred due to sickness of the insured.	Automobile insurance: personal injury protection	Ph/Id: consumer
[20] 8/2/2008 Hanrei-Jihō 2000, 130	**Agreement to postpone due date of payment:** Where an insurer sends a letter to the insured to request cooperation in an investigation, and the insured accepts it, this means that the due date of insurance benefits shall be postponed until the investigation ends, and the prescription period does not start until its end.	Automobile insurance: motor vehicle insurance	Ph/Id: consumer
[21] 4/6/2009 Minshū 63-5, 982	**Limit of cover in shopkeeper insurance:** Where insurance benefits for flood in shopkeepers' insurance has a maximum limit, and the sum payable shall be shared with other insurance of the same kind, the word "other insurance" means insurance which covers the same object.	Shopkeepers' insurance	**Ph/Id: welfare institution**
[22] 20/2/2012 Minshū 66-2, 742 [23] 29/5/2012 Hanrei Jihō 2155, 109	**Subrogation in personal injury protection:** An insurer who had paid insurance benefits under personal injury protection shall be entitled to subrogate the insured's right as far as the total amount of the insured's right against the assailant for compensation and the paid insurance benefits exceed the total amount of damages.	Automobile insurance: personal injury protection	Ph/Id: consumer

Among these 23 cases, in nine cases (cases [1], [2], [4], [5], [6], [8], [9], [13], and [21]) the litigation parties were non-consumers. Until 2005, when the undue nonpayment of insurance benefits scandal was first revealed (see I.4.b)), only two cases can be found concerning consumer protection in a narrower sense. There is no case involving large-scale enterprises. This is a very remarkable feature of Japanese insurance case law. In examining case law, in most cases we only have to focus on "mass risk" insurance. And as far as the interpretation of policy terms is concerned, we do not have to distinguish between consumers and non-consumers of small or medium-sized business entities.

In 12 cases the event was suspected to be fraudulent or the event insured was suspected to be intentionally provoked (cases [2], [4], [6], [7], [8], [9], [11], [12], [13], [14], [15], and [20]). In particular, cases [9], [11], [12], [13], [14], and [15] dealt with similar issues of burden of proof and shared a substantially common background with regard to the industry's inclination to aggressively defend against claims (examined later in II.5.).

Among the rest, in cases [4], [20], [21], [22], and [23] the insurers attempted to cut the amount of insurance benefits or be discharged from their duty by insisting on prescription. As a whole, a majority of cases listed here are related to the undue nonpayment of insurance benefits.

d) A Test Case: Insurer's Duty to Give Reminder Notice of Nonpayment of Premium

Recently we had a test case to foresee the feedback relationship between the new legislation and case law. We failed to create provisions on payment and non-payment of insurance premiums in the Insurance Act. The consumer side demanded clarity in case of non-payment of the premium guaranteeing that insurers would have to give a notice of reminder to urge payment before the insurance contract is terminated (Art. 541 Civil Code). Insurers insisted that making reminder notices to all the contracts whose premiums were unpaid would be costly, and they required an exemption rule to ensure insurers the right to terminate contracts without reminder notices.

Looking at the real world, the actual payment method of premiums had shifted from cash to cashless through pre-arranged bank account transfers, money transfers ordered at convenience stores, or credit cards. Bank account transfer is currently unknown in the Civil Code, and payment with a credit card is subject to provisions of the Installment Sales Act.[14] The Electrically Recorded Monetary Claims Act[15] of 2007 was enacted in cooperation with the FSA, and under the FSA's initiative the Payment Services Act of 2009 was planned to be drafted. It was impractical to create differentiated provisions in the Insurance Act to meet the slight differences in the widely varied payment methods by cash, bank transfer, credit card, debit card, electric money, cash management ser-

14 *Kappu hanbai-hō*, Law No. 159/1961.

15 *Denshi kiroku saiken-hō,* Law No.102/2007, English text: *http://www. japaneselawtrans lation.go.jp/law/detail/?id=2043&vm=04&re=01&new=1.*

vices, etc. More fundamentally, the statutory conditions to enable creditors to terminate contracts were likely to be redefined in the obligation law reform.

Soon after the Insurance Act was enacted, in 2008 a case on the non-payment of life insurance premiums was brought into court. This case ignited a flaming debate.

Life insurers commonly prescribe clauses in their policy conditions explaining that, if an insurance premium is not paid by the payment deadline, a grace period, usually more than one month, starts; if this grace period deadline passes without any satisfactory payment, the insurance contracts shall be *(per se)* terminated (hereafter "Termination Clause"). This clause does not refer to any notice. This is meant to imply that the contract shall be automatically terminated, regardless of whether the insurer has given notice urging payment of premium or terminating the contract.

It was just an ordinary case of premium non-payment until the insurer submitted an arrogant defense. The policyholder claimed that the termination clause shall be void under Article 10 Consumer Contract Act.[16] The insurer proved that it had sent postcards stating that the premium was unpaid and that contracts would be terminated unless the premium was paid by the end of the grace period (the exact wording was not cited in the decision). The insurer insisted that the contract was terminated solely based on the Termination Clause, persisted that the Termination Clause was not void, and did not submit an alternative defense that they had satisfied the requirement of Article 541 Civil Code by sending a postcard for a reminder.

On 30 September 2009[17] the Tokyo High Court held that the insurer's termination without reminder clause eliminated the policyholder's right as a consumer in comparison with the case where Article 541 Civil Code shall be applied, and concluded the clause was void. It also stated that in applying Article 10 Consumer Contract Act, the court should not take the particular facts of the case into consideration. Surprised by an unexpected result, it seemed that the whole life insurance industry moved to overrule the High Court decision at the Supreme Court. They collected around 20 professional opinions, both on the interpretation of the clause and on the interpretation of the Consumer Contract Act.

On 16 March 2012, the Supreme Court[18] reversed the decision and the case was remanded to the High Court. The Supreme Court affirmed in its abstract review that the

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16 Art.10 Consumer Contract Act, *Shōhi-sha keiyaku-hō*, Law No.61/2000, English text: *http://www.japaneselawtranslation.go.jp/law/detail/?id=2036&vm=04&re=01&new=1,* (Nullity of Clauses that Impair the Interests of Consumers One-sidedly). Clauses which restrict the rights of consumers or expand the duties of consumers beyond those under the provisions unrelated to the public order applicable pursuant to the Civil Code, the Commercial Code and such other laws and regulations and which, impair the interests of consumers unilaterally against the fundamental principle provided in the second paragraph of article 1 of the Civil Code, are void.

17 Hanrei Taimuzu 1317 (2010) 72.

18 Minshū 66-5, 2216.

Termination Clause was more disadvantageous to the insured than Article 541 Civil Code. But the Court admitted that under the life insurer's practice, the policyholder's right is protected, to a certain level, by the facts that one month of a grace period is longer than the period required under Article 541 Civil Code, and as long as the automatic loan clause[19] is provided and applicable, the termination of contracts whose premiums have long been paid can be avoided. The Termination Clause may not one-sidedly impair the right of consumers against good faith on the condition that an automatic loan clause is provided, that the insurer establishes a system to give notice for urging premium payments, and that such notices are actually issued without fail.

Thus, the High Court decision was set aside and sent back to the Tokyo High Court to examine the facts. On 25 October 2012, the Tokyo High Court judged the case again.[20] This time the Court held that the Termination Clause did not impair the policyholders' interest and it was not void under Article 10 Consumer Contract Act. The High Court examined the insurer's internal management system, its administration, and the oral conversation between the policyholder and the insurer's salesperson in detail.

The Supreme Court required the facts to be examined rather than the Clause itself. Oral communication is also relevant in this context, but where an evaluation of the oral communication is focused, consumers may find it difficult to persuade judges that they received bad advice. Though a consumer could win in some cases of bad advice, the judgment could only be regarded as a decision made on a case-by-case basis. Consumers should choose a more objective route to win against the unfairness of an insurer's practice. The approach the Tokyo High Court tried to find – a breakthrough to examine the terms itself – was not wrong. The High Court made some mistakes in the interpretation of the Consumer Contract Act and in the terms of "grace period." These mistakes invited a fierce counterattack, not only from the industry but also from academics and professionals. If these mistakes had not been made, the High Court judgment might not have been reversed.

Although the Tokyo High Court did not examine the wording of the reminder notice, future issues could shift to the precise wordings of reminder mails, which might make the role of the clause smaller. Where the wording of the reminder notice is misleading or is not clear enough to inform the policyholder of the accurate situation and instruct the policyholder what to do by the grace period deadline, courts might again find that the policyholders' interested is impaired. By examining the wording of reminder notices in these cases, an improvement of the insurers' practice in drafting documents could be

19 Where a policyholder agreed with the automatic loan clause in an individual contract, he or she shall be entitled to receive an automatic loan in case he or she failed to pay the insurance premium. The loan shall be automatically allotted to the payment of premiums.

20 Hanrei Taimuzu 1387 (2013) 266.

expected.[21] In this respect we can learn from German experiences in case law concerning Article 38 (Art. 39 in the older version) German VVG.

e) Standardization versus Product Innovation

In many cases discretionary provisions depicting the commonly used policy clauses or default practices of insurers were not adopted in the Insurance Act. This is because one of the major purposes of the new legislation was to show the minimum standard of policyholder protection by introducing semi-mandatory provisions. On the other hand, in the field of commercial line insurance, setting default provisions might lead to a negative impact against the product innovation or could impede the insurers' flexible business on a tailor-made basis. The abolition of provisions concerning transit insurance (Art. 669 to 672 Commercial Code prior to amendment) was made from this point of view.

The Act adopted very few provisions applicable to a particular type of insurance.[22] This is mainly because of the private drafts on indemnity, life, accident, and health insurance contract laws prepared by leading academics and the industries' legal staff from the 1960s until 2005. The Indemnity Insurance Contract Law Draft 1995 final version proposed to adopt two special provisions on fire insurance, four on transit insurance, and eleven on liability insurance. This 1995 draft took an attitude to narrow its focus on the special provisions truly necessary in fire insurance, with regard to the fact that the draft was discussed by bearing mainly fire insurance in mind, and that there were a wider variety of indemnity insurance products than at the time the Commercial Code 1899 was enacted.[23] Seeing another example, The Health Insurance Contract Law Draft 2005 version also proposed to adopt only few default exclusions and other commonly used policy clauses.

Once it was discussed to introduce a provision stating that damages caused by earthquakes are excluded from the cover of fire insurance contracts. Damage caused by an

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21 Urged by the FSA under the preparation of the next reform of the IBA (see later in I.4.c)), insurers have already started to review their sales documents, including Contract Summary and Warning Information, (as to non-life insurance: *http://www.fsa.go.jp/singi/singi _kinyu /hoken_teikyou/siryou/20130130/04.pdf*; as to life insurance: *http://www.fsa.go.jp/singi/singi _kinyu/hoken_teikyou/siryou/20130419/02.pdf*) and sought certification of good practice by a third party, e.g., the UCDA (Universal Communication Design Association). Some examples can be found at: *http://www.ucda.jp/jp/kokyaku/*.

22 The few exceptions are found in Art. 16, which provides for a special rule on indemnification of damages caused by extinguishing, evacuation, and other fire defense activities in fire insurance; Art. 17 para. 2, according to which in a "liability insurance" an insured event caused by the insured's grossly negligent conduct shall not exempt the insurer's duty of indemnification; and in Art. 22, which provides that in a liability insurance victims of an accident shall have a statutory lien over the right to claim an insurance benefit.

23 SONGAI HOKEN HŌSEI KENKYŪ-KAI (ED.) [Study Group on Indemnity Insurance Legislation], *Songai hoken keiyaku-hō kaisei shian, shōgai hoken keiyaku-hō (shinsetsu) shian riyū-sho, 1995 kakutei-ban* [Commentaries on Indemnity Insurance Contract Law Draft and Accident Insurance Contract Law (New Legislation) Drafts 1995 final version] (1995) 81.

earthquake is usually excluded from the indemnity insurance product in the mass market. By establishing this provision in the Act, it was expected to promote consumers' correct understanding of the earthquake exclusion. This could lead to diminished litigation for indemnification of damage caused by earthquakes based on a misunderstanding of the products, which is likely to recur every time we have a tremendous earthquake disaster. This idea was not adopted after examining the fact that other exclusion clauses are not typical enough to be prescribed in the Act. We needed to strike a balance among exclusion clauses. As a result, provisions on default exclusion are limited to the exclusion of intentionally or gross-negligently caused events and the exclusion of risks arising from wars or other disturbances (Art. 17, 51, 80).

The number of provisions only applicable to liability insurance is limited mainly because the Act did not follow the proposed solutions of the Liability Insurance Contract Law Draft 1995. This Draft proposed to vest third parties to liability insurance (victims in a tort, etc.) with a right to claim for damages directly to the insurer, and limit the defense of certain sorts of insurers to protect third parties' interests.

The fact is that liability insurance consists of a very wide variety of products, and it is obviously burdensome for insurers to defend all the litigations of all types of liability insurance. In some of them, insurers may find it difficult to investigate the true causes of personal injuries. Owing to this, it was impossible to introduce a direct claim right as a mandatory provision. This could have led insurers to exclude the direct claim right in the policy conditions. Therefore, this would not have promoted protection of the victims. In addition to that, especially where product liability is concerned, a large number of victims might appear by twos and threes over a long term, and the total amount of liability could exceed the limit of cover agreed in the contract. In such cases, it could be very difficult in the framework of direct claim rights to achieve a fair and equitable distribution of insurance benefit. We accepted the non-life insurers' opposition against direct claim rights as a widely applicable default rule. Instead, the Act vested the third parties with a statutory lien over the insured's right to claim insurance benefits (Art. 22).

f) Exception of Minimalism: Procedural Provisions

In spite of its small volume in general, the Insurance Act was equipped with sufficient provisions to enable the insured, beneficiaries, or third parties to secure and execute their rights in the litigation procedure. In addition to Article 22, procedural provisions were introduced on the insured's right to request the rescission of a life insurance or accident and health insurance contract against the policyholder if circumstances changed from the time of the insured's consent to the contract (Art. 58, 87).[24] Another procedural provision prescribes the effect of rescission made by a person other than the contract

24 Compared to these provisions, Art. 34 enables the insured to request the rescission of accident and health indemnity contracts under more relaxed conditions.

parties (attaching creditor or bankruptcy trustee of the policyholder) of life insurance or accident and health insurance of a fixed sum, and beneficiaries' right to intervene in the rescission (Art. 60-62, 89-91).

In promoting policyholders' interest and striking a fair balance of interest among the contract parties and other stakeholders of insurance (beneficiaries, victims in a tort, or other creditors of the insured), it is quite natural to give high priority to establishing procedural provisions.

4. Significant Role of Regulatory Rules and Supervision Practice

In many cases, while examining issues on insurance contract law in Japan, we must bear in mind the history and role of the regulation based on the IBA and especially supervision practices of the authorities. Insurance products and their policy terms are supervised under the IBA. In introducing new products to the market (Art. 4 para. 2 no. 2 to 4 IBA) or changing any consumer products (Art. 123 para. 1 IBA), insurers have to obtain prior approval by the FSA. The FSA has to examine whether the contents of the insurance contracts have no risk of lacking in protection for the policyholders (Art. 5 para. 1 no. 3 (i), Art. 124 IBA).

a) Product Diversity and Market Competition in the Japanese Insurance Market

In 1965, the Ministry of Finance (MOF), the supervisor of the insurance sector at that time, showed an authoritative interpretation of the allowable types of accident or health insurance products, called the "the third category," both to the non-life and life insurers. This interpretation was later renewed in the IBA 1995 when the market entry barrier for cross selling on third-category products was lowered. The type of license for this category is provided in detail (Art. 3 para. 4 and 5 IBA); as a result, a notion of accident and health indemnity insurance was transplanted in the Insurance Act (Art. 2 no. 7). The battle over the third category between non-life and life industries ranged over a wide variety of products, various differences in product features, and policy wordings of accident or health insurance. The intransparency of the Japanese insurance market is, at least partially, attributable to the diversity in the third category. Furthermore, the liberalization of the third category heated up the competition seeking market shares among domestic non-life, life, and foreign insurers.

b) Role of Supervision in Product Control and Claim Handling

Thus, in Japan, there is no urgent necessity to deregulate the *ex ante* product control. While provisions in the Commercial Code were left unrevised for almost a century, the informal administrative guidance executed by the MOF and the FSA's more transparent Supervisory Guidelines have had a significant influence. For example, in 1974, following the proposal in the 4th Report of National Life Council (*Kokumin seikatsu shingi-*

kai)[25] to promote policyholder protection in the field of insurance, the MOF requested life insurers to revise their policy terms to ensure that duty of disclosure shall be limited to those facts questioned to their customers.[26] This practice has now been adopted in the Insurance Act (Art. 4, 37, 66) as semi-mandatory provisions.

From 2005 to 2008, we experienced industry-wide scandals of intentional undue nonpayment and negligent leakage of insurance benefits detected by the on-site inspection conducted by the FSA.[27] Learning lessons from these scandals, the FSA brushed up its supervisory guidelines to watch over the claim processing division, and urged insurance companies to promote integrated management between the product development, sales, and claim processing divisions.[28] In April 2009, the FSA revised its Supervisory Guidelines before the Insurance Act was put into force,[29] and ensured that the requirements of the Act would be observed in the newly revised policy terms.

c) Development of Rules on Insurance Sales

The issue which was most influenced by the long history of regulation was the insurer's duty of product disclosure. In Japan, the insurer's duty of product disclosure was provided neither in the Commercial Code nor in the IBA directly. Since 1998, as amended by the Financial System Reform Act, Article 100-2 IBA provided that an insurance company shall, pursuant to the provisions of the Cabinet Office Ordinance, take measures to ensure sound and appropriate management, such as the explanation of important particulars of its business to its customers. Based on this, Article 53 para. 1, especially no. 10 of the Enforcement Regulation of the IBA,[30] provides that an insurance company shall take appropriate measures to ensure that its insurance solicitors give an explanation to enable their customers to understand insurance products. According to the Supervisory Guidelines of the FSA,[31] since 2006, such measures should be performed by delivering docu-

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25 *http://www.caa.go.jp/seikatsu/shingikai2/kako/spc04/toushin/spc04-toushin-2_4.html.*

26 Art. 644 and 678 Commercial Code before it was reformed in 1998 directed a policyholder to disclose just "material" facts, and the duty of disclosure was not, in its literal wording, limited to those facts questioned by the insurer.

27 The first and most notorious case was that of Meiji Life: *http://www.fsa.go.jp/news/newsj/16/hoken/f-20050225-1.html* (Japanese), *http://www.fsa.go.jp/news/newsj/17/hoken/f-20051028-4.html* (Japanese).

Other administrative orders targeting a wider range of insurers can be found as follows: *http://www.fsa.go.jp/news/newse/e20051125.html* (English), *http://www.fsa.go.jp/news/newsj/17/hoken/f-20051125-5.html* (Japanese), *http://www.fsa.go.jp/en/news/2007/20070314.html* (English), *http://www.fsa.go.jp/news/18/hoken/2007031-2.html* (Japanese), *http://www.fsa.go.jp/news/20/hoken/20080703-6.html* (Japanese).

28 *http://www.fsa.go.jp/news/newsj/17/hoken/20060602-1.html.*

29 *http://www.fsa.go.jp/news/20/hoken/20090428-2.html.*

30 *Hoken-gyō hō shikō kisoku*, Ministry of Finance Regulation No.5/1996.

31 The latest version of the Comprehensive Guidelines for Insurance Company Supervision can be found at: *http://www.fsa.go.jp/common/law/guide/ins.pdf* (Japanese only).

ments that explain the key features and a summary of the products (Contract Summary, *keiyaku gaiyō*) and information that customers should pay attention to before purchasing insurance products (Warning Information, *chūi kanki jōhō*).

There is no statutory or other regulatory requirement to deliver the insurance policy conditions before a customer's application is placed. In practice, policy conditions are well disclosed on the insurer's website. Documents of policy conditions can be obtained beforehand on request, and in the life insurance sector they are to be delivered at the latest when an application form is submitted.

The statutory provision of mandatory disclosure on insurance products was not adopted in the Insurance Act for two reasons. One relates to the discussion on a more general requirement for mandatory disclosure on (consumer) contract terms in the obligation law reform.[32] Rescission rights of customers as a remedy for breach of duty of disclosure on contract terms was rejected once in the Consumer Contract Act 2000. Concerning the issue on the conditions to incorporate general contract terms into (consumer) contracts, we should wait for the result of obligation law reform.

The other is the long history and accumulated regulatory practice by the FSA. Facing a wide variety of suppliers, diversity of insurance products, and segmentation of distribution channels, it was thought to be advantageous that the FSA should take the initiative to establish and maintain detailed rules on product information to be disclosed, and rules on comparative information between products.

The FSA started the discussion in 2008 on the reform of IBA, especially on the rules of insurance sales and solicitation, and published an interim draft on consultation.[33] After suspension between 2009 and 2011 under the "politician-led" Democratic government, which was expected to be more consumer-friendly than the LDP, the discussion restarted in 2012. The final consultation on the reform of IBA was published on 7 June 2013.[34] This proposed to provide principles on product disclosure and the confirmation procedure for the consulted sales of insurance, and to endow rule-making competence to

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32 Compensation for damages as an effect of nondisclosure of an insurance product faced a difficulty in reaching a consensus. Negativists suspected the causal relationship between the breach of duty and the damages incurred to the insured. Where less popular additional coverage is concerned, even where policy terms are properly disclosed there remains considerable probability that policyholders will not purchase an additional coverage by paying an additional premium. Compensation for unsuitable coverage was not regarded as an issue of product disclosure, but that of suitability or duty to give proper advice. The statutory duty of giving advice in the Insurance Act seemed to be too much to demand of the consumer. Furthermore, under Japanese law, compensation for damages could be sought without statutory provisions in the Insurance Act, by applying the general rule of tort (Art. 709 Civil Code) and a rule on liability of insurance companies for the tort commanded by their employees or agents (Art. 283 IBA).

33 *http://www.fsa.go.jp/singi/singi_kinyu/dai2/siryou/20090619-1.html* (Japanese text only).

34 *http://www.fsa.go.jp/singi/singi_kinyu/hoken_teikyou/siryou/20130607.html* (Japanese text only).

the FSA on the details of documentation and other conduct guidelines. After the amendment of the IBA, probably accomplished in the first half of 2014, the FSA is expected to reformulate the current supervisory guidelines and sort them out into Enforcement Ordinances and Guidelines.

III. Anti-Fraud Case Law and Insurance Act

1. General Trends of the Case Law

Among the cases on Japanese insurance law, cases dealing with suspicious fraudulent claims have long been one of the main concerns among insurance lawyers. Since the late 1970s, the insurance industry has suffered from a large number of fraudulent claims. According to the legal database Lex-DB, roughly 1000 cases concerning insurance contracts have been reported since World War II. Among them, not less than 400 cases are related to issues on fraudulent claims or claims where the events were suspected to be provoked intentionally. Surprisingly, around 300 of these anti-fraud cases have appeared since the late 1980s.

In my observations, the majority of judgments offered insurers a good guard against fraudulent claims by finding malicious intention of the insured based on circumstantial evidence, though in some cases insurers found the attitude of the judges unsatisfactory in evaluating the evidence. Consequently, the insurers tried to arm themselves by contract terms to repel fraud in more effective ways. One of the main features of Japanese insurance case law is that the courts have to respond to a variety of defense measures developed by the insurers. Rejecting claims that appear to be suspicious is no doubt a natural response of the insurers, but the question is whether the alleged defenses are adequately formulated and interpreted to avoid infringing upon *bona fide* policyholders' interests. Some aspects of the scandals on intentional nonpayment mentioned above were caused by the insurers' inclination toward excessive self-defense.

2. Exclusion of Intentionally Caused Events and Its Limit

The most typical and simple case of fraud is when a policyholder intentionally evokes an insured event and makes a claim to his insurer for payment of insurance benefit. The Insurance Act retained provisions on the exclusion of an intentionally or gross-negligently caused insured event (Art. 17 para. 1, Art. 51 no. 1 to 3, Art. 80 no. 1 to no. 3).[35] In most cases, the critical issue would be this fact: whether the internal intent of the insured or the policyholder to provoke the insured event could be proved.

In the majority of cases, judges affirmed that, judging from the unnaturally artificial cause of the event, financial difficulty of the insured, suspicious behaviors of the insured

35 In the Commercial Code prior to the 2008 amendment, statutory exclusions of intentionally or gross-negligently caused insured events were provided in Art. 641 and 680 para. 1.

at the time of the event, etc., the events were provoked intentionally by the insured him- or herself,[36] or that the insured presumably commanded or instigated another person to provoke the event.[37]

On the other hand, in some cases, in spite of the extremely unnatural circumstances at the time of the event – such as a murder[38] or drowning[39] of an insured during travels abroad, or when the deceased insured was involved in another insurance fraud case that also involved gangsters[40] – judges hesitated to conclude that the insured had committed him- or herself in provoking the event. Facing the difficulty in presenting sufficient evidence of commitment by the insured at the time of the insured events, insurers were inclined to seek exemption from their duty based on their policy clauses by accusing the insured of bad faith conduct at the time of placing the contract or making the claims.

3. Anti-fraud Defenses of Non-life Insurance Industry

a) Policyholder's Duty to Disclose Other Insurance Contracts

Non-life insurers were first inclined to rely on their policy clauses, which require a policyholder to disclose the fact that he or she had cumulatively concluded the same kind of other insurance contracts, and any breach of that duty enables the insurer to rescind the policy with a defense to refuse the payment of the insurance benefit. This duty of disclosure is required, both at the time of placing the application (duty to disclosure other contracts) and whenever other contracts are concluded throughout the contract period (duty to give notice of other contracts). These clauses were commonly found in homeowners' or shopkeepers' insurance, automobile insurance, and accident insurance.

Excessive accumulation of insurance contracts may induce the insured to seek unjustifiable benefits, or in cases of bad faith the concealment of such accumulation by the insured could be regarded as a sign of the insured's malicious intention to make fraudulent claims. On the other hand, several kinds of accident insurance are often purchased

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36 Osaka District Court, 25 December 1987, Hanrei Jihō 1277 (1988) 152 = Hanrei Taimuzu 669 (1988) 209; Nagoya District Court, 5 October 1990, Kōtsū Minshū 23-5 (1992) 1266; Fukuoka District Court, 17 March 1992, Hanrei Taimuzu 820 (1993) 233; Yamaguchi District Court (Tokuyama Branch), 14 September 1994, Hanrei Jihō 1547 (1995) 128 = Hanrei Taimuzu 880 (1995) 274; Asahikawa District Court, 12 July 1995, Hanrei Jihō 1547 (1995) 138 = Hanrei Taimuzu 895 (1995) 273; Matsuyama District Court, 8 December 1995, Hanrei Jihō 1568 (1996) 125 = Hanrei Taimuzu 909 (1996) 246; Hiroshima District Court, 25 July 1996, Hanrei Taimuzu 938 (1997) 243, etc.

37 Sapporo High Court, 31 October 1997, Hanrei Jihō 1635 (1998) 149; Osaka High Court, 27 May 1998, Hanrei Taimuzu 984 (1998) 238; Tokyo District Court, 25 May 2000, Hanrei Taimuzu 1063 (2001) 209; Sapporo District Court (Takigawa Branch), 27 March 1995, Hanrei Taimuzu 912 (1996) 247, etc.

38 Tokyo High Court, 25 December 1984, Hanrei Jihō 1144 (1985) 146.

39 Tokyo District Court, 19 March 1990, Hanrei Taimuzu 744 (1991) 198.

40 Osaka District Court, 27 February 1987, Hanrei Jihō 1238 (1987) 143.

cumulatively, some of which are packaged with other types of cover,[41] or others have a saving element. In normal cases insurers would not refuse the purchase of these packaged products, and presumably insurers and their agents do not care much about the non-disclosure of other insurance contracts until an insured event occurs under an unnatural circumstance.

The only Supreme Court judgment on this clause is found in the pre-war period.[42] It stated that the breach of duty to disclose other insurance shall not result in the automatic nullity of the contract, the prescribed effect in the terms at that time; instead, the insurer is entitled to acclaim the nullity of the contract only when there are good reasons and it is appropriate to do so.

In the post-war period, non-life insurers started in the 1970s to rely on the defense of the breach of this duty. The first reported case denied the insurer's defense, stating that a failure to give notice of the other fire insurance did not cause the aggravation of risk, the insurer was therefore not exempted from its duty, and the rescission of contract had no effect.[43] Soon after, courts began to support the insurer's defense on rescission and exemption from duty where there was no sufficient evidence that the insured had intended to provoke the event. Regardless of affirming the defense as a conclusion or not, the majority of judgments restricted the application of the clauses by interpreting them in one or more of the following ways:

- As far as the duty to give notice is concerned, the insurer's rescission right shall be limited in cases of intentional or gross-negligent breach of duty.[44]
- The accumulation of contracts is material to the insurer's decision, that is to say, the total amount of insurance benefits exceeds the insurer's internal underwriting limit.[45]
- The insurer has to prove that the insured had the intention to abuse the insurance.[46]
- Rescission can be affirmed only where rescission is appropriate judging from the standard view in society, such as non-disclosure or breach of duty to give notice was committed for the purpose of dishonestly obtaining insurance benefits[47] (in

41 In Japan, accident insurance is often packaged not only in automobile or travel insurance, but also in homeowner's or shopkeeper's composite insurance.

42 *Daishin-in* (Imperial Court in Pre-war Japan), 2 December 1935, Hanketsu Zenshū 2-24, 1268.

43 Takamatsu High Court, 10 June 1983, Hanrei Taimuzu 509 (1983) 152.

44 Tokyo High Court, 27 November 1991, Hanrei Taimuzu 783 (1992) 235; Tokyo High Court, 28 September 1993, Hanrei Jihō 1479 (1994) 140 = Hanrei Taimuzu 848 (1994) 290.

45 Osaka High Court, 18 November 2002, Hanrei Jihō 1826 (2003) 143.

46 Tokyo District Court, 19 March 1990, Hanrei Taimuzu 744 (1991) 198.

47 Tokyo District Court, 30 January 1986, Hanrei Jihō 1181 (1986) 146; Tokyo District Court, 25 July 1991, Hanrei Jihō 1403 (1992) 108 = Hanrei Taimuzu 779 (1992) 262; Tokyo High Court, 28 September 1993, Hanrei Jihō 1479 (1994) 140 = Hanrei Taimuzu 848 (1994) 290; Tokyo District Court, 12 May 2003, Hanrei Taimuzu 1126 (2003) 240.

this ruling, the burden of proof is allocated to the insurer).
– The insured is entitled to reverse the effect of rescission when he or she proves that he or she had no abusive intention to obtain insurance benefits dishonestly[48] (in this ruling, the burden of proof is allocated to the insured).

By requiring materiality as a condition, the case law here regards the duty to disclose other contracts as a kind of duty of disclosure on material fact (Art. 644, 678 Commercial Code prior to amendment). From this point of view, the primary purpose of the duty is to collect information on indications of moral risk in order to correct the information deficit between the insurer and the insured, and enable insurers to decide whether to conclude or continue contracts or not.[49] On the other hand, in order to justify the exemption from the insurer's duty to pay the insured benefits, the case law rules look into the intention of the insured at the time the insured event occurred, rather than the intention at the time the insured breached his or her duty. There was an influential criticism against these case laws: looking at the circumstances at the time of the event occurred would deviate from the original purpose of the rules.[50]

The discharge of the insurer's duty to indemnify based on the breach of duty to disclose another insurance contract is now governed under the Insurance Act by the provisions on an insurer's rescission right on grave grounds (Art. 30, 57, 86 Insurance Act).

b) The Insured's Duty to Explain the Details of Event Insured

Another category of insurance fraud often found in indemnity insurance concerns an insured who makes a claim against his or her insurer based on a fictitious event, or based on an actual event but the declared damage is intentionally overestimated. There was no statutory provision on these issues in the Commercial Code, nor in the Insurance Act 2008. Before the Insurance Act was put into force, it was commonly prescribed in the policy conditions that if an insured made a false statement in declaring damages or in other documents representing the situations of the event insured, the insurer was exempted from his duty to indemnify.

There is no Supreme Court decision on this issue, and lower courts tend to observe that it is not appropriate to discharge insurers from their duty just because there are mistakes in evaluating damage, a discrepancy over the evaluation of damages between the

48 Tokyo High Court, 27 November 1991, Hanrei Taimuzu 783 (1992) 235.
49 Originally, as stated in *Daishin-in*, *supra* note 42, the duty to disclose or give notice of another insurance contract targets indemnification in the case of multiple insurance policies. By receiving notices properly, insurers are afforded an opportunity to handle the claim, adjust losses, and share the liability in cooperation with other insurers.
50 T. YAMASHITA, *Ta-hoken keiyaku no kokuchi gimu, tsūchi-gimu* [Duty to Disclose or Give Notice of Other Insurance Contracts], in: *Gendai no seimei, shōgai hoken-hō* [Contemporary Life and Accident Insurance Laws] (1999) 242.

insured and insurers, or just a false statement[51] when such a false statement can be well explained by the natural human impulse to evaluate damage at the maximum value.[52]

Based on this recognition, a majority of lower courts affirmed to discharge the insurer's duty only on narrower conditions. The conditions raised by the courts vary as listed below:

- The insurer shall be exempted from its duty in the case when a false statement was made on the "material" facts either intentionally or in an grossly negligent way.[53]
- The insurer shall be discharged from its duty by focusing on the false statement as an indication of dishonest behavior by the insured when the insured event is suspected of being intentionally caused by the insured but there is not enough evidence to prove that.[54]
- The court discharged the insurer's duty with no restrictive interpretation of the clause, recognizing that the insured made a false statement intentionally and the false statement was likely to disturb the process of finding the truth and might lead to insurer misevaluation.[55]
- The court discharged the insurer's duty with no restrictive interpretation of the clause, recognizing that the insured made an (extremely) false statement intentionally (a) without any justifiable reasons,[56] (b) with an intent to obtain huge amounts of insurance benefits,[57] (c) with an intent to hinder the appropriate evaluation of damages to be compensated, or (d) with a not-approvable purpose in view of good faith – for example, the insured had an intention to deceive the insurer to obtain insurance benefits.[58]
- The insurer shall be exempted from its duty when, judging by all the facts and circumstances, it is inevitable to discharge the insurer from its duty to maintain the sound operation of the insurance business. The inevitability shall be determined by examining the information submitted to the insurer, its influence on the insurer's evaluation of damages, the subjective attitude of the insured, especially whether he or she recognized that the information was false or recognized that

51 Osaka District Court, 13 May 1967, Hanrei Jihō 500 (1967) 63 = Hanrei Taimuzu 210 (1967) 207.

52 Sendai High Court, 29 August 2007, Hanrei Taimuzu 1268 (2008) 287.

53 Tokyo High Court, 30 June 1999, Hanrei Jihō 1688 (1999) 166; Tokyo District Court, 30 January 2002, Lex-DB 28071495.

54 Osaka District Court, 21 October 1994, Hanrei Jihō 1518 (1995) 117 = Hanrei Taimuzu 864 (1995) 252; Sendai High Court, 29 August 2007, Hanrei Taimuzu 1268 (2008) 287; Fukuoka High Court, 29 January 2008, Hanrei Jihō 2009 (2008) 144.

55 Osaka District Court, 20 December 2007, Kōtsū Minshū 40-6 (2009) 1694.

56 Tokyo District Court, 16 February 1998, Hanrei Jihō 1664 (1999) 139 = Hanrei Taimuzu 987 (1999) 243.

57 Kobe District Court, 14 May 2003, Lex-DB 28082147.

58 Osaka District Court, 3 October 2003, Hanrei Taimuzu 1153 (2004) 254; Tokyo High Court 11 March 2004, Kinyū Shōji Hanrei 1194 (2004) 15; Saitama District Court, 26 September 2006, Lex-DB 28112449.

> the false statement might lead the insurer to a misevaluation, whether such false information was later withdrawn, when and how it was withdrawn, etc.[59]

In conclusion, there was a clear trend in the case law to restrictively interpret or apply for the exemption rule, but no judgment was found to deny the discharge of an insurer's duty if a fraudulent claim was intentionally made with a false statement on the facts. Behind these lower court cases, a leading case of the Supreme Court on 20 February 1987[60] concerning the policy clause on the insured's duty to give notice of the occurrence of the insured event reads as follows:

> "It should be possible for the insurer to avoid liability to cover losses where the policyholder or the insured has failed to notify the insurer of the accident for reasons impermissible pursuant to the principle of good faith, such as to defraud the insurer of insurance benefits or to obstruct an investigation into the circumstances of the accident or into whether the insurer is liable to cover the loss or the determination of the amount of coverage. However in other cases, when the insurer is exempted from liability to compensate the loss because the insurer did not receive notification of the accident within the period above, this should be limited to the amount of damages the insurer is entitled to claim in respect of losses suffered by reason of not having received notification".

Despite these clear case law trends, after the Insurance Act was put into force the policy clause ceased to prescribe the discharge of the insurer's duty when a false or fraudulent statement was submitted by the insured. Instead, the policy conditions prescribe the insurer's right to ask the insured for compensation of damages caused by a false statement. Again, under the Insurance Act, this issue is linked to the semi-mandatory character and the interpretation of the insurer's rescission right for grave cause (Art. 30, 57, 86 Insurance Act).

4. Anti-fraud Defense of Life Insurance Industry

a) Defenses against Extreme Accumulation of Insurance

In life insurance, the accumulation of insurance is also deemed to be a bad sign of insurance fraud. In contrast to indemnity insurance, in fixed sum insurance the benefits payable for an event are not limited to the indemnification. There is a larger incentive for wrongdoers to earn unjust profits by accumulating fixed sum insurance contracts. However, life insurers' policy conditions do not include clauses on a policyholder's duty to disclose or to give notice of other life, accident, or health contracts. The direct cause of this attitude is the existence of a Supreme Court decision in the pre-war period[61] stating that the existence of other insurance contracts is not a material fact to be disclosed under

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59 Nagasaki District Court, 18 March 1998, Hanrei Taimuzu 984 (1998) 245.

60 *http://www.tomeika.jur.kyushu-u.ac.jp/result.php?s=9a0ed61c342e7ba6b9fa62fecd5c1c60&c=d670ba05636a395d68dec 876483e685c.*

61 *Daishin-in,* 2 November 1927, Minshū 6, 593.

the Commercial Code. Facing a soaring number of fraudulent claims, this decision itself might be outdated.

There is another reason that duty to disclose other life insurance is unlikely to work. In the case of indemnity insurance, most contracts are concluded by the insurance agents, and the insurer is able to check the accumulation of contracts at a later stage, after the documents are sent to the insurer's office. But in life insurance, all the application forms (offers) for contracts are medically examined and accepted at the main office. There is a database system registering contracts to check the accumulation [Policy Data Registration System; *Keiyaku naiyō tōroku seido*] in both life[62] (since 1980) and non-life[63] insurance industries, and only life insurers are able to check the accumulation of contracts before finally deciding to accept the offer. Under the rules on duty of disclosure, an insurer is not able to terminate contracts if the insurer knew the undisclosed material fact. It is difficult for life insurers to argue that the insurer was deceived by the mere fact that a number of contracts were accumulated beforehand.

Instead, life insurers tend to argue that the policyholder concluded an insurance contract fraudulently, and, based upon that fact, insurers should be entitled to rescind contracts according to Article 96 para. 1 Civil Code, or the contracts should be *per se* void.[64] There are some reported policyholder fraud cases concerning accumulated contracts that affirmed the insurers' defense by finding deceptive intention from the following facts: a large number of insurance contracts were concluded in a very short term, the total amount of insurance benefits payable was extremely excessive, the total amount of premiums the policyholder had to pay was extremely heavy compared to the policyholder's economic situation and it would be impossible to pay them continuously, or the insured was repeatedly hospitalized unnecessarily. In these cases, judging from the whole circumstances of the case, the policyholder had an intention to conclude all these contracts fraudulently from the very beginning.[65] One question in this argument is whether policyholder silence on the fraudulent intention can be treated as a deceptive action, which is deemed to be required under Article 96 para. 1 Civil Code.

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62 The database is maintained by the Life Insurance Association of Japan. As to the outline of the database system, see: *http://www.seiho.or.jp/english/publication/2011/pdf/25.pdf*.

63 The database is maintained by the General Insurance Association of Japan. As to the outline of the database system, see: *http://www.sonpo.or.jp/about/guideline/kyodoriyou/0011.html* (Japanese).

64 According to the life insurance policy, it was commonly prescribed that contracts concluded fraudulently shall be void. This clause was meant to modify the effect of a contract concluded by fraud (Art. 96 Civil Code). After the Insurance Act was put into force, this modification was not provided in the policy terms. This amendment of policy terms was made to adopt the same wording as used in Art. 64 no. 1, Art. 93 no. 1 Insurance Act .

65 Tokyo District Court, 26.10.1990, Hanrei Jihō 1387 (1991) 141; Tokyo High Court, 17 October 1991, Kin'yū Shōji Hanrei 894 (1992) 27; Fukuoka High Court, 20 October 1999, Hanrei Jihō 1716 (2000) 72 = Hanrei Taimuzu 1063 (2001) 226; Tokyo District Court, 1 December 1999, Hanrei Taimuzu 1032 (2000) 246.

Another variation of the insurer's defense against an unjust accumulation of contracts was to argue that, at the time of placing the contracts, the policyholder had a malicious intention to abuse the insurance, those contracts concluded under such an intention violate the public policy, and therefore all these contracts should be void under Article 90 Civil Code. Here again we have some cases in which the insurer's defense was affirmed.[66] In this defense the question is whether the internal intention to abuse a contract is a justifiable reason to nullify the contracts under Article 90 Civil Code.

b) Ex Post Abuse of Life, Accident, or Health Insurance

In the case of extreme accumulation of insurance, it is easier to find the indication of malicious intention. Similar to the cases in indemnity insurance, there were some cases where abuse of life insurance could be observed at the time an insured event occurred in a suspicious manner, but no satisfactory evidence was found to prove the abusive intention at the time of concluding the contracts. The insurer may fail to prove that the death of the insured was intentionally caused by the policyholder or the beneficiaries. Where benefits for health insurance are claimed, hospital treatment may be extended far beyond a truly necessary period, or from the beginning hospitalization may not be necessary at all. Insurers wish to refuse paying insurance benefits in these cases. Besides the defense of intentional occurrence of the insured event, life insurers tried to innovate on more effective defenses to fight against such *ex post* abuse of insurance.

A lower court[67] once affirmed that Article 656 Commercial Code prior to amendment (aggravation of risk) shall be applied to life insurance, where an insured traveled abroad to Manila, the Philippines, asked others to have him killed by professional murderers in order to obtain insurance benefits, and soon afterward was actually shot by someone in the crowd of Manila. In this case, the court affirmed that the insurance contract was *per se* terminated when the insured asked for his own murder, and this caused the underwritten risk to be aggravated. This was obviously an exceptional case because there was a clear moment of aggravated risk in the objective facts before the murder was carried out.

Normally life insurers did not seek an application of rules on aggravated risk. Under the Insurance Act, the provision on aggravation of risk can be applied only where the risk is material to the decision of an insurer, the material fact is questioned at the time of placing the contract (Articles 4, 37, 66 Insurance Act), and in the policy terms the insurer requires the insured to give notice in case the aggravation of risk actually occurred (Arti-

66 Tokyo District Court, 11 May 1994, Hanrei Jihō 1530 (1995) 123; Osaka District Court, 25 December 1996, Hanrei Jihō 1625 (1998) 111 = Hanrei Taimuzu 956 (1998) 182; Osaka District Court, 17 June 1997, Hanrei Jihō 1625 (1998) 107.
In contrast, the defense of public policy was denied in the following cases: Kyoto District Court, 26 Oktober 1988, Hanrei Jihō 1323 (1990) 148 = Hanrei Taimuzu 691 (1989) 230; Tokyo District Court, 27 August 2004, Kin'yū Hōmu Jijō 1729 (2005) 66; Tokyo High Court, 30 May 2007, Hanrei Taimuzu 1254 (2008) 287.

67 Sapporo District Court, 26 March 1990, Hanrei Jihō 1348 (1990) 142.

cles 29, 56, 85 Insurance Act). In other words, the role of the aggravation of risk is purified to correct the asymmetric information in the dimension of a recalculation of risk (see *Table 4*). It is unrealistic and not appropriate for life insurers to require all insured parties to notify the aggravation of risk in the sense that an insured event will be artificially provoked. Thus, there is no room for application of this rule under the Insurance Act.

Table 4: Rules for Redress of Asymmetric Information and Anti-fraud under the Insurance Act

	Redress of Asymmetric Information	Anti-fraud
At Placing Contract	Duty of Disclosure Art. 4,37,66 Insurance Act	Rescission of Contract due to Fraud Art. 96 para.1 Civil Code
During Insurance Period	Aggravation of Risk Art. 29,56,85 Insurance Act	Rescission for Grave Cause Art. 30,57,86 Insurance Act

c) Special Consideration in Case of Suicide

Where a suicide of the insured is concerned, we have to consider its special features. Suicide as a measure to obtain insurance benefits inevitably sacrifices the life of the insured, and the insured him- or herself has no opportunity to enjoy the insurance benefits. Suicide committed after a considerable period has passed may be an unavoidable choice due to economic hardship or a poor state of health. It is expected for life insurance to secure the life of the beneficiaries in such cases of "ought-to-be-sympathized" suicide. Thus, life insurance policies commonly specify that the suicide of an insured within one, two, or three years after the contract was concluded shall be excluded. The period of exclusion differs from insurer to insurer.

In Japan, since the bubble economy burst and the long recession started, the number of suicides increased and maintained a very high level for more than a decade. In some cases, suicides were evidently caused or forced by the threatening pressure of loan creditors. In order to prevent the abusive use of life insurance, life insurers decided to refuse paying insurance benefits in cases where a suicide was committed exclusively or mainly for the purpose of benefitting the beneficiaries. The insurers' argument was that suicide for pursuing undue benefits is against public policy, and the policy terms designed to limit the default exclusion of suicide in Article 680 para. 1 no. 1 Commercial Code shall not be applied.

This time again some lower courts, including the Tokyo High Court, affirmed the insurers' argument and discharged the insurers' duty.[68] The Supreme Court[69] in 2004 re-

68 Okayama District Court, 27 January 1999, Kin'yū Hōmu Jijō 1554 (1999) 90; Yamaguchi District Court, 9 February 1999, Hanrei Taimuzu 1039 (2000) 230; Tokyo High Court, 31 January 2001, Kō-minshū 54-1, 1.

69 Supreme Court. 25 March 2004, Minshū 58-3, 753.

versed the High Court decision and held that life insurers were not exempted from their duty when a suicide was committed after one year had passed since the contract was concluded, even where the intention of the insured was to have the beneficiaries obtain the insurance benefits. According to the Supreme Court, insurers shall be exceptionally exempted from their duty only where such a suicide was contributed to by criminal offenses and the payment of insurance benefits would be against public policy. The Supreme Court took a much narrower view in finding a violation of public policy among such suicides. The exception would be affirmed where those who had a chance to enjoy the benefits from the insurance money forced the insured to commit suicide,[70] or where suicide is committed with a criminal offense and the measure is regarded as against social justice.[71]

5. Seeking Ultimate Defense: Burden of Proof of "Accidental" Event[72]

As the duties to disclose and to give notice of other insurance were likely to be restrictively interpreted, the non-life insurers started to argue that the insured should prove that the event occurred accidentally. This argument was first applied to accident insurance, where an insured event is defined in the policy terms with three elements: an insured event must have occurred suddenly, accidentally, and externally. There was no doubt that, as the occurrence of an insured event is included in the cause of action, suddenness and externality must be proved by the insured.

As to the accidental occurrence of the insured events in accident insurance, there was an inconsistency of terms concerning the allocation of the burden of proof. As shown above, the policy terms describe an accidental occurrence of the event as a cause of action. On the other hand, however, the policy prescribed that events provoked intentionally by either the policyholder or the insured shall be excluded from the cover: this meant that the intention of the insured to provoke the event must be proved as a defense. The latter clause was identical to the default provision in the Commercial Code: Article 641 as to indemnity insurance and Article 680 para. 1 as to life insurance. Under the Commercial Code, however, there was no statutory provision directly applicable to fixed sum accident insurance.

Concurrently, life insurers also began to argue that the beneficiary must prove the accidental occurrence of the injury in accident insurance. Since 1990, lower courts han-

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70 Tokyo District Court, 6 September 2004, Hanrei Taimuzu 1167 (2005) 263.

71 In order to reduce suicides caused by pressure from loan creditors, in 2006 the FSA urged life insurers to reconsider the sales of creditor's group life insurance [*dantai shin'yō seimei hoken*] that was bought by the loan creditors, leaving the borrowers with no choice but to accept being insured: *http://www.fsa.go.jp/news/18/20060915-8.html* (Japanese).

72 KOZUKA / LEE, *supra* note 3, 83, 84.

dling fraudulent claims on accident insurance tended to show their understanding on the burden of proof,[73] and the majority supported the insurer's argument.

On 20 April 2001, the Supreme Court[74] held that those who claim insurance benefits against the insurer must bear the burden of proof that the event occurred accidentally (hereafter "Supreme Court 2001 judgment"). The Supreme Court justified this conclusion by understanding that the exclusion clause was just meant to draw the attention of the insured. More decisively, the Court raised a policy consideration as follows: any other course of action might raise the possibility of making dishonest claims easier; such a situation could threaten the sound operation of insurance and might lead to jeopardizing the interests of insured parties of good faith.

Since then, lower courts judging suspicious claims on accident insurance have followed the ruling of Supreme Court 2001.[75] Non-life insurers, who enjoyed a taste of success in accident insurance, started to argue in other types of indemnity insurance that the insured has to prove the accidental occurrence of the event insured. This argument was based on the definition of an indemnity insurance contract in Article 629 Commercial Code before amendment, which stated that an indemnity insurance contract shall be effective when an insurer promises to indemnify damages that may arise from a certain "accidental" event. Accidental occurrence of the insured event was argued to be by nature a hidden condition of the covered risk.

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73 Judgments that allocated the burden of proof explicitly to the insured: Tokyo District Court, 4 July 1991, Hanrei Jihō 1409 (1992) 115 = Hanrei Taimuzu 779 (1991) 268; Fukui District Court (Takefu Branch), 22 January 1993, Hanrei Taimuzu 822 (1993) 261; Nagano District Court (Ina Branch), 11 November 1996, Hanrei Taimuzu 946 (1997) 259; Tokyo High Court, 16 October 1997, Hanrei Taimuzu 962 (1997) 230; Fukuoka High Court, 22 January 1998, Hanrei Taimuzu 982 (1998) 256; Tokyo District Court, 26 January 1998, Hanrei Taimuzu 982 (1998) 263; Takamatsu High Court, 15 June 1998, Hanrei Taimuzu 986 (1998) 286; Fukuoka High Court, 29 June 1998, Hanrei Taimuzu 1019 (1999) 233; Osaka High Court, 18 March 1999, Hanrei Jihō 1691 (1999) 143; Yamaguchi District Court (Tokuyama Branch), 24 November 1999, Kōtsū Minshū 32-6 (2001) 1843; Tokyo District Court, 10 May 2000, Kin'yū Shōji Hanrei 1099 (2000) 42.
On the other hand, judgments that allocated the burden of proof explicitly to the insurer after 1990: Kobe District Court, 18 July 1996, Hanrei Jihō 1586 (1997) 136; Kobe District Court, 26 August 1996, Hanrei Taimuzu 934 (1996) 275.

74 Minshū 55-3, 682 (life insurers' products); Hanrei Jihō 1751 (2001) 171 = Hanrei Taimuzu 1061 (2001) 68 (non-life insurers' products).

75 Ōtsu District Court, 28 August 2001, Kōtsū Minshū 34-4 (2002) 1106; Nagoya High Court (Kanazawa Branch), 29 August 2001, Hanrei Taimuzu 1198 (2006) 263; Kobe District Court (Amagasaki Branch), 29 March 2002, Hanrei Taimuzu 1145 (2004) 232; Yamagata District Court (Shinjō Branch), 6 June 2002, Kin'yū Shōji Hanrei 1162 (2002) 45; Okayama District Court (Kurashiki Branch), 23 March 2007, Kōtsū Minshū 40-2 (2008), 409; Osaka District Court, 12 March 2008, Hanrei Jihō 2079 (2010) 118; Osaka District Court, 23 March 2009, Kin'yū Shōji Hanrei 1334 (2010) 42; Fukuoka High Court, 2 October 2009, Hanrei Jihō 2059 (2010) 139; Osaka District Court, 7 July 2011, Kōtsū Minshū 44-5 (2012) 1121.

Soon, some lower courts supported the insurers' argument by referring to the Supreme Court 2001 judgment,[76] but in 2004 the Supreme Court denied the insurer's interpretation in the fire insurance case,[77] then similarly in 2006 in two cases on motor vehicle insurance[78] and in other cases on all-risk tenancy composite insurance.[79] Even where theft of automobile is concerned, although the notion "theft" normally includes things that are taken away by others against the owner's will, in 2007 Supreme Court rejected the insurer's argument and held that the insured had only to prove the superficial fact that the automobile was taken away by somebody other than the insured, and the insurer had to prove that the taking away of the automobile was caused by the will of the insured.[80]

In all these decisions, it was clearly recognized that the "accidental" in Article 629 Commercial Code meant that it is uncertain whether the risk was realized at the time of placing the contract. As this understanding had been widely supported among academics and industries, the change of insurers' interpretation was abrupt, self-centered, and lacked sufficient theoretical justification. The timing was worst for the industry. As mentioned earlier, since the FSA in 2005 detected evidence of a life insurer's unjustifiable refusal of paying insurance benefits, the FSA was always very active to detect undue nonpayment of insurance benefit. The FSA ordered insurers to improve their overall management and administration system to deal with insurance claims fairly. Receiving this following wind, the Supreme Court reacted very quickly and consistently to contain the issue of accidentality. From the insurers' point of view, the only decision that survived in the headwind was the first judgment on accident insurance.

From the consumer side, the enactment of Article 80 Insurance Act was expected to be a turning point. Article 80 explicitly provides that an event intentionally provoked by a policyholder, an insured, or a beneficiary is a statutory exemption from the insurer's duty, and now Article 10 Consumer Contract Act is no doubt applicable to accident insurance. A lower court, however, held that the policy clause of an accident insurance

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76 Nagoya District Court, 1 February 2002, Lex-DB 28070993 (Burglary Insurance of Yacht and Motorboat); Tokyo High Court, 30 January 2003, Hanrei Jihō 1817 (2003) 153 (Fire Insurance); Maebashi District Court, 25 July 2003, Lex-DB 28082631 (Fire Insurance); Nagoya High Court, 28 October 2003, Hanrei Taimuzu 1152 (2004) 262 (Fire Insurance); Nagoya District Court, 23 January 2004, Kōtsū Minshū 37-1 (2005) 131 (Automobile Liability Insurance); Osaka High Court, 4 March 2004, Minshū 58-9, 2438 (Fire Insurance); Fukuoka High Court, 16 September 2004, Hanrei Taimuzu 1192 (2006) 283 (Automobile Vehicle Insurance).

77 Minshū 58-9, 2419.

78 Supreme Court, 1 June 2006, Hanrei Taimuzu 1218 (2006) 187 (submersion of vehicle); Supreme Court, 6. June 2006, Hanrei Taimuzu 1218 (2006) 191 (scratch).

79 Supreme Court, 14 September 2006, Hanrei Jihō 1948 (2006) 164 = Hanrei Taimuzu 1222 (2007) 160.

80 Supreme Court, 17 April 2007, Minshū 61-3, 1026; Supreme Court, 23 April 2007, Hanrei Jihō 1970 (2007) 106.

which defines the injury as a sudden, external, and accidental event is not a breach of Article 10 Consumer Contract Act.[81]

6. Insurer's Right to Rescind Contract for Grave Cause

a) Historical Development of the Rule

As shown above, not a few defensive measures against fraudulent claims turned out to be unjustifiable or needed restrictive interpretation. This was why the Insurance Act did not adopt defensive measures other than the provisions on insurers' rescission rights for grave cause (Art. 30, 57, 86).

This rule was originally developed in order to discharge life insurers from contracts where insurance benefits were claimed in bad faith and such claims were likely to be repeated. In order to achieve this goal, the theoretical basis of this doctrine was sought in the general rule of good faith (Art. 1 para. 2 Civil Code) and in rules on the termination of long-term contracts, such as labor contracts, on the grounds that the trust relationship was destroyed (special rescission right based on good faith [*tokubetsu kaiyaku-ken*]).

There was a debate as to the effect of rescission of contracts. Promoters who offered its theoretical basis argued that when contracts were rescinded, insurers should be discharged from their duty retrospectively from the time the trust relationship was destroyed.[82] The situations are quite similar or worse than the aggravation of risk attributed to the insured's acts or behaviors (Art. 656 Commercial Code prior to amendment). At the time of debate, the desirable effects of aggravation of risk were considered an insurer's rescission right, and exemption from the insurer's duty was retroactive to the time the risk was aggravated (as adopted in Art. 31 para. 2 no. 2, 59 para. 2 no. 2, 88 para. 2 no. 2 Insurance Act), and this rule was argued to be analogically applied. Opposing observers disagreed with this opinion and denied the retroactive effect, insisting that general civil law rules should be followed.[83]

In 1985, the first case that applied the theoretical rule of special rescission rights appeared.[84] In this case, an insured of a life insurance policy first committed a murder, disguised the murdered body as himself, and made the beneficiary claim the benefits in order to repay his loan. Soon after, the disguise of murder was revealed and the insured committed suicide. The court affirmed that the contract should be terminated and the insurer was discharged from its duty.

In 1987, life insurers amended their policy conditions and adopted a clause on rescission rights for grave cause (hereafter "Rescission Clause"). The policy terms allowed the

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81 Osaka High Court, 17 September 2009, Kin'yū Shōji Hanrei 1334 (2010) 34.

82 M. NAKANISHI, *Shōgai hoken keiyaku no hōri* [Doctrines on Accident Insurance Law] (1992) 323, 374.

83 YAMASHITA, *supra* note 50, 258.

84 Osaka District Court, 30 August, 1985, Hanrei Jihō 1183 (1986) 153 = Hanrei Taimuzu 572 (1986) 82.

insurer to rescind the contract (1) when an insured event is intentionally committed by a policyholder, insured, or beneficiary; (2) when a claim for benefits is made fraudulently; (3) when a total amount of benefits is excessively large and that might cause an abusive use of insurance; or (4) other situations where a damaged trust relationship between the insurer and the insured lowers the expectation to continue the contract.

Since then, lower courts have been fond of applying the clause in cases where fraud was suspected.[85] In applying the Rescission Clause, there was confusion in the case law about the retroactive effect of the rescission. As to the effect of rescission, the Rescission Clause provided that the clause concerning duty of disclosure shall be applied *mutatis mutandis*. On the analogy of duty of disclosure, insurers intended to treat the rescission as if the contract were terminated retroactively from the very beginning. But there is no justifiable reason to nullify the contract from the very beginning, far before the time when the trust relationship was destroyed.

b) Rescission for Grave Cause in the Insurance Act

The Insurance Act entrusted the defensive measure against fraudulent claims to the insurer's rescission right. Under the Insurance Act, the rules on this rescission right were made widely applicable to all sorts of insurance. The provisions were made semi-mandatory in order to rationalize the conditions and effect, and prohibit over-defensive contract terms.

As to the effect of the rescission, its retroactive effect is clearly provided. By the rescission the contract shall be terminated in the future, no retroactive effect, but the insurer shall be discharged from its duty retroactively to the time when the trust relationship between the insurer and policyholder etc. was destroyed. Where it is possible to prove that the trust relationship was destroyed before the insured event occurred, the insurer will be discharged from its duty by rescinding the contract for grave cause. Where the destruction of a trust relationship and the commitment of an insured event coincide, the insurer is not able to be discharged from its duty by rescinding the contract. The insurer has to prove that the committed event falls under one of the exclusions.

If a policyholder, insured, or beneficiary intentionally provokes – or tries to provoke – an insured event for the purpose of obtaining insurance benefits, the insurer is entitled to

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85 Tokyo District Court, 18 September 1995, Hanrei Taimuzu 907 (1996) 264; Hiroshima District Court, 10 April 1996, Hanrei Taimuzu 931 (1997) 273; Osaka District Court, 22 February 2000, Hanrei Jihō 1728 (2001) 124; Gifu District Court, 23 March 2000, Kin'yū Shōji Hanrei 1131 (2001) 43; Sapporo High Court, 30 January 2001, Hoken Jirei Kenkyū-kai Repōto 178 (2003) 1; Fukuoka High Court, 27 March 2003, Hoken Jirei Kenkyu-kai Repōto 189 (2004) 1; Tokyo District Court, 25 June 2004, Hoken Jirei Kenkyū-kai Repōto 197 (2005) 5; Oita District Court, 28 February 2005, Hoken Jirei Kenkyū-kai Repōto 213 (2007) 14; Sendai District Court, 28 November 2007, Lex-DB 25472692; Nagoya District Court, 30 November 2007, Hoken Jirei Kenkyū-kai Repōto 233 (2009) 7; Sendai High Court, 5 September 2008, Lex-DB 25472691.

rescind the contract (Art. 30 no. 1, 57 no. 1, 86 no. 1). In examining the purpose of the wrongdoer, it could be helpful to argue that the policyholder violated his or her duty to disclose other insurance contracts, and such a fact could enable the insurer to persuade the judges that the policyholder had a bad faith intention from the very beginning of the contract. But, as far as no. 1 of Articles 30, 57, or 86 are concerned, the insurer's duty cannot be discharged beyond the point of commitment to the insured event. For insurers to gain discharge from their duty, they must prove that the destruction of the trust relationship was made before the insured event occurred. This would mean that the breach of duty to disclose other insurance came closer to the defense due to fraud (Art. 96 Civil Code).

Where a policyholder, insured, or beneficiary commits – or tries to commit – a fraud in making claim to insurance benefits, the insurer is entitled to rescind the contract (Art. 30 no. 2, 57 no. 2, 86 no. 2). The retroactive effect can be useful if the claims for insurance benefits are repeated and there is insufficient evidence of a fraudulent claim regarding the second claim, but the insurer finds sufficient evidence to prove that the first claim is groundless and made by fraud. In this case, the insurer is entitled to reject both of the claims, because the first claim is groundless, and as an effect of the rescission the insurer is discharged from the second claim.

There is a controversy over the scope of Article 30 no. 2. Under Article 30 para. 2, the point of the destruction of a trust relationship occurs at the time a fraudulent claim is made. If an insured suffered a loss to be indemnified by indemnity insurance, and he or she tried to make a claim with an excessively exaggerated amount of damages, it could constitute a fraudulent claim as well as a breach of duty to explain the details of the event. In this case, the point when the trust relationship was destroyed was at the time of making a claim based on the false statement. The insured event occurred before such a claim was made, thus making it impossible for the insurer to be discharged by rescinding the contract.

The question is whether the insured's duty to explain the details of the event is within the scope of the semi-mandatory provision of Article 30 no. 2. If we see that rescission for grave cause is a provision to determine the conditions under which insurers are entitled to terminate contracts, then the duty to explain the details of the event has nothing to do with the rescission, and the policy clause that prescribes the exemption of the insurer's duty is outside the scope of the semi-mandatory provision of Article 30.[86]

On the contrary, if we see Article 30 as setting minimum standards of policyholder protection against the insurer's inclination toward wider exemption from its duty, then we have to say that it would violate the semi-mandatory character of Article 30 to prescribe a contract term which would enable the insurer to be discharged from its duty on

86 T. YAMASHITA, *Hoken-hō to hanrei hōri e no eikyō* [The Insurance Act and Its Influence on Case Law], Jiyū to Seigi 60-1 (2009) 29; H. SUZAKI, Hoken keiyaku no kaijo ni kansuru ichi-kōsatsu [A Commentary on the Rescission of Insurance Contract], Hōgaku Ronsō 164, 1-6 (2009) 242.

the grounds that the insured made a claim with a false statement. Such contract terms prescribe a wider retroactive effect[87] against a less wicked breach of duty than that of Article 30 no. 2. Following the Supervisory Guidelines of the FSA, there are no longer policy terms to prescribe that the insurer is exempted from its duty where the insured violated his or her duty to explain the details of the event insured.

IV. CONCLUSION

The legislation process of the Insurance Act was a good opportunity to look back at the achievements of case law. We must not forget a number of other cases that could not be examined here, but at present it may well be confirmed that a vast majority of case law is a battle in a relatively narrow field of the whole insurance business, and the range of issues is also quite limited. Consumer protection is likely to be promoted only where insurers go beyond the fair defense zone and seek to establish a more effective defense system. In such cases, policyholders' interests are actually not significantly improved; instead, they have just recovered the position they ought to occupy. From this point of view, it would be misleading to call the Supreme Court's exceptionally active period from 2005 to 2008 "judicial activism."[88]

There is a considerable possibility that the active response of the Supreme Court was merely a transient fever. Without the timely information fed by the on-site investigation of the FSA, and without the support of public opinion against the undue nonpayment of insurance benefits, courts might not have stepped in with freedom of contract. The case law trend in Japanese insurance law cannot be separately examined without the policy priorities of the FSA. Of course, there is another possibility that still remains. The result of the obligation law reform may again fuel the courts to detect a wider range of issues to be discussed.

As to the innate issues on insurance law, we must fill in the blank spheres of the Insurance Act. Now we have well-crystallized provisions on aggravation of risk and an insurer's rescission right for grave cause. These would be good tools to regulate some aspects of over-defense or attempts to seek exemption from the insurer's duty combined with termination of contract. On the other hand, we do not have sufficient criteria for reviewing exclusions without terminating contracts. This imbalance could lead insurers to prefer exclusion clauses with a wider range of application. It would be one of our next missions to establish a more workable framework of reviewing policy clauses to strike a balance between the freedom of contract and reasonable expectations of the insured.

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87 HAGIMOTO, *supra* note 9, 103.
88 KOZUKA / LEE, *supra* note 3, 76.

SUMMARY

The Japanese Insurance Act (hereafter "the Act"), enacted in 2008, is more concise than corresponding laws in major European countries. This paper tries to explain the Act's concise form by examining discussions during the Act's preparation, the influence of the reform of the law of obligations, the supervisor's regulatory practice and, above all, trends of insurance case law in Japan.

The Act included a very limited number of provisions applicable only to a certain type of insurance. Freedom of contract was respected to promote product innovation and flexibility in the insurance industry. Unlike in the EU, the ex ante product control over the mass market products survives until now. Under such circumstances, the Japanese insurance market experienced diversification of products since 1995. On the other hand, the dominant influence of supervisory body prevented rules concerning product disclosure from being incorporated into the Act.

The Act also does not contain specific rules where the general contract law is applicable. It was difficult to extend the protection of the weaker party in the Act before the obligation law reform was commenced. Just after the Act was enacted, the Tokyo High Court tried to set a higher standard of consumer protection by nullifying a policy clause as unfair in the case of nonpayment of premium. Thus, the level of protection for the weaker party in Japan is determined by regulatory practice and case law. Reading through the Supreme Court cases, the Court does not seem to distinguish between consumers and small and medium-size business entities when interpreting policy clauses.

In Japan, the largest cluster of insurance law cases is that concerning fraudulent claims. In defending against such claims, insurers were tempted to apply a series of policy clauses which were expected to enable insurers to decline such claims under easier conditions. However, in such cases lower courts tended to restrict the literal meaning of the policy clauses. Soon insurers started to argue that the accidentality of the insured event should be proved by the insured or the beneficiary, but the Supreme Court from 2004 until 2007 repeatedly declared that the burden of proof with regard to accidentality is on the insurers.

The attitude of the Supreme Court against the insurers' excessive defense was a natural response to an industry-wide scandal. In 2005 the supervisory authority detected a huge number of intentional or negligent nonpayment of insurance benefits. It was the worst period for insurers to ask the legislator to authorize their defense clauses. Among the anti-fraud defenses, insurers' right to rescind a contract for grave cause was exceptionally incorporated into the Act. Still, the provisions are characterized as semi-mandatory in order to create a safeguard against insurers' excessive defense seeking to discharge their duties. The trend in the anti-fraud case law was attributable to the insurers' excessive defense. It would be misleading to call the Courts' response judicial activism. Whether consumer protection will be promoted under the Act cannot be foreseen without taking the policy priorities of the supervisor and the result of obligation law reform into consideration.

ZUSAMMENFASSUNG

Das japanisches Versicherungsgesetz von 2008 (im folgenden „das Gesetz"), ist knapper als die entsprechenden Gesetzeswerke in wichtigen europäischen Staaten. Der Beitrag versucht den geringeren Umfang zu erklären, indem er die Diskussion während der Gesetzesvorbereitung, den Einfluss der Schuldrechtsreform, die Praxis der Finanzaufsicht und, insbesondere, die Entwicklungen der Rechtsprechung auf dem Gebiet des japanischen Versicherungsrechts untersucht.

Das Gesetz erhält nur wenige Vorschriften, die nur für bestimmte Versicherungsarten anwendbar sind. Der Vertragsfreiheit wurde Vorrang eingeräumt, um die Produktinnovation und die Flexibilität in der Versicherungswirtschaft zu fördern. Anders als in der EU, gibt es in Japan noch heute eine Produktkontrolle ex ante. Aber deswegen sind Versicherungsprodukte in Japan seit 1995 sehr diversifiziert. Der dominante Einfluss der Aufsichtsbehörde hat verhindert, dass Regeln zu den privatrechtlichen Produktinformationspflichten in das Gesetz aufgenommen wurden.

Das Gesetz enthält nur wenige Spezialregeln, wo die Regeln des allgemeinen Vertragsrechts anwendbar sind. Es war schwierig, einen weitergehenden Schutz der schwächeren Parteien in das Gesetz aufzunehmen, bevor die Schuldrechtsreform begonnen wurde. Nun hat, nach Inkrafttreten des Gesetzes, das Obergericht Tokyo versucht, in die Angemessenheitskontrolle einer AVB-Klausel (betreffend den Verzug mit der Zahlung von Versicherungsprämien) ein höheren Niveau des Verbraucherschutz zu bringen. Das Schutzniveau für die schwächere Partei in Japan wird von der Aufsichtspraxis und der Rechtsprechung bestimmt. Die Rechtsprechung des Obersten Gerichtshofs unterscheidet bei den Auslegung von AVB-Klauseln nicht zwischen Verbrauchern und kleinen und mittleren Unternehmen.

Die größte Fallgruppe in der japanischen Rechtsprechung zum Versicherungsrecht betrifft die arglistige Beanspruchung von Versicherungsleistungen. Gegen derartige Ansprüche macht der Versicherer Einwendungen aufgrund verschiedener AVB-Klauseln geltend, gemäß denen Versicherer die Leistung unter leicht zu erfüllenden Voraussetzungen ablehnen zu können. Aber in solchen Fällen legen die Gerichte die AVB-Klauseln häufig einschränkend aus. Versicherer haben die Ansicht vertreten, dass der Versicherte oder der Bezugsberechtigte die Zufälligkeit des versicherten Ereignisses beweisen müsse. In den Jahren zwischen 2004 und 2007 hat aber der Oberste Gerichtshof wiederholt entschieden, dass die Beweislast insoweit beim Versicherer liegt.

Die strenge Linie des Obersten Gerichtshofs war eine natürliche Reaktion auf einen umfangreichen Skandal. Die Finanzaufsicht hatte seit 2005 zahlreiche Fälle aufgedeckt, in denen entweder vorsätzlich oder fahrlässig Versicherungsleistungen rechtswidrig nicht gezahlt wurden. Dies war ein denkbar ungünstiger Zeitpunkt für die Versicherungswirtschaft, um den Gesetzgeber um die Aufnahme eines Abwehrrechts ins Gesetz zu bitten. Als Ausnahme wurde lediglich ein Kündigungsrecht des Versicherers wegen gravierender Gründe in das Gesetz aufgenommen. Dabei handelt es sich um eine halbzwin-

gende Vorschrift, womit man einen Schutz gegenüber einer exzessiven Verteidigung des Versicherers schaffen wollte. Die Entwicklung der Rechtsprechung bei der Betrugsbekämpfung war geprägt durch die übermäßige Verteidigung der Versicherer. Es wäre deshalb missverständlich, das Verhalten der Gerichte als 'richterlichen Aktivismus' zu bezeichnen. Ob der Verbraucherschutz unter dem Gesetz weiter gestärkt werden würde, kann niemand voraussehen, ohne die Prioritäten der Finanzaufsicht und das Ergebnis der Schuldrechtsreform zu berücksichtigen.