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Definition of a claim in professional liability insurance

The Federal Court confirms a strict interpretation

Par Philipp Fischer le 13 May 2025

When several clients are harmed in the same case of fraud, an important question arises in insurance : is this a single claim or several claims ? In its ruling 4A_626/2024 of 21 March 2025, the Federal Court answered in the affirmative. It upheld an arbitration award that denied a bank any insurance coverage on the grounds that each claim by an aggrieved customer had to be considered a separate claim, subject in particular to a separate deductible. The ruling highlights the importance of reviewing insurance policy clauses.

An employee of a Swiss bank embezzled funds belonging to around 70 clients over a period of several years. The bank compensated the clients to the tune of around CHF 11 million and then asked its professional liability insurer to cover the loss. The insurance policy provided for an excess of CHF 2.5 million per claim. The insurer refused cover, arguing that there were as many claims as there were customers affected and that no compensation exceeded the excess. The arbitral tribunal ruled in favour of the insurer. The bank then appealed against the arbitral award to the Federal Court.

The heart of the dispute lies in the interpretation of the deductible clause, which raises the following question : should the compensation paid to customers be interpreted as a single claim or treated separately ?

The Federal Court first noted that, according to Art. 393(e) CPC, an arbitral award may be challenged on the grounds that it is arbitrary in its outcome because it is based on findings of fact that are manifestly contrary to the case file or on a manifest violation of law or equity (consideration 2.1). It emphasises that this requirement implies considerable restraint on the part of the Federal Court.

In the present case, the Federal Court finds that the arbitral tribunal considered each claim to be a separate claim, insofar as the fraudulent acts of the employee were individualised. The arbitrators noted that ‘Although NL’s [the bank employee] wrongdoings were of the same nature and may have followed a similar pattern, it is not disputed by Claimant that NL had to decide independently for each customer when to sell the options (and in what amount) and when and to what amount customer funds should be used for illegal purposes, in particular to hide earlier malversations.’ (consideration 2.2). They therefore held that this was not a single event, but a series of separate claims.

The Federal Court confirmed that the interpretation adopted was based on reasoned findings of

fact and a defensible reading of the insurance contract. It criticises the appellant for failing to recognise the narrow scope of the complaint of arbitrariness within the meaning of Art. 393(e) CPC with regard to the establishment of the facts. The criticisms raised do not reveal any obvious contradiction with the case file, but essentially concern the arbitral tribunal's assessment of the statements and evidence produced. It notes in particular that even if the disloyal employee was following a general strategy and had an overview, she still had to decide 'für jede einzelne Kundenbeziehung', i.e. for each individual customer relationship, when and to what extent to sell the options (consideration 2.3). According to the Federal Court, this justifies considering each case of fraud separately. It concludes that there is no arbitrariness in this case.

Even though the Federal Court's review was limited to arbitrariness in view of the arbitration clause (which is not unusual in general insurance terms and conditions), this ruling shows the very concrete effects that imprecise wording in an insurance contract can have. In the absence of a clause allowing all misappropriations to be considered as a single claim, each case was treated separately, resulting in the application of a deductible to each claim. The threshold of CHF 2.5 million was not exceeded in any case, and the bank therefore received no compensation from its insurance company, despite total damages of CHF 11 million.

This ruling offers an important lesson for banks : when damage may result from similar acts affecting several customers, it is essential that insurance policies allow them to be grouped together. Otherwise, insurance cover may not apply, even in the event of significant loss. This applies above all to internal fraud, but could also, depending on the circumstances, concern other situations such as a technical incident affecting several customers.

Finally, the ruling illustrates the Federal Court's restraint in reviewing arbitral awards. Even a questionable interpretation of a contract is not sufficient to render the decision arbitrary within the meaning of Art. 393(e) CPC, the application of which remains strictly limited. This reinforces the responsibility of the parties when drafting and negotiating insurance policies and must be taken into account when assessing whether or not to resort to arbitration as a means of dispute resolution.
